Mental Illness-Related Structural Stigma:

The Downward Spiral of Systemic Exclusion Final Report

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MENTAL ILLNESS-RELATED STRUCTURAL STIGMA

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EXECUTIVE SUMMARY

Increasingly, governments, non-governmental organizations, and private corporations in Canada and around the world are mobilizing resources towards preventing and addressing mental illness-related stigma. The Mental Health Strategy for Canada [1] highlights the need to "fight stigma by including opportunities in promotion, prevention and early intervention initiatives to meet and talk with people living with mental health problems and illnesses" (p. 23) and to "review and, where necessary, update legislation and revise policies across jurisdiction and sectors to achieve alignment with the UN Convention on the Rights of Persons with Disabilities" (p. 45). In addition, the Mental Health Commission of Canada initiated Opening Minds in 2009, which is a systematic effort to reduce stigma related to mental illnesses, with a specific emphasis on healthcare providers, youth, media, and the workforce. At the same time, many Canadian provinces and territories have released long-term mental health plans that identify stigma-reduction as a priority for action [e.g., 2,3,4].

Across multiple life domains, people with mental illnesses must contend with arbitrary restrictions on their rights and opportunities—even in countries with advanced legislative protections against discrimination, such as Canada. Stigma cannot be eradicated without attending to structural stigma; that is, the inequities and injustices that are woven into the policies and practices of our institutional systems. Despite the dearth of empirical evidence about how to address mental illness-related structural stigma effectively, there is a robust body of knowledge offering brilliant ideas about the most promising methods for beginning to break down the structural barriers facing people with mental illnesses.

This report summarizes what is known about mental illness-related structural stigma. It begins with an overview of the concepts of stigma and structural stigma, including how they are understood by contemporary scholars. The report then outlines the different ways in which structural stigma manifests in modern institutional systems and social contexts, including: healthcare; employment and income; housing; education; criminal justice; privacy; public participation; travel and immigration; media; and reproduction and parenting. It is apparent there are few areas of social policy affecting people with mental illnesses that remain untainted by stigma. The final sections of the report synthesize the existing knowledge pertaining to addressing structural stigma. The most promising methods involve a combination of legal and policy action, advocacy, inclusive efforts, healthcare reform, education, and research.

PREAMBLE

This work was funded by the Mental Health Commission of Canada, which requested that a narrative literature review be conducted on the topic of structural stigma, including: (a) the definition, origins, and nature of structural stigma; (b) examples of how it manifests in today's society; (c) promising avenues for producing structural change to promote greater equity for people with mental illnesses; and (d) specific case examples of systematic change.

The narrative review process began in March 2013 with a comprehensive search of the literature by entering keywords (e.g., structural stigma, institutional stigma, institutional violence, structural discrimination) into several electronic databases (e.g., Web of Knowledge, JSTOR, Google Scholar, CINHAL). Literature pertaining to mental illness, other health conditions (e.g., HIV/AIDS) and disabilities, race/ethnicity, sexuality, gender, and was included. This process generated over 160 relevant articles, books, and reports that were reviewed and synthetized. The report was written deliberately with an emphasis on Canadian examples of structural stigma and efforts to address it.

This is not a best practice document. The recommended strategies contained herein for reducing mental illness-related structural stigma are based primarily on an accumulation of wisdom-based knowledge as opposed to scientifically validated evidence. As such, this report identifies approaches and strategies that, based on a range of information sources (e.g., expert opinions, lived experiences, and research in different contexts), hold promise for effectively addressing structural stigma.

WHAT IS STIGMA?

As a result of [...] over-arching social and economic circumstances, individuals with schizophrenia are systematically excluded from full participation in civic and social life, and are constrained to live lives that are shaped, in large part, by stigma, isolation, homelessness and the denial of basic human rights.

Kelly [5]

Illnesses are comprised of biological, psychological, and social dimensions [6,5,7]. The biological dimension includes features related to genetics, neurochemistry, anatomy, and medical interventions (e.g., medications). It also encompasses the functional impairments and limitations directly created by an illness, such as the inability to see or walk in the case of blindness or paraplegia, respectively. The psychological dimension relates to how people think and feel about themselves and the world around them, which can be affected by an inherent characteristic of an illness (e.g., symptom) or as an indirect response to the illness. For instance, whereas depression directly affects a person's long-term emotional state, living with a physical illness, such as HIV/AIDS or cancer, can have an indirect, but significant, negative effect on an individual's mood. Finally, the social dimension encompasses how illnesses, and the people who live with them, are viewed and dealt with by society. Few would disagree that social, economic, and political forces play a significant role—beyond an individual's biology and psychology—in shaping the health and well-being of people who live with a mental illness.

Stigma is principally a psychological and social phenomenon. It is first and foremost a social process that aims to exclude, reject, shame, and devalue groups of people on the basis of a particular characteristic [8]. Through time, society identifies certain attributes as being socially significant, and collectively defines them as abnormal, unacceptable, and deserving of formal and informal condemnation [9,10]. This is the key for stigma: most socially relevant attributes are not inherently significant or problematic but, rather, through a complex social process they become defined and treated as such. Although stigma may manifest in how people think, feel, and act toward others who are deemed to be different, it is a product of the social context that allows the denigration of difference to exist [11].

Therefore, stigma reveals more about society than it does about individuals who carry stigmatized characteristics or persons who harbour negative beliefs about others. It sheds light on who in society has access to the power and privilege necessary to define rules and apply sanctions for violating them [12,13]—those who do, become the beneficiaries of stigma; those who do not, become its subjects [14]. In turn, the subjects of stigma are redirected on a path where their identities are engulfed, their relationships transformed, and the direction of their lives shifted because they have been marked by a stereotyped attribute [15,11]. The negative effects of stigma are intersecting and cumulative, such that inequities and injustices amass across time, generations, and contexts. For example, a single mother who is denied a job because she lives with a mental illness may, as a consequence, have difficulty finding decent (e.g., affordable, stable, secure, healthy) housing in a safe neighbourhood, which can influence her and her children's' life chances [16]. Undoubtedly, stigma can produce a negative spiralling effect on the life course of people with mental illnesses, which tends to create 'downward social drift', or a decline in social class [17]. Of course, this is not inevitable; many people successfully resist [18,19].

These ideas are reflected in the most influential conceptualization of stigma to date. Drawing from classical labeling theorists in sociology[i], Link and Phelan [25] define stigma as the process whereby labeling, stereotyping, separation, status loss, and discrimination co-occur in the context of power. Labeling refers to the social process of constructing

[i] See, for instance: [10,20-24]

and applying oversimplified, socially salient categories of human difference. Through this process, labeled persons are believed to be distinctly different. Stereotyping involves cultural endorsement of the association between social labels and undesirable characteristics. In the next component, separating 'us' from 'them', persons bearing a stereotyped label are set apart and isolated from the rest of society. Thus, a "stigmatized them" is created [25]. The preceding components can then lead to devaluation, rejection, and exclusion of certain groups, which creates social disadvantage and loss of social status.

It is important to highlight three aspects of the framework advanced by Link and Phelan [25] and embraced by the current report. First, the construct of stigma encompasses both status loss and discrimination. Although some scholars prefer to distinguish between stigma and discrimination [e.g., 26,27], a sociologically-informed definition of stigma blends the attitudinal and behavioural dimensions. Maintaining a division between stigma and discrimination does not make sense when stigma is framed in a non-individualistic, multi-dimensional, and multi-level manner grounded in a common understanding of the concept. Second, the production of stigma is contingent on social, economic, and political power [25]. Privileged groups maintain their advantage and authority in society by using stigma as a tool to prevent others from gaining access to power and resources [28]. Third, and relatedly, stigma spans micro- and macro-levels [29,30][ii]. As such, it is useful to think about stigma as existing on three interacting and mutually reinforcing levels: self, social, and structural [33,11,34].

Self-stigma exists at the individual level and involves the perceptions and experiences of those who possess stigmatized attributes. Individuals with stereotyped characteristics, such as a mental illnesses, are socialized into believing that they are devalued members of society, which leads to adopting negative feelings about self, engaging in maladaptive behaviour, and identity transformation [35]. Individuals who feel devalued have a tendency to modify their social expectations such that they settle into their low social position; they may not seek to advance their social status (either through education or work) or they may be reluctant to challenge the barriers standing in their way to a better life [36,37]. Research indicates that mental illness-related self-stigma is associated with hopelessness, poorer self-esteem, disempowerment, reduced self-efficacy, and decreased quality of life [35].

Social stigma exists at the group level and refers to community members who judge particular traits to be contrary to community norms and behave in a harmful manner, either through action or inaction, towards individuals who possess the devalued attribute [38,33,39]. It is produced by the individual and collective beliefs of dominant members of society, from which the rules of engagement take shape and acceptable ways of behaving toward oppressed groups are defined [28]. It is expressed behaviourally during interpersonal interactions, which is why the terms 'individual' and 'interpersonal' discrimination are often used to describe this form of stigma [29,25]. Social stigma provides fertile ground for the production of self- and structural stigma. For instance, an individual who believes that all people with schizophrenia are dangerous may be disinclined to befriend anyone with a mental illness (contributing to self-stigma) and may be supportive of coercive mental health interventions (contributing to structural stigma). Scholars of racism and sexual prejudice have observed that social stigma in modern society is more likely to be expressed subtly (also known as aversive racism or modern prejudice), since there is growing social pressure against overt and blatant forms of prejudice and discrimination [40,41]. Research examining the experiences of people with mental illnesses has also documented these subtle, yet significant, forms of stigma that unfold in different social contexts such as the workplace [e.g., 42].

Although this report is principally focused on mental illness, it is important to recognize the relevance of a broad range of characteristics and statuses to which stigma theories have been applied. Many scholars believe that exclusionary processes produced by race/ethnicity, gender, age, class, sexual orientation, and different types of disabilities share

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[ii] Other conceptual models that provide a framework to link stigma at micro- and macro-levels include the Ecological Approach to Stigma [31] and the Framework Integrating Normative Influences of Stigma [32].

similarities with the stigmatization of mental illnesses [43,28]. Non-dominant groups in society share histories of systematic oppression, segregation, denial of basic human rights, and depletion of social, economic, and political resources. In Canada, for example, there is a striking resemblance between the historic treatment and current realities of Aboriginal peoples and persons who live with a mental illness in that both groups have been subjected to systematic and direct discrimination, social dislocation, and poor social and economic conditions [44].

In addition to sharing commonalities, it is clear that stigmatized characteristics and statuses do not act in isolation. Every individual is comprised of multiple attributes (i.e., race, gender, disability status, and so on) that work together to influence a person's formation of identity, subjective experiences, and life chances [45-47]. A revealing study of almost 1,000 individuals with psychiatric disabilities in the Unites States found that many had perceived discrimination based on factors other than their mental illness. For instance, 66% of African American respondents reported racial discrimination, 34% of female respondents perceived gender-based discrimination, 83% of gay respondents reported discrimination owing to their sexual orientation, and 49% of physically disabled respondents indicated that they had been discriminated against because of their physical disability [48]. Therefore, it is important to consider multiple dimensions of inequity in any discussion about mental illness-related stigma, especially since people who experience racism, sexism, classism, and so on are at risk for experiencing poor mental health [8]. Additionally, mental illnesses commonly co-occur with other stigmatized traits, such as being economically disadvantaged, institutionalized, or having substance use problems. Research indicates that living with a mental illness amplifies existing power inequities created by the intersection of gender, race, and class [49].

A distinctive feature of disabilities is that, unlike race/ethnicity, gender, sexual orientation, or other attributes, they can cause impairment. Mental illnesses, for example, have deleterious effects on cognition, social relations, and functioning, which can exert harmful effects across multiple life domains. A person with schizophrenia may be unable to form and maintain friendships because of symptoms that increase social withdrawal and decrease motivation. Alternatively, a person with an anxiety disorder may have difficulty working because uncontrollable fear or worry gets in the way of completing tasks. Stigma exacerbates the impairment-related restrictions that are imposed on persons with disabilities [50,34]—a point that is elucidated by the social model of disability. This model, also known as the disability inclusion model, advances the view that disability arises through the interaction between individual impairment and the barriers located in the social environment (e.g., attitudinal or structural) preventing participation as a full citizen in society [51,52]. The idea that stigma is created and sustained by disabling environments is pertinent to the following discussion on the topic of structural stigma. Mental illnesses are also unlike other physical or sensory disabilities in that they often become a master status [10]; that is, a person's identity is engulfed by their illness, which dictates how they are perceived and treated by society. So, people with mental illnesses who protest against instances of structural stigma risk having their resistance disregarded, silenced, and pathologized (e.g., 'she's angry because she's not taking her medications', or 'his personality disorder causes him to act out') [52].

WHAT IS STRUCTURAL STIGMA?

*The policies and institutional practices we create to address social problems are critical for stigma –
they can induce it or they can minimize or even block it.*

Link et al. [47]

Scholars in the field of ethnic/racial and gender studies have produced much of what is known—empirically, conceptually, and theoretically—about structural stigma. In the context of mental illness, structural stigma refers to the rules, policies, and practices of social institutions that arbitrarily restrict the rights of, and opportunities for, people with mental illnesses [53,54]. In this form of stigma, dominant cultural ideology is embodied in institutional systems so that power differentials are legitimated and social disadvantages are perpetuated [33,11,55].

Inequities and injustices are woven into the fabric of society causing people with mental illnesses to have unequal access to social, economic, and political resources and power [56,57]. In turn, society becomes designed by and for people without mental illnesses. With time, stigmatizing institutional policies and practices become the norm by which society operates. Once this occurs, stigma is no longer dependent on individual action; instead, disadvantage and exclusion are routinely perpetrated by institutional systems [58]. Structural stigma is reinforced in law, internal regulations and procedures of private and public institutional systems, and the practices of professionals [59,60]. These structures conspire to preserve dominant ideologies and maintain social hierarchies [61].

Structural stigma can be intentional or unintentional [62,29,63][iii]. Intentional structural stigma requires conscious and purposeful effort to restrict the rights and opportunities of people with mental illnesses. This can be overt, such as policies that disqualify people from health insurance coverage because of having a mental illness. Alternatively, it can be covert, in which case institutions deliberately use a criterion that is strongly correlated with mental illness (i.e., a proxy) to deny equal opportunities to people with mental illnesses [63]. An example of this would be organizations who deny jobs or volunteer opportunities to individuals who have a police record, knowing that the practice causes unequal harm for people with mental illnesses who routinely use the police to access emergency mental health services. Covert structural stigma might also take the form of institutional leaders who fail to mitigate known inequities and injustices [64]. An example would be police officials who continue to support the disclosure of mental health-related information (e.g., mental health apprehensions, suicide attempts) on routine police or criminal record checks after becoming aware that such a practice arbitrarily limits the life opportunities of people with mental illnesses, such as obstructing volunteer and employment opportunities.

Unintentional structural stigma produces inequities for people with mental illnesses through inadvertent means [65]. Usually, this occurs because of people with mental illnesses being disproportionately represented in certain groups who find themselves the subject of a given social policy. For instance, 'tough on crime reforms' that impose harsher sentences for less serious offences (e.g., drug offences) will have disproportionate effects on people with mental illnesses because of the prevalence of concurrent mental health and substance use problems. Some scholars argue that unintentional forms of structural stigma are actually contemporary reformulations of past policies and practices that were designed to intentionally stigmatize [66]. Hence, structural stigma is rooted in historical practices that produce a "legacy of disparity" [39], with disadvantage reproducing across time and over generations. For example, people with

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[iii] Some scholars prefer to distinguish between institutional and structural stigma on the basis of intent, with the later construct used to describe unintentional effects [e.g., 29].

mental illnesses who were intentionally segregated from society through institutionalization remain so today through economic and social policies that keep them from becoming full members of the community.

It is worth highlighting a few things about unintentional forms of structural stigma. Firstly, although it is pervasive in society, it is quite difficult to detect and document, since it hides in the shadows and lacks overt intentionality [65]. In order to expose the reasons why people with mental illnesses experience injustices and inequities in contemporary society, multiple layers of stigmatizing social policies and institutional practices must be peeled back and connected. Scholars often cite the fact that many of today's restrictions of the rights and opportunities of people with mental illnesses are the consequence of a legacy of underfunded research and treatment for mental illnesses, relative to other health conditions [67,68], combined with modern preoccupations with cost-effectiveness in healthcare. Secondly, unintentional structural stigma can convert into an intentional form once its harmful effects become known and are not rectified by institutional leaders, such as policy-makers or healthcare planners [63]. Thirdly, intentionality is not required to support claims of discrimination. As such, legal redress can be sought for instances of unintentional structural stigma.

In a thoughtful discussion about sexual stigma and gay marriage, Herek [69] makes an important observation about structural stigma. Laws do not magically appear. Rather, they are negotiated through a social process that often involves dialogue between politicians, lobbyists, and the public—sometimes broadcast by the media. For those who are the subjects of structural stigma, this democratic process reveals, first, that their fellow citizens and elected representatives endorse stigmatizing views; second, that their fundamental rights are open for debate; and third, that they have relatively limited power to resist the dominant ideology. Moreover, although a particular law may be bounded by jurisdiction (for instance, gun control regulations concerning people with mental illnesses in the United States have no direct impact on Canadians), the social discourse surrounding the social problem spills across jurisdictional boundaries. Consequently, the existence of mental illness-related structural stigma anywhere is a global threat to an individual's sense of worth and personal security.

Not all policies and practices that restrict the rights and opportunities of people with mental illnesses are instances of structural stigma. Some restrictions and distinctions may be justified, as was observed by the BC Human Rights Tribunal: "Not every differentiation in treatment arising due to a person's mental disability, real or perceived, will be sufficient to establish discrimination [...] In some cases, differentiation in treatment is necessary in order to address people's real needs and circumstances" [70]. It may be appropriate to suspend the driver's licence of an individual living with a condition, such as moderate dementia, that is significantly impairing their cognitive abilities. Or, it may be justifiable to apprehend and hospitalize a person who is suffering from a condition, such as acute psychosis, that is causing them to behave violently towards others. How can these scenarios be differentiated from those considered cases of structural stigma?

Arbitrariness is the key criterion for structural stigma. As was articulated by the Supreme Court of Canada's Justice Abella in a case involving job accommodations for an individual with a disability: "It is the link between that group membership and the arbitrariness of the disadvantaging criterion or conduct, either on its face or in its impact, that triggers the possibility of a remedy. And it is the claimant who bears this threshold burden" [71, para. 49]. Structural stigma is likely to involve policies or practices that curtail a right or deny an opportunity based on broad categories, such as current or past diagnosis of a mental illness, rather than specific and measurable criteria based on individualized assessments of impairment, capacity, or risk. As well, it is likely to surface when restrictions are imposed on multiple life domains and social contexts, rather than on a specific activity for a circumscribed duration.

Scholars have proposed a series of questions to ascertain whether a practice or policy exemplifies structural stigma [62,72,38,73]:

- Does the institutional practice/policy contravene provisions of existing human rights statutes?

- How broad/specific is the criteria being used to restrict persons' rights or opportunities?

- How broad/specific is the domain that is being restricted?

- Are public and private institutions making reasonable efforts to assist individuals (e.g., providing services or supports) to enjoy access to the full range of rights and opportunities?

- To what extent will the restriction remain in place when the impairment diminishes?

- Do alternative methods (e.g., less restrictive or less onerous) exist that may be equally, or more, effective at achieving the same outcomes?

- Would the stigmatizing institutional practice/policy be rejected by those who may be affected?

- What is the nature and scope of harm (e.g., social isolation, health or economic inequalities) that will be produced by the institutional practice/policy in comparison to its expected benefits?

Answering these questions may be useful when preparing to raise a complaint because of mental illness-related structural stigma. The problem is that different people will likely arrive at different conclusions. For instance, determining whether an employer is making reasonable efforts to accommodate an employee depends on an individual's perception of reasonableness. Clearly, the ideology endorsed by an individual, as well as the dominant ideology in society, will exert a significant influence on their readiness to perceive structural stigma when it materializes.

The most common way in which structural stigma is expressed is in the realm of professional practices. A series of studies examining instances of institutional discrimination related to HIV/AIDS found few occurrences in legislation and policy; however, discrimination was relatively common in the unwritten procedures and practices of health service providers [74]. The existence of stigmatizing practices among health professionals is certainly echoed in research that taps into the perceptions and experiences of people with mental illnesses (as is discussed later). At this point, it should be acknowledged that not all scholars agree that the attitudes and behaviours of trainees (e.g., medical students, police cadets) and professionals are rightly placed in the 'structural' level of stigma. Certainly, the poor behaviour of a few professionals (e.g., psychiatrists, employers, police officers) should not be conceptualized as structural stigma. However, if the unfair practices of professionals in any institutional system are recurring (i.e., not isolated events), symptomatic of problems within organizational culture, tolerated or condoned by organizational leaders, and/or not rectified despite known problems, then they are indicative of structural stigma [29,59,75].

WHAT DOES STRUCTURAL STIGMA LOOK LIKE?

Canada has promised the creation of an egalitarian society, but it has systematically excluded, marginalized, and segregated its citizens with disabilities.

Kaiser [76], s. 7, para. 1

Stigma has been compared to a many-headed hydra, a Greek mythological creature, on account of its fierce ability to appear and reappear in a multitude of social domains [77]. The empirical and observational literature reveals that few areas of social policy remain untainted by the effects of stigma. People with mental illnesses are—to varying degrees—rejected, excluded, and devalued in the policies and practices of most institutional systems, such as healthcare, employment, social welfare, and housing.

Researchers have employed a range of approaches to study the nature and magnitude of structural stigma. The first approach is to survey members of the public to ascertain their willingness to endorse social policies or political decisions that are likely to curtail or advance specific rights and opportunities for people with mental illnesses. For instance, researchers have examined public support for policies that would prohibit driving licences, withdraw voting rights, or recommend terminating a pregnancy for people with mental illnesses [78]. Studies have also assessed public preferences for coercive and benevolent legislation and treatment practices, such as involuntary hospitalization, targeting people with mental illnesses [79]. Along a similar vein, surveys have investigated public support for increasing or reducing funding levels targeted toward mental healthcare [80,81].

The utility of this body of attitudinal research is that it gives insight into community members' perspectives on issues of public policy. In turn, this provides an approximation as to which political decisions might be likely to receive widespread support or opposition. The limitation of this research is that survey respondents may respond to questions in a socially desirable manner, which provides an underestimate of the magnitude of stigma that exists in society. As well, this research typically does not account for the degree to which participants are involved in the political process (e.g., vote in elections) or have the ability to influence policy-makers [82]. The presumption is that individual members of society have an equal opportunity to influence policy decisions, which does not reflect the hierarchical structure of power in society. In every democratic society, individuals with resources and power have an increased likelihood of influencing social policy; therefore, it may be that ascertaining the perspectives of these powerful few is especially important for this line of research.

A second way in which structural stigma has been studied is through policy analysis. In this type of research, the actual content of policies and statutes is scrutinized in order to uncover instances of (or protections from) structural stigma. This is a common approach that has been used to investigate discrimination pertaining to persons with HIV/AIDS [83,74]. With respect to mental illness, Corrigan and colleagues [54] reviewed almost 1,000 mental health-related bills across the United States for evidence of structural stigma. They found that structural stigma was uncommon in State legislation, with 3% of bills constricting liberties (e.g., permitting involuntary medication or compulsory community treatment), 1% promoting discrimination (e.g., restricting access to firearms, diminishing parental rights, restricting placement of mental health facilities), and 4% reducing privacy (e.g., allowing disclosure of mental health information for the purpose of public safety). Proactive protections against stigma were also scarce within the mental health bills, with 1% expanding liberties (e.g., creating options for advance directives), 1% protecting against discrimination (e.g., requiring parity mental health funding, disallowing parental mental health status to be used in child custody decisions), and 6% expanding privacy rights (e.g., prohibiting the disclosure of mental health information).

One of the most important findings of the Corrigan et al. [54] study was that the majority of bills expanding or contracting protections were based on a person's status of having a mental illness (e.g., past or present diagnosis), rather than the level of cognitive capacity or degree of functional impairment. Several scholars have underscored the fact that treating people with mental illnesses as though they are a homogeneous group, regardless of their levels of functional or cognitive impairment, is an example of structural stigma since it is clearly unjustifiable [54,84,85]. The advantage of this research approach is that it relies on an objective data source to reveal the overt presence of stigma within current social policy. The major weakness is that it grossly underestimates the pervasiveness of structural stigma, since research repeatedly indicates that stigma is more likely to materialize in institutional practices, usually guided by unwritten customs or procedures, rather than enshrined in policy [83].

The most common approach for investigating structural stigma has been the use of interviews, surveys, and focus groups to examine the experiences of people with mental illnesses and their associates, such as friends, relatives, and service providers [e.g., 86]. This research taps into subjective perceptions of stigma that can be attributed to social structures and policy. For example, Stuart and colleagues [87], found that almost half (44%) of a sample of Canadian mental health service users reported that they had been treated unfairly or had their rights denied because of their mental illness. Similarly, a survey of roughly 700 Americans with psychiatric disabilities revealed that one-quarter to one-half of participants reported experiencing mental illness-related discrimination within a variety of institutional systems, including employment (52%), housing (32%), mental health services (28%), law enforcement (27%), and education (24%) [48].

Whereas these studies report on the actual stigmatizing experiences of people with mental illnesses, some research suggests that it is the anticipation of structural stigma, such as the fear of involuntary treatment or of receiving inadequate medical care, that may be especially problematic for people with mental illnesses [e.g., 88]. For instance, a study in Poland found that almost half of a sample of people with schizophrenia anticipated structural stigma, while only 6% reported an actual experience considered to be structural stigma [89]. Research also indicates that a large share of the stigma that is reported by people with mental illnesses concerns direct interactions with others (i.e., at an individual or interpersonal level), rather than at the level of structural imbalances and injustices [90]. Herein lies the difficulty with this type of self-report research: structural stigma often is absent from view and may not be perceived by those whom it oppresses. In general, people are more likely to attribute their bad hand in life to factors that are immediate and directly observable, rather than a complex web of invisible social forces. Structural stigma is difficult to detect and study because it is "buried beneath layers of rules and regulations" [91].

Bearing in mind the way that structural stigma is conceptualized in this report, as well as the different traditions that have been used to study it, the following sections highlight the ways in with structural stigma manifests in ten different institutional systems and social contexts: healthcare, employment and income, housing, education, criminal justice, privacy, public participation, travel and immigration, media, and reproduction and parenting.

Healthcare

The healthcare system is consistently identified as a significant contributor to structural stigma related to mental illness as well as other stereotyped health conditions such as HIV/AIDS [31] and addictions [92]. Although many people with mental illnesses receive the help and support they need from dedicated healthcare professionals, the healthcare system is also a place where people encounter unfairness and injustice [93]. The primary ways in which mental illness-related structural stigma manifests in the healthcare system are through insufficient funding of mental health services and research, the coercive philosophy of care that underpins the delivery of mental health services, and the unprofessional practices of mental health professionals.

Insufficient funding. Mental illnesses have been systematically deprioritized in the allocation of healthcare funding [56,94,32,95,96]. As a result, many people with mental illnesses have poor access to substandard care that does not meet their needs—an experience considered by many to be the most damaging form of stigma [91,86]. For instance, individuals might be able to access short-term mental health services during times of crisis, but not during other times of need. Or, cheaper medications may be made available to people with mental illnesses, rather than comparatively newer, more expensive, and more effective medications that carry fewer side effects [75,97]. As well, people with mental illnesses might have access to pharmacological interventions, but not other forms of care known to be equally or more effective, such as psychological therapies [84]. Public and private health insurance plans may provide insufficient coverage for mental healthcare compared to that which is provided for physical illnesses [e.g., 98]. Gaining access to appropriate mental healthcare often carries a significant financial cost that people with mental illnesses and their families simply cannot afford [86].

Although many gaps in the public mental health system are filled by services offered by non-governmental and consumer organizations, these essential services subsist on fragmented and temporary forms of funding. Clearly, the ineffectiveness of such a mental healthcare system places people with mental illness at a disadvantage by reducing their choices, hindering their recovery, and placing them at risk for a host of negative outcomes (e.g., victimization, medical problems, etc.). It also reinforces the belief that mental illnesses either cannot be treated or require coercive forms of care such as involuntary hospitalization. Kelly [99] contends that the absence of an effective mental healthcare system represents an "unfreedom" (p. 2112) preventing people with mental illnesses from achieving other forms of freedom such as full participation in social and political life. For other health conditions, such a poor quality system of care would not be tolerated [62], highlighting the devaluation of mental illnesses by society, which translates into systematic inequities in the distribution of healthcare resources.

Related to the inadequate funding levels for services and supports, scholars in Canada, the United States, and Australia have also observed that mental health research is deprioritized in the allocation of scientific funding [100-103]. In spite of the fact that mental illnesses exert a tremendous cost and burden on society, researchers who study mental health issues receive relatively less money than their colleagues who study other diseases. For instance, a recent study in Australia found that mental health research received lower levels of funding than most other health conditions (e.g., cancer, cardiovascular disease), mental health research was underfunded relative to its disease burden, and that the increase in research funding for mental health has not kept pace with the growth in research funding for other health conditions [104]. This inequitable distribution of research funding is problematic since it leads to an underdeveloped body of scientific evidence from which decisions pertaining to mental health policy and services are made. Improving this situation may require attracting more students and researchers to the mental health field in order to build up workforce capacity in mental health research [104].

Coercive underpinnings. Across Canada, mental health statutes tend to focus on involuntary interventions (i.e., medications, community treatment, or hospitalization) that are designed to curtail the rights and freedoms of people with mental illnesses [105]. In fact, the provincial/territorial Mental Health Acts are a misnomer, as they rarely speak to obligations of the government to ensure the mental health of its citizens [106]. This legislation is intended to serve a protective function, such as safeguarding individuals from causing harm to themselves or others; however, rather than being applicable to all members of society who pose such threats, it creates a special class of citizen by targeting people with mental illnesses. One must ask why society is willing to use coercive preventive measures for people with mental illnesses but not for other groups of citizens [107,52].

Some argue that such legislation perpetuates the idea that people with mental illness are inherently different from others (i.e., a greater risk to public safety) and are less deserving of fundamental human rights [108,52]—especially because it disproportionately affects the most disadvantaged and vulnerable members of society [109]. Moreover, this legislative framework clearly delineates those who occupy positions of power (i.e., mental health service providers) and those who do not (i.e., people with mental illnesses), and conflates the social control and treatment functions of the mental health system [96]. It is known that the coercive underpinnings of mental health services can be a strong deterrent from seeking help for mental health issues [110,111]. Structural stigma manifests in the failure of governments to counterbalance these coercive interventions by offering high-quality, voluntary mental health services; providing ready access to legal advocacy services; and rigorously assessing the degree to which these practices and policies are achieving their desired effects (e.g., improving quality of life) relative to their collateral consequences (e.g., diminishing treatment engagement).

(Un)Professional practices. People with mental illnesses and their families routinely report that the attitudes and behaviours of health and mental health professionals exacerbate their experiences with stigma [42,7,56,112]. In the health system, people with mental illnesses who seek treatment for physical ailments may be ignored or rejected. Professionals in the mental health system may engage in other practices that contribute to stigma, such as failing to provide patients/clients with information about their illness and treatment (e.g., side effects), using legal leverages and coercion to gain treatment compliance, tolerating the routine application of dehumanizing practices (e.g., seclusion, strip searches, physical restraints), excluding people with mental illnesses from the treatment process, and adopting a paternalistic stance towards people with mental illnesses [75,42]. Additionally, people with mental illnesses are subjected to intrusions on their private lives by health and social service professionals in ways that would not be acceptable for treating people with other health conditions. The fact that people with mental illnesses in numerous studies report these experiences across multiple settings signifies that they are systematic and structural problems, as opposed to isolated or rare occurrences.

Employment and Income

People with mental illnesses routinely encounter barriers to obtaining and maintaining employment [56,84,51,113]. Rates of unemployment are extremely high among people with mental illnesses. Those who do find work tend to be relegated to jobs that offer lower levels of compensation and fewer opportunities for advancement [114]. Evidence indicates that mental illness-related stigma exerts a negative effect on an individual's ability to participate in the workforce that operates independent of the difficulties caused by functional impairments and skills deficits [115]. Three ways that structural stigma surfaces in the employment and income contexts are through refusal to hire, failure to accommodate, and disincentive to work [116].

Refusal to hire. Most people will not disclose that they have a mental illness to a prospective employer. They know that sharing such information is likely to have a negative impact on being hired. Employers are typically not allowed to ask questions about whether or not someone has a disability or health condition; however, employers might inquire about other proxy indicators that signal whether or not an applicant is living with a mental illness. For example, many job application forms continue to ask questions pertaining to whether or not an applicant has ever received, or is currently receiving, mental health treatment [117]. Individuals with mental illnesses who have been hospitalized or received a disability pension may be asked by employers to explain lengthy gaps in their employment record. Moreover, most occupations today require applicants to provide criminal record checks, which can flag those who have been apprehended by police for mental health reasons

(i.e., mental health emergency, suicide attempt). Therefore, an encounter with police, regardless of whether or not it was criminal in nature, may be used to deny people with mental illnesses from entering the workforce. Because people with mental illness encounter the police more frequently than those without mental illness, such hiring practices disproportionately affect applicants with mental illnesses. Although laws exist to protect people with mental or physical disabilities from discrimination, hiring decisions—especially in the private sector—are cloaked in mystery. Proving that a hiring decision was based solely on a person's mental illness is a task of herculean proportions requiring an enormous amount of time and resources. Substantial numbers of job-seeking persons with disabilities are unlikely to have access to the financial or emotional resources needed to embark on such a fight.

Failure to accommodate. People with mental illnesses may require certain accommodations in the workplace, such as alterations to their work environment (e.g., reducing distractions), a flexible work schedule, additional feedback on their performance, or unpaid leaves. Employers are legally required to make reasonable accommodations for persons with disabilities. In spite of this, organizations fail to offer accommodations to employees with mental illnesses [84]. Additionally, workplaces can be unsafe spaces for people to disclose that they have a mental illness and require accommodations. People with mental illnesses fear being fired or otherwise treated unfairly, including being denied promotions or relegated to less rewarding tasks [42]. Employers and professional regulatory bodies may also place individuals who reveal that they have a mental illness under extreme scrutiny. For example, in a case heard by the BC Human Rights Tribunal, a lawyer, who disclosed that he had previously received psychiatric treatment, was required to submit to excessive and intrusive examinations and investigations about his mental competence by the Law Society of British Columbia [118]. The tribunal ruled that the Law Society acted in a discriminatory manner based on a perceived mental disability and order them to pay $100,000 to the complainant for legal expenses, injury to dignity, and lost wages.

Disincentive to work. When people receive disability benefits, the amount of income that they are allowed to receive through employment may be capped. This means that individuals who earn more than a given amount through employment (e.g., $500 per month) will have their disability benefits reduced or terminated, regardless of the precariousness of their job situation or their recovery. Although this social policy is intended to prevent people who are capable of working from claiming disability benefits, it also establishes a strong disincentive for people with mental illness to seek opportunities for competitive employment. Disability benefits barely cover basic living expenses (food, shelter, clothing, etc.), so individuals may look to supplement their income out of necessity. This can be considered a form of structural stigma because it, in effect, reinforces a person's economic dependence on the State and prevents them acquiring a decent standard of living [51].

Housing

The closure of large psychiatric institutions combined with medical advancements has resulted in more people with mental illnesses being able to live in the community. Finding safe, stable, decent, affordable housing can be made difficult by living with a mental illness [84,119]. Landlords may refuse to rent to people with mental illnesses and/or those who are receiving disability benefits. This is illustrated in a case of the BC Human Rights Tribunal that involved a man with recurring mental illness who was denied an apartment on the basis of receiving a disability pension as a primary source of income [120]. The tribunal found that the property owner acted in a discriminatory manner toward someone based on a disability and order the landlord to pay $1,000 to the complainant for the injury to his dignity.

Housing may be unaffordable for a proportion of people with mental illnesses whose income is limited by the fact that they are unable to work because of their impairments. There is a lack of available affordable housing in many communities. Indeed, the expansion of affordable and supported housing in the community has not kept pace with

the contraction of institutional mental healthcare. Moreover, the policies and practices of housing services may be unsuitable for people with mental illnesses. For instance, they may be overly paternalistic, unpleasant, unsupportive, and force residents to partake in unwanted interventions. Eligibility criteria for housing may require medication compliance, abstinence from alcohol or substance use, or attendance in addiction treatment [121,122]. Therefore, substantial numbers of people with mental illness find themselves living in unstable situations with family or friends, or in deplorable and dangerous conditions.

Housing designed for people with mental illnesses sometimes faces fierce community opposition and discriminatory zoning laws [123]. Therefore, housing that is affordable and/or offers support services tends to be located in communities that are geographically segregated and socially disorganised—systematically channelling people with mental illness into neighbourhoods that place them at greater risk of social isolation, victimization, disease, and other stressful life situations [124-126,52]. Indeed, disparities in income and wealth combined with other forms of structural stigma have a significant influence on housing choices for people with mental illness.

Education

As established in numerous conventions and declarations of the United Nations, equitable access to education is a basic human right [127]. For people with mental illnesses, the educational system can be a place where they confront significant barriers. Research has demonstrated that poor mental health is associated with poor educational attainment, termination of schooling, and not entering or graduating from university [128,129,127]. Of course, the impairments directly created by mental illness are major contributors to poor educational outcomes for children, youth, and adults with mental illnesses. However, the policies and practices of educational systems—at all levels—either create or fail to mitigate barriers that stand in the way of achieving a formal education. This creates long-term, far-reaching disadvantages in employment, financial security, social functioning, and health and well-being [72].

Structural stigma may surface as insufficient funding for services to support students with mental illnesses, failure to provide reasonable accommodations, segregation from mainstream classrooms, or exclusion from activities/ opportunities offered to students without mental illnesses [84,52]. An illustration of this is an incident involving a university student in British Columbia with recurring depression who had an acute episode during which she attempted to jump through a plate glass window. She returned to school after her recovery and was denied access to property that was customarily available to other students (e.g., keys for a computer lab, a rating sheet required for a hospital internship application). The BC Human Rights Tribunal ruled that the student had been discriminated against by the school on the basis of her mental disability [130].

Similar to problems that arise in the workplace, students with mental illnesses who are applying to post-secondary school programs can be questioned about, and subsequently denied opportunities because of, gaps in their transcripts related to the time taken to recover from mental health issues [131]. In some educational systems, access to mental health assessment and treatment services is excessively delayed, leading to extensive interruptions in students' education [131]. Moreover, compared to students with physical disabilities, those with mental illnesses may have more difficulty obtaining necessary accommodations, such as alternative methods of testing, extensions of assignments, and additional support—owing to either institutional policies that fail to recognize the needs of people with mental illnesses or educators' negative responses toward students having trouble related to mental illnesses. As such, problems that arise because of a mental illness, such as behavioural issues or absences from school, may be responded to with skepticism, scrutiny, and disciplinary action rather than support and accommodation.

Criminal Justice

People with mental illnesses are grossly over-represented in the criminal justice system [132]. Although there are a number of explanations for the high rates of mental illnesses in the criminal justice system, there is consensus that structural biases and social inequities play a large role. Indeed, the factors that shape mental health are generally the same as those that influence crime; for example, poverty; unemployment; lack of education; poor living conditions; and inequitable access to wealth, power, and resources [133,134].

As such, structural stigma that materializes in other life domains (e.g., unequal access to employment or educational opportunities) can place people with mental illnesses at risk for coming into conflict with the law. For instance, deficiencies in the health and social service systems contribute to the transformation and use of criminal justice processes (e.g., arrest, criminal charges, and convictions) and agents (e.g., police, judges, and probation officers) as a means for gaining access to mental health services. The proliferation of specialized police teams, courts, and correctional services for people with mental illnesses are telltale signs of deep-rooted social problems that have channelled certain citizens into criminal justice services. Conversely, people with mental illnesses who have been victimized are systematically denied protection by the justice system, with some reporting that their claims are not believed by police and prosecutors [27,135]. Therefore, some people with mental illnesses are reluctant to seek assistance from criminal justice officials.

Once people with mental illnesses enter the criminal justice system, they get entrenched in structural stigma. Having a mental illness makes it more difficult to be granted parole [136,137], and to succeed in the community under correctional supervision [138]. Some of these problems have been attributed to the substandard mental health and social services available to people with mental illnesses in correctional settings and in the community. For instance, inmates without access to appropriate mental health and substance use services in jail or prison may be more likely to be charged with breaking institutional rules or involved in a verbal or physical altercation, all of which reduce their chances of succeeding in requests for temporary absences and parole. Compounding this problem is the fact that inmates with mental illnesses may also be denied parole because appropriate mental health and substance use services do not exist to support them in the community.

There is also reason to believe that criminal justice professionals, such as police, judges, and correctional officers [139] routinely endorse negative stereotypes about people with mental illnesses (i.e., that mental illness alone is a significant risk factor for violent and criminal behaviour), which then affects policy and practice. For example, people with mental illnesses on probation tend to be subjected to supervision that is more intensive and monitoring compared with their counterparts without mental illnesses. Additionally, the presence of mental illness appears to lower probation officers' threshold for breaching people under their supervision [140]. These are but some of the ways in which people with mental illness are systematically disadvantaged in the criminal justice system.

Privacy

Mental illnesses are (for the most part) concealable, which means that the majority of people who live with them are able to choose whether to disclose their illness to others. However, this choice is unfairly taken away by the policies and practices of workplaces, schools, social services, and other institutional settings in many ways. Similar experiences have been reported by people living with other illnesses, such as HIV/AIDS, who have fought for years to have their individual privacy rights protected from mandatory disclosure in the interest of public safety [62,6].

An egregious example is the routine disclosure of mental health information by the police [141], a practice that exists today in Canada. When police use the provisions of the Mental Health Act to apprehend a person who is in crisis,

information about this incident is often recorded in police databases. This information can subsequently be shared between criminal justice agencies (e.g., police, corrections, border security agencies) and disclosed in routine 'police record checks,' even though no offence has been committed and no charge has been laid. This disclosure can make it difficult for some people living with a mental illness to volunteer, get a job, or travel outside the country [e.g., 142]. A collateral consequence of these policies and practices is that some individuals will be reluctant to call for help during a mental health crisis because of fears about how personal information will be recorded and used by police in the future.

Public Participation

Historically, people with mental illnesses have been prevented from exercising their right to public participation, which may include voting in elections, serving as jurors, or holding political office. Although progress has been made in these areas, systematic exclusions from public participation on the basis of mental illness persist today around the world [52,127].

A 2001 study of 63 democracies found that only four countries, including Canada, did not restrict the voting rights of people with mental illnesses [143]. However, Canada did disqualify people with mental illnesses from voting in federal elections until the early 1990s, a change that was instigated by a Federal Court of Appeal decision in 1988 [144]. A more recent study of 27 European Union Member States found that the majority of countries continued to exclude people with mental illnesses from political participation (either voting, being elected, or both), nine countries placed some restrictions on political participation (e.g., based on individual assessment of capacity), and only five countries permitted full participation in the electoral process [145].

In the United States, Hemmens and colleagues [85] reviewed State laws to ascertain the degree to which the civil rights of people with mental illnesses were constrained. The findings were troubling in that the restrictions on rights were common and, in many cases, were imposed broadly on people with mental illnesses ('mental illness' restrictions) as opposed to being applicable specifically to those who lacked capacity or posed a risk to public safety ('incompetency' or 'public safety' restrictions). The study revealed that 44 States restricted the right to serve on a jury (17 with 'mental illness' restrictions), 37 States restricted the right to vote (19 with 'mental illness' restrictions), 24 States restricted the right to hold public office (16 with 'mental illness' restrictions), 27 States allowed mental illness to be used as a grounds for divorce (21 specifying 'mentally ill'), and 27 States permitted the restriction of parental rights on the basis of mental illness (21 with 'mental illness' restrictions).

Although a cursory glance at similar provincial and territorial statutes suggests that Canadians with mental illnesses are seldom excluded from public participation, such discrimination does exist. For instance, people with mental illnesses in Quebec are disqualified from serving on a jury (Quebec Jurors Act, s. 4h). Ontario and British Columbia also have similar policies, but these provinces specify that this only applies to cases in which the mental impairment will negatively affect the individual's ability to carry out juror duties (Ontario Juries Act, s. 4a; BC Jury Act, s. 3.1o). Further study of this issue is needed in Canada in order to gain an understanding of the extent to which people with mental illnesses are disqualified, either formally or informally, from exercising their civil rights.

Travel and Immigration

International travel and immigration is more difficult for people with mental illnesses. Impairment produced by the illness is not the cause of such difficulties but, rather, the policies themselves create barriers for people with mental illnesses. They have more difficulty obtaining travel insurance that covers mental health, even when their illnesses have been stabilized [97,146]. They may be required to disclose their mental illness on travel visas and face additional screening procedures. For example, prior to visiting, citizens of selected countries who plan to travel to Canada must obtain a Temporary Resident Visa, which requires applicants to complete a form that asks whether they have "any

physical or mental disorder that would require social and/or health services other than medication during [their] stay in Canada." Applicants who indicate "yes" are then asked to provide details and may be asked to supply confirmatory documentation (e.g., letter from physician). Similarly, travellers who are applying for a Visa waiver to the United States are asked whether they have "a mental disorder associated with a display of harmful behavior, including self-harm." It is unknown how often travellers are denied entry into other countries because of mental illness; however, as mentioned earlier, Canadians who have had police involvement in a mental health crisis (e.g., mental health emergency, suicide attempt) can be denied entry into the United States.

Prior to immigrating to Canada, individuals are required to complete a form that asks whether they or any family member listed in the application have ever had any serious disease, or physical or mental disorder. It is interesting to note that this question is adjacent to others that ask about criminal convictions, incarcerations, and involvement in crimes against humanity and armed violence. Applicants must then undergo an immigration medical exam that requires screening for psychiatric conditions to determine whether they will likely pose a danger to public health, a danger to public safety, or will cause excessive demand on health or social services in Canada (e.g., require ongoing institutional care). Those who do not pass this exam are designated "inadmissible" under Canada's Immigration and Refugee Protection Act.

Some have suggested that permitting such discrimination against persons with disabilities stands in stark contrast with recent efforts to abolish immigration policies and practices that discriminate on the basis of race, gender, religion, or sexual orientation [147]. Though immigration policy does not deny entry to Canada for all people with mental illnesses (which is a positive shift from the historical practice of using categorical exclusions), the 'excessive demand' clause is an extremely difficult barrier to overcome. Moreover, it sets a utilitarian tone to assess persons who are or are not valued (or who are worth investing in) in Canadian society. People who live with a mental illness may, on that basis, be characterized as burdens and deemed unworthy of being citizens of our tolerant, inclusive society [107,52].

Media

Perhaps no subject pertaining to structural stigma has received as much scholarly attention as the way in which the media depicts mental illnesses. Media accounts and representations of mental illnesses are a primary source of mental health information for many citizens. Media coverage does much more than simply present an objective description of the facts of mental illness; journalists also interpret and explain events, and try to influence people to see things and to act in particular ways [148]. Media coverage has a role to play, not only in what audiences attend to but also in what they think and feel about a problem [149].

So, while news media may indeed reflect what goes on in a community, they also shape social phenomena in important ways. For example, Corrigan and colleagues [150] use the term structural stigma to describe the systematic manner in which the news media encourage stigma by framing people with mental illnesses in a negative light. As Holstein and Miller [151] suggest, the way problems are constructed has a direct bearing on the kinds of solutions that are seen to be appropriate for addressing them. Media representations thus contribute to public understandings of mental illnesses, influence how people with mental health problems are regarded and treated [e.g., 152], and play a role in debates about public policy pertaining to mental illnesses [e.g., 153].

Numerous studies have systematically examined media representations of mental illnesses [154-158]). The general conclusion from this body of research is that media coverage of mental illnesses is disproportionally negative—framing people with mental illnesses as violent, prone to criminality, unpredictable, incompetent, undesirable, and undeserving. One systematic review concludes that media portrayals of mental illness simply reflect the traditional, common sense, lay understandings of madness through their depictions of people with mental illnesses as inferior to, and separate from, normal society [159].

Such negative findings have been replicated by several studies examining representations of mental illnesses in Canadian media—with little to no improvements observed over time [160-164]. One study by Stuart [165] investigated media representations of mental illness in two local newspapers in Calgary, Alberta. The study was designed to evaluate the effectiveness of a media intervention in the late 1990s that sought to change newspaper portrayals of severe mental illnesses (e.g., schizophrenia). The pre-post design content analysis revealed that while the average number of positive news stories about mental illness increased by 33%, the number of negative news stories also increased by 25%, indicating that the intervention produced minimal positive effects. A more recent analysis of Canadian newspaper coverage from 2005-2010 found that danger, violence, and criminality were direct themes in 40% of articles about mental illness, and that no improvements in mental health reporting were observed during the study period [160], even though there has been an upsurge of mental health awareness and anti-stigma activity in Canada.

The media are often described as having widespread symbolic power through their ability to broadcast to large numbers of people over wide geographical areas. A more complex perspective is provided by Couldry [166] who conceptualizes 'media power' as a social process in which all members of society—journalists, media owners, advertisers, readers, listeners, viewers—are implicated in the production and reproduction of particular versions of social issues such as mental illness. This conception of 'media power' offers the possibility that it can be resisted and contested, and that patterns of reporting and reading can be changed through the active engagement of ordinary people in journalistic matters. It also offers the possibility of a civic oriented journalism [e.g., 167] in which journalists come to recognize and understand the implications of the ongoing narrative for both audience and policy responses and, perhaps, work directly with people who experience mental health problems in order to interrupt the dominant narrative.

Reproduction and Parenting

A tragic history surrounds the reproductive rights of people with mental illnesses. Many countries, including Canada, implemented enforced sterilization programs for people with mental and physical disabilities in the early to mid-20th century [168]. Although these barbaric programs no longer exist, some observers argue that they have been replaced with covert structural barriers that serve to prevent people with mental illnesses from becoming or being parents [27,52].

This primarily stems from the perception that a child's health and safety is seriously jeopardized when a parent has a mental illness. Moreover, the moralistic message is that people with mental illnesses are undeserving of having children. Those who live with mental illnesses are widely viewed by laypersons and professionals as incapable of being good parents—a belief that can be internalized by people with mental illnesses, leading them to choose not to have children or self-doubting their capabilities as parents. People with mental illnesses are strongly discouraged from starting families, which may materialize in the form of advice from health professionals to not have children, refusal by professionals to help manage psychiatric medications that would enable pregnancy, disqualification from adoption, encouragement to abort during pregnancy, or denial of access to in vitro fertilization [169,27,170].

People with mental illnesses who do have children report unfair treatment by mental health professionals, social workers, educators, judges, nurses, and physicians [169,170]. They can be subjected to intensive surveillance (e.g., by health, education, and social service professionals), and may continually face the risk of losing their children. In fact, in response to a tragic (but isolated) event in British Columbia involving the deaths of three children by a parent with a mental illness, the provincial child advocate suggested that the government implement systematic screening of current and expectant parents to determine whether or not they have a mental illnesses, which was framed as a way to protect the safety and well-being of children [171, Recommendation 1A]. To date, it seems that such systems of scrutiny have been ruled to be justified for the protection of children [e.g., 172].

A parent's mental illness is routinely raised during child custody disputes and as grounds for denying or restricting child visitation. One study in the United States found that the majority of States permitted the restriction of parental rights for people with mental illnesses [85], such as permitting a person's parental rights to guardianship to be terminated by reason of mental illness [54]. Clearly, stereotypes that all people with mental illnesses are unstable, incompetent, and dangerous place parents who live with mental illnesses in powerless positions when it comes to child custody issues. A collateral consequence of such policies and practices is that parents may choose not to seek professional help because of the potential for being subjected to paternalistic practices or losing custody of their children. Like structural stigma that materializes in other life domains, unfair treatment of parents with mental illnesses will exacerbate marginalization and disadvantage for them and their children.

HOW CAN STRUCTURAL STIGMA BE ADDRESSED?

> Cynics might argue that institutional discrimination is so entrenched within our society that any serious thoughts of its eradication by whatever means are both utopian and unrealistic. Such people need to be reminded that [...] institutional discrimination, in common with everything else in our world, is little more than a social creation, and as such can be socially eradicated.
>
> Barnes [51]

There is no shortage of recommendations about how mental illness-related structural stigma could be addressed. Unfortunately, few of these suggested strategies have been tested and evaluated. Presently, an evidence-based formula for reducing structural stigma does not exist. In fact, the current state of knowledge for effectively diminishing mental illness-related stigma on any level (i.e., social, self) is rather weak.

In the absence of solid evidence, individuals and agencies seeking to reduce stigma must turn to other sources of knowledge to inform the direction of their programs. This would include the opinions of scholars and other experts who have spent their careers thinking about and researching mental illness-related stigma. Their advice is contained in numerous books, articles, and reports that provide guidance on how to address structural stigma [e.g., 52,127,116,56,131]. Another valuable source is the experienced-based knowledge from people with mental illnesses and their associates (e.g., families, friends) whose lives have been directly impacted by stigma. Astute program planners should also harness the wisdom of those who, over several decades, have succeeded or failed to fight against structural stigma in other communities marginalized by race/ethnicity, gender, sexual orientation, or disability and illness (e.g., HIV/AIDS).

Despite the lack of empirical evidence, several trends can be discerned from the existing body of literature. Generally, there is consensus that, in order to be successful, anti-stigma strategies must target multiple levels by employing a mixture of approaches [173,174,56,175,176,72,77,99]. So, interventions must be designed to target stigma at the individual (micro), social (meso), and structural (macro) levels [37]. Effectively reducing stigma will also require the collective and collaborative efforts of many groups and organizations with a mix of skill sets and expertise (e.g., lawyers, activists, business leaders) [77]. Effectively combatting mental illness-related structural stigma also requires attending to the root causes of injustice and inequity, which essentially means creating a social movement to shift the dominant cultural ideology into one that does not just tolerate, but values and embraces human difference [43].

Other health conditions, such as cancer, have achieved significant progress at the social and cultural level over the past few decades. The impact of a health social movement, combined with the feminist movement, on the illness experience is eloquently illustrated by Maren Klawiter in a powerful study of one woman's (Clara) experience of being diagnosed with breast cancer in the United States during the late 1970s and then again in the late 1990s [177]. Whereas Clara's first experience with breast cancer was characterized by stigma, isolation, power disparities, and invisibility, her more recent experience following the social transformation of breast cancer was characterized by inclusion, empowerment, choice, and sisterhood. A comparable social transformation is greatly desired by people living with mental illnesses and their supporters; however, the social and structural barriers faced by people with mental illnesses are relatively more challenging and entrenched, and much more difficult to overcome.

Recent commentary reveals a growing cynicism and impatience with present-day anti-stigma programs, which have tended to employ public service announcement-type campaigns in order to educate, raise awareness, and improve attitudes among the public. Many scholars and advocates express a desire to shift the focus of anti-stigma initiatives

from 'soft' goals (e.g., improving knowledge and attitudes) to 'hard' goals that produce concrete improvements in the lives of people with mental illnesses, such as strengthening human rights protections, improving social and economic equity, and enhancing quality of life [178,56]. Since three levels of stigma are mutually reinforcing, it is likely that the greatest improvements will be achieved through a combination of strategies that target 'hard' and 'soft' goals, as opposed to choosing one over the other [7,72,179,84,52]. It is also apparent from research conducted in other areas (e.g., race/ethnicity, gender, sexuality) that ameliorating stigma at a structural level will not be quick; rather, it will require persistent efforts to yield incremental change over multiple decades and generations.

Researchers have asked people with mental illnesses about their preferences in relation to addressing stigma. Studies in the United States found that the anti-stigma strategies favoured by participants were taking legal action either through litigation (37%) or mediation (22%); seeking help from government agencies (26%); making a complaint to an employer/landlord by phone (13%) or letter (2%); getting help from an advocacy group (13%); or looking for a job/apartment elsewhere (10%) [180]. Another study in the United Kingdom found that most participants prioritized institutional reforms over public education approaches to address stigma [181]. Their suggested approaches included increasing investment in mental health to improve access to services, improving knowledge and attitudes among general practitioners and mental health professionals, and shifting away from the medical model toward more holistic care. Building upon these suggestions, a scan of the literature points to six interrelated approaches that are needed to prevent and protect people with mental illnesses from structural stigma, including; (1) legal and political action, (2) advocacy, (3) inclusive efforts, (4) healthcare reform, (5) education, and (6) research. Each of these is considered below.

Legal and Political Action

Tackling mental illness-related structural stigma will require significant legal and policy action, such as creating new laws; contesting, amending, or repealing harmful laws and policies; and enforcing existing laws [51,182,27,127]. The ultimate goal is to develop a robust system of protections that serves to thwart instances of structural stigma across all domains of life (e.g., employment, health, housing, and so on). A strong system would also facilitate ready access to mechanisms for people with mental illnesses to challenge structural stigma when it materializes, such as supporting individuals to bring their concerns to administrative tribunals, professional regulatory bodies, and the courts [173]. Such reforms would also shift the way in which people with mental illnesses are framed in social policy, which may achieve improvements in self and social stigma [179].

Laws already exist to prevent discrimination and inequity for people with mental illnesses. Unlike other developed nations (e.g., United States, England and Wales, Australia), Canada does not have federal disabilities legislation; however, its citizens have access to protections that are granted by numerous international, national, and provincial/territorial texts. The majority of these texts offer what is known as first generation (or negative) protections, in that they require the government not to engage in certain activities [56]. For instance, governments are not to arbitrarily curtail the liberty of individuals through apprehension, detention, and hospitalization. More scarce are second generation (or positive) protections which emphasize the government's obligation to provide social entitlements that address social, economic, and political inequities, such as those created by structural stigma [56,127].

A range of international human rights texts prohibit discrimination, including the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights, to name a few. These texts articulate norms and principles by which nations have agreed to abide; State parties that fail to do so may face political and economic sanctions by the international community. In the Canadian legal system, international laws that are ratified by the federal government are generally enforceable by Canadian courts when their provisions have been transformed into domestic law (i.e., legislation has been enacted). Specific to mental illness-related structural stigma, one of the most pertinent international agreements is the United Nations' Convention on the Rights of People with Disabilities (CRPD), which was ratified by Canada in 2010.

As a human rights instrument, the CRPD is designed to promote and protect the human rights and fundamental freedoms of all persons with disabilities, including mental illnesses. The CRPD is underpinned by eight guiding principles: (a) respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; (b) non-discrimination; (c) full and effective participation and inclusion in society; (d) respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; (e) equality of opportunity; (f) accessibility; (g) equality between men and women; and (h) respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities. The CRPD articulates 20 areas of human rights that are guaranteed to persons with disabilities, such as: equal recognition before the law (article 12); access to justice (article 13); liberty and security of the person (article 14); freedom from torture or cruel, inhuman or degrading treatment or punishment (article 15); protecting the integrity of the person (article 17); living independently and being included in the community (article 19); respect for privacy (article 22); education (article 24); health (article 25); habilitation and rehabilitation (article 26); adequate standard of living and social protection (article 28); and participation in political and public life (article 29). The CRPD is an important document that should inspire legal and social progress towards improving protections of rights and freedoms, improving access to social entitlements, and eliminating mental illness-related structural stigma [76,183,127,56].

In Canada, the Charter of Rights and Freedoms, the Canadian Human Rights Act, the Employment Equity Act, and the Canada Health Act are some of the federal statutes that provide protections to all citizens. The Charter of Rights and Freedoms is the supreme law in Canada, meaning that it establishes the standard for assessing the legitimacy or all other laws in this country. The Charter is a vital tool for challenging instances of structural stigma, as it offers a host of protections to Canadians, including: voting in elections (s. 3); right to life, liberty and security of the person (s. 7); right not to be arbitrarily detained (s. 9); access to legal counsel (s. 10); right not to be subjected to cruel and unusual treatment or punishment (s. 12); and equal protection under, and equal benefit of, the law (s. 15). The rights and freedoms that are guaranteed by the Charter are not absolute; the government is permitted (by section 1) to impose restrictions on individuals in certain situations. For instance, although compulsory treatment infringes an individual's right to liberty, it has been held to be justified by the objective of protecting and helping secure the safety and well-being of the individual and society. The reasons for curtailing rights must be specific, as legislation that uses overly broad criteria, such as a history or label of mental illness, will be struck down as arbitrary. Theoretically, any citizen who believes their Charter rights have been infringed can seek remedy in court (s. 24.1), which should serve as a powerful mechanism for countering structural stigma. Pragmatically, however, preparing a case for court (especially for the Supreme Court of Canada) is expensive, time-consuming, and beyond the means of many people with mental illnesses.

The Canadian Human Rights Act applies to workplaces and services that are covered by federal laws, such as banks, airlines, postal services, and the federal government. This statute provides individuals with protections against discriminatory practices based on gender, race, disability, and other grounds that occur within any federally regulated service or activity. Claims of discrimination are investigated and enforced by the Canadian Human Rights Commission, and are adjudicated by the Canadian Human Rights Tribunal. Public and private services that are covered by provincial laws, such as provincial employers, landlords, or service providers, are governed by provincial/territorial human rights codes. Each province/territory has established tribunals to adjudicate human rights complaints. Additionally, some provinces have created more assertive agencies, such as the Ontario Human Rights Commission, that proactively provide a range of important services (e.g., developing policy, educating the public, monitoring trends, and conducing inquiries) to prevent and protect against discrimination.

In addition to the aforementioned human rights statutes, provincial/territorial mental health statutes offer some legal protections to Canadians with mental illnesses. For instance, they articulate the criteria and processes by which people can (and cannot) be involuntarily treated, hospitalized, and compelled to abide by conditions in the community.

However, it has been observed that Canada's mental health legislation does little to promote the rights of people with mental illness, empower them to make choices about their lives, provide them with legal protections, or ensure their full participation in the community [106]. Scholars suggest that mental health legislation should do more to protect and advance the positive rights of people with mental illnesses (e.g., access to housing, healthcare, adequate standard of living) and articulate the services that are needed to support individuals so that they may avoid compulsory treatment, rather than merely articulating the reasons for curtailing rights and freedoms [105,106,127]. It has also been recommended that society move away from creating unique institutional arrangements for detaining people with mental illnesses but, rather, create legislation in which preventative detention can be applied to all citizens who lack capacity or pose a significant safety risk regardless of its cause [108].

Most legislative protections that currently exist are not specific to people with mental illnesses—either they are human rights codes that apply broadly to all citizens (e.g., Charter of Rights and Freedoms) or to persons with any form of disability (e.g., CRPD). It is questionable whether laws and policies that specifically refer to people with mental illnesses are necessary or desirable. Indeed, any policy that reinforces the notion that people with mental illnesses are different from others, whether it is in the context of curtailing rights though compulsory treatment or providing greater protections, risks exacerbating stigma [84,52]. Of importance is ensuring that the rights and opportunities of people with mental illnesses are protected in the same manner as they are for all other members of society [82,7]. Disability rights laws should apply equally to persons with physical and mental disabilities. For instance, similar to the way in which reasonable accommodations are made in the workplace for people with physical disabilities, people with mental illnesses should also have access to necessary resources and supports to manage their impairments [184,66]. Beyond equality, people with mental illnesses—like many other socially marginalized groups (e.g., Aboriginal peoples)—need equity; that is, additional resources and supports to offset the social, economic, and political disadvantages so that they may experience the same rights and opportunities as other community members. The collateral consequence of equity policies is that they can exacerbate stigma by reinforcing a distinction between 'us' and 'them'. This critique has been directed by some civil libertarians and psychiatric survivors at criminal justice diversion strategies for people with mental illnesses, the 'Not Criminally Responsible on Account of Mental Disorder' defence, and other mental illness-specific social policies and institutional practices [52].

Although the aforementioned international and domestic texts are important for establishing universal human rights, scholars have observed that they have been ineffective, in many respects, for improving the material conditions and status of people with mental illnesses [106,52]. Indeed, structural stigma persists in most developed countries, including Canada, despite the existence of highly advanced legislative and policy frameworks [185,56]. An array of contributing factors is responsible for this paradox. The first problem is that laws may be inherently flawed [179]. For instance, protections may not extend to certain subgroups, such as persons with substance use problems or histories of criminal justice involvement. The experience in the United States with the Americans with Disabilities Act suggests that the most marginalized and vulnerable members of society (e.g., people who are severely impaired by mental illness such as schizophrenia) are the least likely to benefit from legislative protections [52]. Laws and policies may also contain vague and ambiguous language that provides too much discretion with respect to interpretation and implementation. Consequently, stigmatizing practices or procedures may flow from lack of clarity, such as overly general principles, in laws intending to protect people from discrimination.

A second reason that structural stigma exists in societies with seemingly robust legislative protections relates to the fact that it is a phenomenon that is difficult to document, especially when it manifests in unintentional and covert forms [182]. Research indicates that people are less likely to perceive institutional forms of discrimination as compared to individual forms of discrimination [65]. Consequently, it is extremely difficult to produce enough evidence to support claims pertaining to structural stigma [173,84]. Another important factor is that, despite the presence of laws

prohibiting discrimination, people with mental illnesses either do not seek or have access to legal redress [105,84,127]. Research indicates that only a small fraction of disability discrimination and human rights complaints are acted upon by enforcement agencies [182,173]. Perhaps, people with mental illnesses are unaware of their individual rights or how to challenge infringements of their rights. They may not be able to afford the financial expense associated with litigation, or they may not be in a position to invest the time and energy into resisting inequity or injustice.

By definition, individuals who are the subjects of structural stigma are prone to shame, disempowerment, and self-stigma [72], all of which serve as strong deterrents from asking for support or fighting against powerful institution systems. Fear of being exposed as a person who lives with mental illness is a significant factor that explains why structural stigma remains unchallenged [179]. Many people chose to conceal their mental illness out of fear of being exposed to numerous exclusionary processes. For instance, a person who unveils their mental illness in one life domain (e.g., seeking job accommodations) opens themselves up to additional exclusionary practices and intense scrutiny in other domains (e.g., parenting).

A final explanation of the persistence of structural stigma in contemporary society is the fact that challenging it poses a significant threat to the legitimacy of the social hierarchy [65]. As such, those in positions of power protect their privilege and justify the social hierarchy by discounting claims about inequality/injustice and making it difficult for low-status groups to access the resources required to instigate change. Structural stigma thrives in environments with weak infrastructures for monitoring and enforcing rules, or when people with mental illness are not provided with the means to contest violations [186].

Courts and human rights tribunals can react to cases and rectify instances of structural stigma, but more proactive approaches are needed, such as auditing policies and practices [173]. Efforts must be made to establish internal and external monitoring mechanisms to assess, promote, and facilitate adherence with existing law and policies, such as the CRPD regulations [99]. Also, legislation seeking to remedy structural stigma must be complemented with enforcement bodies that are authorized to penalize institutional systems for violating existing statutes [77].

Advocacy

Although important, legal and policy action alone will not eradicate structural stigma [127,7,52]. Other approaches are required to bridge the chasm between policy and practice, and to overcome the power imbalances that are inherent in structural stigma. Because of their marginalized social location, some individuals with mental illnesses do not have access to the necessary resources to challenge inequities and injustices that they routinely face. As such, there is a need for legal and social justice advocacy services, with the aim of supporting people with mental illnesses and influencing public policy and resource allocation decisions within political, economic, and social systems [99,51,183,86,97,96], as is noted by Campbell and Deacon [50]: "… where there is power, there may also be the potential for individual/collective resistance" (p. 413). Advocacy decentralizes power by creating additional avenues for people with mental illnesses to seek redress whenever they encounter instances of structural stigma [183].

The leaders of our institutional systems, such as politicians, bureaucrats, and healthcare decision-makers, need to be convinced that it is wrong for community members to endure arbitrary restrictions on their rights and opportunities simply because they have a mental illness [29]. Furthermore, people with mental illnesses need a vehicle or forum to mobilize their interests in an organized, effective, and forceful manner. Advocacy groups should be supported to undertake a range of important activities, including: organizing mental health communities and mobilizing grassroots support; empowering and engaging people with mental illnesses in the advocacy process; gathering and disseminating information pertaining to structural stigma; lobbying for change in social policies, legal protections, and professional practices; promoting greater accountability, with an emphasis on human rights and quality in mental health services;

and monitoring progress [173,99,183,106]. Advocacy groups should also play a significant role in assisting the Canadian government in its obligation to promote, protect, and monitor implementation of the UN Convention on the Rights of Persons with Disabilities [107].

Some scholars posit that advocacy groups should remain independent of government influence, which would provide them with the liberty to assert seemingly radical positions on issues of public policy [51,106]. In other words, advocates must feel free to engage in a political debate without fearing that their funding, and continued existence, is in jeopardy. For instance, if government plans to enact legislation that unreasonably curtails the liberties of people with mental illnesses, then advocacy groups need to be able to fight fervently against such injustices. It is argued that agencies with semi-autonomous status who receive substantial funding from government cannot serve this function effectively since they are, on the one hand, ignored by government for being independent and, on the other hand, subdued by government through the control of resources [51,106]. However, it should be recognized that multiple forms of advocacy are needed to address structural stigma. For instance, mental health service providers and their professional bodies can serve as strong advocates for the equitable distribution of resources to the mental health system and for the treatment of people with mental illnesses [56]. Also, organizations that have close ties with government typically have ready access to officials who are willing to listen and discuss issues of importance. Despite having some encumbrances owing to their funding arrangements, semi-autonomous organizations may be ideally positioned to detect and seize on enlightened opportunities to educate, advocate, and create change with respect to breaking down structural barriers— or at least priming the pump for eventual change.

Advocates in areas such as physical disabilities, cancer, and tuberculosis are recognized for playing critical roles in transforming societal attitudes, which have often translated into increased funding for research and improved treatments [99,96]. In the HIV/AIDS field, a number of advocacy programs have increased the availability of treatment for people living with HIV/AIDS and have reduced experiences of stigma. For instance, HIV/AIDS groups have partnered with lawyers' organizations (e.g., Lawyers Collective in India and the AIDS Law Project in South Africa) to use the law to advance and defend legal protections [59]. The key elements of these HIV/AIDS advocacy programs are the leadership and active engagement of people living with HIV/AIDS in advocacy, education, litigation, and related activities [59]. Another exemplary advocacy program is the Disability Rights Commission in Great Britain (renamed the Equality and Human Rights Commission in 2007), which provides information and advice to people with disabilities, businesses and service providers; assists persons with disabilities to reclaim their rights; and advises government [187]. Importantly, this program provides people with mental illnesses access to an enforcement body that formally investigates claims of discrimination on mental health grounds [187].

Enhancing political participation is another promising approach. This strategy may involve enhancing voting rates among people with mental illnesses and their associates (e.g., families, friends, service providers), supporting political role models to speak out about their own mental health problems, and promoting the formation of stronger interest/ advocacy groups so that the concerns of people affected (directly or indirectly) by mental illnesses are added to the political agenda [99]. An example is the Canadian Mental Health Association's (BC Division) Vote Mental Health 4All campaign (http://www.votementalhealth4all.ca/), which mobilized the mental health community in British Columbia to ensure that mental health issues were part of the campaign conversation in the 2013 provincial general election. Indeed, numerous human rights and mental health advocacy organizations in Canada and elsewhere have strong records of resisting coercive, paternalistic, and unfair social policies and professional practices. The creation and funding of a formal national network of advocacy organizations that is controlled and run by people with mental illnesses is recommended as an important way to combine resources and efforts that are aimed at eradicating mental illness-related structural stigma [51].

Inclusive Efforts

Structural stigma causes social exclusion; that is, "the enforced lack of participation in key social, cultural and political activities" [188]. Therefore, counteracting it will require the promotion and creation of opportunities for the inclusion and participation of people with mental illnesses in our institutional systems.

Building on the concept of community development, the goal is to mobilize the mental health community, so that they are engaged in the process of identifying local needs (i.e., injustices and inequities), and then empowered with the knowledge, skills, and authority to develop and implement local solutions [189,56]. Such activities should be designed to stimulate interaction between persons with mental illness, their families/friends, and other community members/institutions, including media, businesses, schools, volunteer agencies, and political officials. Inclusive efforts also include a range of strategies to remove barriers that reduce the chance for people with mental illnesses to participate in any domain of life, including work, school, family, healthcare, and politics, which intersects with the other approaches for preventing and protecting against structural stigma that are discussed elsewhere in this report.

One way to accomplish this goal is to support a range of local initiatives that encourage people with mental illnesses to contribute to their communities, thereby demonstrating that they are more than a societal burden [174]. For instance, health authorities could ensure that people who live with mental illnesses are meaningfully involved in decision-making processes regarding mental health services, such as monitoring the quality of treatment or identifying structural barriers [97]. Another excellent example is presented by Sayce [52] who describes a consumer-run drop-in centre in Berkeley, California, that resisted community opposition by beautifying the neighbourhood, nurturing relationships with local community members, and making local decision-makers aware of existing anti-discrimination statutes. Strategically funding community-based research projects, in which academic researchers and community members work together to study and solve issues affecting the daily lives of people with mental illnesses, is another promising method for mobilizing and empowering marginalized communities.

Healthcare Reform

Clearly, mental health services should reduce, rather than exacerbate, problems for people with mental illnesses. However, the reality is that mental health systems, through their policies and professional practices, can operate in ways that either tolerate or produce unfairness, injustice, and inequities. Addressing structural stigma requires that people with mental illnesses have access to the same range, quality, and standard of healthcare that is enjoyed by persons with physical illnesses [56]. Similar to other health conditions, stigma related to mental illness is entwined with the quality of treatment. Decreasing stigma will lead to more funding (e.g., more private donors, enhanced public/political support) to increase capacity for research and to discover more effective treatments for mental illnesses; conversely, improvements in mental health treatment will lead to decreasing stigma by reducing the impairments that keep people from enjoying full social, political, and economic participation [96].

As many Canadians can attest, simply having access to universal healthcare is not a sufficient remedy for structural stigma. Scholars recommend that mental health services be structured around the concept of recovery-oriented care (or another paradigm espousing similar values), which provides persons with mental illnesses with self-determination and control over healthcare decisions [96,56,92]. The goal should be to shift away from paternalistic healthcare practices, toward systems of care that support patients' choices, address their individual and holistic needs, respect their human rights and dignity, and acknowledge the value of their lived experiences [190-193]. Under such a system of care, power is shared between healthcare providers and the person living with a mental illness, and therapeutic relationships are non-hierarchical and respectful. Supporting mental health recovery is achieved through a system that provides a range of services that extend beyond psychotropic medications and other medical interventions, such as

having access to crisis intervention, psychoeducation, counselling and psychological therapies, self-management and peer support, and advocacy.

Working towards the elimination of coercive practices and compulsory interventions in the mental health system is an essential step for reducing structural stigma [52]. Involuntary services may be necessary in narrowly defined situations; however, curtailing an individual's rights and freedoms should not be tolerated as a way to fix a broken system. Greater effort and investment is needed to study and rectify the systemic problems (i.e., gaps in institutional systems) that place people in situations where compulsory care may be required. Additionally, in order for governments to have addressed structural stigma in a meaningful way, they must—at a minimum—counterbalance their coercive interventions by offering a high-quality, voluntary, accessible, and appropriate continuum of mental health services, combined with ready access to legal advocacy services (e.g., legal aid) [107]. Strong evidence supports the premise that the need for involuntary interventions will be significantly reduced by investing in a mental health system that offers a continuum of crisis stabilization and intensive outpatient services [194]. Individuals who are receiving involuntary mental healthcare should not be forgotten, since opportunities can be created to meaningfully involve them in their own care and recovery [e.g., 192,195], and to ensure that they are transitioned to less restrictive interventions in a timely manner.

Anti-stigma efforts can be supported by quality assurance processes for mental health services that identify and rectify stigma-producing policies and professional practices [8]. Standards of care should incorporate indicators of social inclusion and participation, in addition to other more conventional measures of organizational performance [188]. In this respect, accreditation standards for health services may be an effective tool to promote recovery-oriented care and to reduce structural stigma that is embedded within the mental health system [56].

The colossal transformation of California's mental health system that is currently underway offers a case study of mental health reform that appears to be guided by progressive care philosophies [196]. The State recently passed legislation imposing a 1% tax on personal income that is being used to re-focus their community mental health system on prevention and wellness, supporting mental health recovery, promoting community integration, empowering people with mental illnesses and their families to direct their own care, and expanding services to underserved populations. Approximately one billion dollars is being allocated annually to support mental health prevention and early intervention strategies, including anti-stigma initiatives that, among other activities, contest discriminatory policies that negatively affect people with mental illnesses.

Education

Anti-stigma efforts that focus on improving knowledge and attitudes are limited in the magnitude and longevity of impacts they can achieve at the structural level [56]. However, the question remains as to whether such changes are prerequisites for achieving broader structural improvements. Can barriers to social participation be removed for people with mental illnesses without first transforming the values and beliefs (i.e., the social context) that reinforce structural stigma? Will politicians and community leaders prioritize this issue if the public is indifferent towards, or supportive of, arbitrary restrictions on the rights and opportunities of people with mental illnesses? Will practices change if professionals, such as landlords, employers, and educators, are unaware of their obligations under existing regulations and laws concerning the treatment of people with mental illnesses? Because the aforementioned strategies will not necessarily transform attitudes and beliefs about mental illness, it is necessary that they be complemented by other strategies for activating and supporting change within institutional systems [84,173,77,182].

Most scholars assert that in order for mental health awareness and education campaigns to achieve substantive structural changes, they should be aimed at powerful professional groups that control our institutional systems [53]. For instance, the World Psychiatric Association's anti-stigma initiative (called 'Open the Doors') targeted a range of

groups including medical staff, journalists, police, employers, and church leaders [184]. Another suggestion is to raise awareness among elected officials and policy-makers concerning how their actions can perpetuate mental illness-related structural stigma. A range of tactics to improve knowledge, attitudes, and behaviour among different professional groups are cited in the literature; these include: developing and distributing educational/instructional materials about human rights, stigma, and accommodations; modifying training curricula in universities and other educational programs to include issues pertaining to mental illness and stigma; cultivating partnerships between mental health agencies and other professional groups; and creating core competencies and standards for professionals (e.g., police, primary care physicians) that include knowledge/skills related to mental illnesses and stigma.

Shifting the way in which mental illness is framed by journalists and presented in films/television programs is routinely mentioned as a key mechanism for addressing structural stigma [77]. Anti-stigma campaigns in several countries, such as Australia and New Zealand, have demonstrated promising findings by developing strategic partnerships with news media [197]. Another approach taken has been to embed curricula in university journalism programs that is designed to improve knowledge and attitudes about mental illness, and to shift journalistic practices with respect to reporting stories about people with mental illnesses [197].

In addition to the media, employers are also recognized as a key target group [116]. Educating employers by dispelling myths about the capabilities of people with mental illnesses, and supplying them with knowledge on how to accommodate people with mental illnesses, are essential ways to counteract structural stigma [84]. A systematic review of 22 initiatives that addressed stigma in the workplace, primarily through the use of educational approaches (e.g., workshops, psychoeducation, experiential group learning), found that the overall effectiveness of these programs was mixed; however, some demonstrated improvements in professionals' knowledge and attitudes toward people with mental illnesses [113].

At a minimum, employers should be informed about their legal obligations under existing laws regarding people with mental illnesses [184]. Numerous tools are available to educate employers about providing job accommodations for people with mental illnesses, including resources developed in the United States [e.g., 198,199], Scotland [e.g., 200], and Canada [e.g., 201]. Similar tools also exist for landlords and municipal planners, such as the Ontario Human Rights Commission's web-based resource about rights and responsibilities in the context of rental housing [202] and municipal planning [203]. Although not specific to mental illness, these resources provide good guidance about non-discriminatory housing practices.

Since people with mental illnesses routinely mention professional practices in healthcare as a significant source of stigma, efforts should be directed toward educating mental health and medical professionals. An opportune time to reach this particular group is when they are training to become nurses, counsellors, psychiatrists, physicians, and so on. Several programs have demonstrated success with improving the attitudes of medical students towards working with people who have mental health and substance use problems [184,175]. Since stigmatizing practices can arise when professionals are unaware of their responsibilities and obligations, healthcare providers should be trained about existing legislation and policies that prohibit discrimination. It has also been suggested that continuing education programs and accreditation organizations ensure that recovery-oriented, patient-centred care principles are embedded within the policies of mental health organizations and practices of mental health service providers [184,56].

Some caveats with the aforementioned educational strategies should be acknowledged. Many of them have little evidence to support their effectiveness. So, for instance, we know that developing and enacting social policy is a complex process influenced by numerous social actors and a broad range of factors. Therefore, it would be naive to suggest that improving knowledge and attitudes among a subset of politicians or bureaucrats will necessarily translate into broad-based structural change. Additionally, we do not know about the differential levels of effectiveness that

each strategy has for different professional groups. What works in the employment arena may not be as effective for changing the behaviour of criminal justice personnel. Lastly, many of these education-based solutions target covert and intentional forms of structural stigma (i.e., policies/practices that purposefully restrict rights and opportunities). As such, they will have limited impact on unintentional or covert forms of structural stigma [66].

Research

To date, little research has been conducted on the topic of mental illness-related structural stigma, particularly in Canada. Other fields, such as HIV/AIDS, have produced a common, systematic approach to collecting data to understand the magnitude and nature of structural stigma [64]. For instance, the Protocol for the Identification of Discrimination against People Living with HIV is a tool created by UNAIDS to identify and monitor incidents of arbitrary discrimination internationally. An important characteristic of this Protocol is the fact that it is designed to identify the presence of discrimination within written texts (i.e., laws, policies) and unwritten procedures/practices, and draws data from multiple sources, including interviews with people living with HIV/AIDS. Documenting incidents and trends pertaining to structural stigma, thereby exposing the prevalence and perniciousness of the phenomenon, represents a necessary step toward addressing it.

A handful of tools are available to assess human rights protections in legislation for people with mental illnesses. For example, in 2011, an evaluation tool called the Mental Health and Human Rights Evaluation Instrument ('Evaluation Instrument') was produced by a research team that received funding from the Mental Health Commission of Canada [105]. The Evaluation Instrument was designed to examine whether existing mental health laws, policies, and standards in Canada align with the principles of the UN Convention on the Rights of Persons with Disabilities and uphold fundamental human rights. Although the Evaluation Instrument requires further refinement, it provides a useful foundation for initiating a research agenda focused on gaining an improved understanding of mental illness-related structural stigma in Canada. Such research is aligned with Canada's obligation to measure its level of compliance with the Convention on the Rights of Persons with Disabilities.

Once chronicled by rigorous research, the systematic exclusion of persons with mental illnesses by our institutional systems can no longer be ignored or reframed as a rare occurrence. Documenting incidents of structural stigma through research has several advantages including the ability to monitor change over time (e.g., before and after an anti-stigma initiative), compare different jurisdictions (e.g., provinces, countries), and identify priority areas for action [64]. Such data can equip mental health and human rights advocates with accurate, current information in order for them to prioritize their own efforts as they rally for change [54,56,106].

In addition to studying the prevalence and incidence of mental illness-related structural stigma in Canada, research should also examine the degree to which the public is supportive of policies and practices that restrict the rights and opportunities of people with mental illnesses. Such information would help with knowing where to allocate resources strategically to support education, advocacy, and lobbying activities. Researchers should also study the relationship between structural stigma and health/social outcomes for people with mental illnesses [204], which is important in order to understand the public health significance of this issue. Researchers in the United States found that reducing structural stigma related to sexual orientation (i.e., legislation that permits/prohibits gay marriage) appears to have exerted a positive effect on a population's mental health [205]. Gaining an improved understanding of the impact that reducing structural stigma has on the health and well-being of people with mental illnesses would be a fruitful avenue for future research.

Although traditional research approaches are suitable for examining some research questions, a community-based participatory research approach should be prioritized in any research agenda focused on studying and addressing

structural stigma. As Corrigan and colleagues [112] note: "Stigma robs people of rightful opportunities; hence, these people need to be at the research table as investigators take on the task of understanding stigma and stigma change" (p. 48). Research that actively engages people with mental illnesses in the process of producing knowledge can achieve numerous anti-stigma-related goals, such as fostering empowerment, mobilizing social justice, supporting social inclusion, and decentralizing power [206]. It also establishes an additional forum that can be used by people with mental illnesses to understand and solve issues that affect their daily lives.

CLOSING

> There is no question but that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice.
>
> Supreme Court of Canada's Chief Justice Lamer
> *R v. Swain* [1991] at p. 994

Structural stigma is an issue of social justice, citizenship, human rights, ethics, and public health. Given the enormous scale of the problem, the task of addressing it seems unfathomable. However, there is good reason to remain optimistic about the prospect of creating an inclusive, equitable, and just society in which people with mental illnesses are not subjected to arbitrary restrictions on their rights and opportunities. A number of major legislative reforms in the United Kingdom and United States have been implemented to improve the protections and supports that are provided to people with mental illnesses, such as providing them with greater control over treatment decisions, expanding funding for mental health research, and supporting individuals who are returning to the workforce [116,52].

The State of California recently commenced on implementing a comprehensive 10-year mental health strategy focused, in part, on eliminating structural stigma that is embedded in federal and State legislation [95,196]. The following are some of the activities that will be undertaken to achieve this goal:

- Develop and disseminate educational fact sheets about applicable State and federal laws and regulations protecting individuals with mental illness in different contexts, such as schools, housing, guardianship, employment, and healthcare;

- Establish local groups that are tasked with developing and implementing strategies for promoting the compliance and enforcement of current anti-discrimination laws and regulations;

- Establish regular meetings with government and non-profit civil rights enforcement agencies to ensure protections of people living with mental illness;

- Train staff in institutional systems (e.g., higher education, prisons, health facilities) to ensure the understanding and proper implementation of existing protections;

- Train legal officials, such as lawyers, on recognizing and prosecuting mental illness-related discrimination;

- Facilitate the creation of legal opinions on areas of discrimination encountered by persons with mental illnesses; and

- Develop a statewide committee comprised of legal experts and diverse community members to review existing laws and regulations for discriminatory provisions and gaps, and to recommend corrective strategies.

On the face of it, this program incorporates many of the recommended mechanisms for dismantling structural stigma, such as employing a mixture of approaches (e.g., legal action, advocacy, education, healthcare reform) and developing multi-sectoral/cross-disciplinary collaborations. The evaluation plan that complements this anti-stigma initiative provides promise for generating new knowledge about the relative effectiveness of these strategies for eradicating mental illness-related structural stigma.

Reducing structural stigma will require both big and small changes to our institutional systems, as is nicely articulated by Sayce [52]: "In a sense, we are all responsible – through democratic means, through our own actions – for creating a society that does not discriminate on mental health grounds" (p. 127). On a small scale, perhaps an employer can

be convinced of the value of providing an employee with accommodations that will allow them to succeed in the workplace. Or, perhaps a mental health service provider will realize the benefits that are gained by meaningfully engaging people with mental illnesses in the treatment planning process. On a large scale, perhaps mental health services will be funded at a sufficient level such that people with mental illnesses have access to an appropriate range, quality, and standard of care. Or, perhaps people with mental illnesses will be able to find affordable, decent housing in socially integrated neighbourhoods. It is worthwhile to imagine a world without structural stigma; making it a reality will take time, persistence, and a legion of supporters.

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