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**Title:** Dismantling Structural Stigma Related to Mental Health and Substance Use: An Educational Framework

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Dismantling Structural Stigma Related to Mental Health and Substance Use: An Educational Framework

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Abstract

Stigma related to mental health and substance use (MHSU) is a well-established construct that describes how inequitable health outcomes can result from prejudice, discrimination, and marginalization. Although there is a body of literature on educational approaches to reduce stigma, anti-stigma education for MHSU has primarily focused on stigma at the social, interpersonal/public, and personal (self-stigma) levels, with little attention to the problem of structural stigma. Structural stigma refers to how inequity is manifested through rules, policies, and procedures embedded within organizations and society at large. Structural stigma is also prominent within clinical learning environments and can be transmitted through role modeling, resulting in inequitable treatment of vulnerable patient populations. Addressing structural stigma through education, therefore, has the potential to improve equity and enhance care. A promising educational approach for addressing structural stigma is structural competency, which aims to enhance health professionals’ ability to recognize and respond to social and structural determinants that produce or maintain health disparities. In this article, the authors propose a framework for addressing structural MHSU stigma in health professions education that has 4 key components and is rooted in structural humility: recognizing structural forms of stigma; reflecting critically on one’s own assumptions, values, and biases; reframing language away from stereotyping toward empathic terms; and responding with actions that actively dismantle structural MHSU stigma. The authors propose evidence-informed and practical suggestions on how structural competency may be applied within clinical learning environments to dismantle structural MHSU stigma in organizations and society at large.
Stigma is socially constructed and structurally embedded. Historically, stigma has been used to refer to a discrediting label applied to individuals to mark them as discrepant from the norm.\(^1\) Through labeling, devaluation, mistrust, and discrimination, stigma perpetuates inequities in care.\(^2,3\) Although stigma is associated with several groups and social categorizations, our focus in this article is stigma related to mental health and substance use (MHSU). Despite widespread anti-stigma campaigns and educational interventions, MHSU stigma persists in health professions education, particularly within the informal or hidden aspects of health professions curricula and learning environments.\(^4\)

MHSU stigma refers to prejudice and discrimination that disproportionately affects individuals with MHSU. Stigma can include negative beliefs about and behaviors toward oneself (personal/self-stigma) and the beliefs and behaviors of others, such as labeling, stereotyping, distancing, or withdrawal (interpersonal/public stigma). Stigma can also be structurally embedded and reproduced through policies and practices (structural stigma).\(^5-7\) Health professions learners may come across tangible examples of structural MHSU stigma. For example, they may encounter patients admitted to hospitals for physical treatment who also need MHSU treatment but who must go without because hospitals lack sufficient resources. They may learn about mental health, physical health, and substance use as separate topics without consideration of how the 3 are integrated in practice. Patients may experience structural MHSU stigma in their interactions with health professionals in systems of care that are misaligned with their needs, in which people with MHSU problems are considered as less treatable and less deserving of care.\(^8-10\) Clinical manifestations may also include quality-of-care issues, such as diagnostic and treatment overshadowing, negative prognostication, failure to adopt inclusive or recovery-oriented models of care, or ongoing coercive and punitive practices, including forced
treatment and criminalization. Overall, structural stigma reinforces other forms of stigma through cycles of blame, shame, and mistrust of individuals who seek help for their mental illness or substance use disorder. Taken as a whole, MHSU stigma has been shown to have negative consequences on an individual’s self-efficacy and help-seeking and can be empirically linked to suicide. It is therefore imperative that clinical learning environments teach about MHSU stigma and its impacts, especially the ability to detect and respond to manifestations of structural stigma that influence learners, teachers, and patient outcomes within clinical environments.

The need to address structural MHSU stigma within health professions education is clear. However, common educational approaches for reducing MHSU stigma for learners and practicing health professionals have tended to focus on interpersonal/public stigma. (Table 1 shows the different levels of MHSU stigma and related educational interventions.) Through the interpersonal lens, stigma is conceptualized as a social process that occurs between individuals, and key elements of the interventions often include a combination of education and social contact. The outcomes of these interventions are measured at the individual level rather than the level of the organization or system at large. While such interventions have indeed improved attitudes, they are unlikely to produce sustained outcomes as many are one-off programs and tend to pay little attention to the ways in which stigma is also rooted in structures and organizational culture and embedded within organizational policies and practices. Effectively addressing MHSU stigma therefore requires greater attention to how stigma may manifest in practice and the larger culture of caring, which means giving explicit attention to structural stigma.
Within health professions education, clinical learning environments represent a potential opportunity to consider a novel approach to structural stigma education. Medical learners, for example, can experience significant moral distress when encountering structural forms of stigma that influence learner well-being, and these forms of stigma have implications for teaching and learning about equity.\textsuperscript{16} However, addressing structural stigma training within such contexts can be challenging due to the lack of literature in this area. Any approach that seeks to address structural stigma through education requires improving learners’ understanding of the economic, sociopolitical, cultural, and historical underpinnings of inequity related to MHSU. It should also provide learners with a deeper understanding of how structural stigma is connected to explanatory schemas regarding MHSU disorders.\textsuperscript{17} For example, teaching students and residents about how underlying assumptions shape our understanding of MHSU and exposing learners to alternative models of understanding can help highlight how structural stigma shapes policies, behaviors, attitudes, and our design of systems of care.\textsuperscript{4} A shift in anti-stigma education for health professionals toward structural stigma can also help contribute to structural change that would improve health care delivery. In this article, we describe a potential framework for MHSU structural stigma recognition and management that is informed by existing literature on structural competency and focused specifically on clinical learning experiences in health professions education.

**Understanding Structural Competency**

In the context of health professions education, the concept of structural competency has been defined as the ability of health care professionals to recognize and respond to social and structural determinants of health that produce or maintain health disparities.\textsuperscript{18,19} In this conceptualization, structure refers to social and economic policies, laws regulating distribution of
health resources, race, religion, gender, and ethnicity. Structural competency also includes a focus on skill development, and that is the focus used in adopting this approach to address structural MHSU stigma in a clinical learning environment. Skill development includes enhancing health professionals’ ability to recognize and respond to structural factors that affect MHSU as well as structural factors that affect the quality of care people receive. Health professions learners would also have opportunities to learn tools and skills that would enable them to address structural aspects of health and well-being. Structural competency can be integrated into both formal and informal instruction by providing learners with knowledge about the structural determinants of MHSU while also improving their ability to recognize and describe structural factors that shape how health systems respond—thereby helping to illuminate important structural processes that often go unseen.

Structural competency also helps foster attitudinal change by teaching health professionals to reframe their perceptions of patients who struggle with treatment by shifting from blaming the patient toward a comprehensive understanding of the patient’s experiences. This shift in perspective promotes empathy while also encouraging professionals to imagine and implement structural change in how services are designed for and delivered to stigmatized populations. In addition, structural competency and its concepts align with Mezirow’s concept of transformative learning, which has been described as a useful tool to address implicit and structural bias.

Table 2 provides a summary, with examples, of the 4 key components of structural competency that make up the proposed framework for addressing structural MHSU stigma in health professions education: recognize, reflect, reframe, and respond, or the 4 R’s. Each is discussed in depth in the following sections.
Proposed Framework for Addressing Structural MHSU Stigma in Health Professions Education

Recognizing structural stigma

Learners and practicing professionals cannot address what they cannot name. In the context of structural MHSU stigma in clinical learning environments, recognizing structural stigma requires explicit understanding that mental illnesses and substance use disorders are complex health issues with social, economic, and public determinants as well as impacts. Health professionals must be trained to understand the biologic as well as psychosocial causes and consequences of MHSU through an understanding of structural factors, such as public health, housing, education, food security, laws, policies, and systemic racism. In addition, they must be trained to recognize where and how patients with MHSU encounter structural barriers in the health care system and how these barriers influence their care experiences and outcomes.

Imagine a scenario that takes place during medical rounds within a clinical teaching unit. An individual is admitted overnight for antibiotic treatment of an infected skin ulcer resulting from repeated intravenous drug use. During rounds, the medical team introduce the patient as a “drug user,” and several members of the team make comments about how this patient may be “difficult,” “behavioral,” or “drug seeking.” Requests for pain medication are denied. In contrast, the patient next door, who is being treated for a skin infection unrelated to injection drug use, is described as “pleasant.” The team prioritize attention to and relief of the second patient, easily accommodating that request for medication.

In this example, recognizing structural stigma means recognizing that an infected skin ulcer may relate to structural factors. It also means recognizing how moral judgments and attributions of blame can result in framing a medical problem in stigmatizing ways. Further, it means
recognizing that such judgments exist not just at the level of individual health professionals, but they are also structurally embedded and reinforced within the larger culture of caring through the ways that patient information is captured and discussed.

**Reflecting and critical consciousness**

Critical consciousness is a key ingredient of structural competency. Rooted in critical theory, critical consciousness is a “reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships.”

To develop critical consciousness, learners must engage in cognitive and affective processes, including critical reflection and discourse. Critical reflection allows learners to understand and identify individual assumptions, values, and biases that explicitly or implicitly affect behavior. Discourse allows learners to link training with human values and helps them understand systemic, institutional, and interpersonal barriers. When applied to structural stigma, critical reflection includes critical questioning of assumptions that underpin how health care services are framed and delivered. In the example above—health care professionals responding differently to the pain of 2 patients—fostering critical consciousness may include questioning underlying schemas related to MHSU and critically reflecting on how such assumptions have shaped policies and practices such as pain management.

In another example, consider a pediatric team rounding on a recently admitted 16-year-old patient with significant abdominal pain. The attending physician notes a history of psychiatric treatment and challenges the team to critically reflect on how knowing that a patient has had psychiatric treatment may influence their judgment or interpretation of that individual’s pain. In this situation, the teacher challenges learners to critically reflect on judgments or assumptions they may have about this person and how their judgments or assumptions may be informed by
underlying explanatory schemas or beliefs about individuals with MHSU problems and their treatability and their trustworthiness or about the way the medical system should respond to the needs of such individuals. Cultivating this kind of critical reflection can be crucial for addressing the problem of diagnostic and treatment overshadowing because MHSU problems are often implicitly associated with blame, misattribution of personal responsibility, and schemas that minimize the wisdom, strengths, and expertise of individuals who are suffering.\textsuperscript{12,34} The clinical teacher can also encourage learners to critically reflect on how they describe and document in an electronic health record individuals presenting for common complaints related to mental illnesses or substance use problems.

**Reframing**

Reframing involves shifting the language used to describe an encounter to reflect structural components. In the context of substance use, rather than framing behavior as “good” or “bad,” clinical teachers can help learners appreciate the function of substance use for the individual, such as providing relief from pain. Reframing includes cultivating a deeper understanding of a patient’s biogenetic vulnerability for MHSU-related illness. In addition, to reframe, learners must know that substance use may be a form of self-medication, nervous system regulation, or relational connection and that it is often related to experiences of trauma. This form of broader understanding reframes the individual seeking care from a deviant, a criminal, or a problem for society to a normal human. In the example of a patient with an infected skin ulcer, reframing would help shift the perception of the patient and the descriptive language away from stereotypes of difficult patients toward a more empathic, structurally informed, and compassionate assessment of the situation.
Reframing is also useful for debriefing conflictual or tense incidents with patients. Instructors can shift from labeling the patient as a diagnosis to a person with a name and from reframing tension that arises within interactions from dangerous and to be avoided to necessary, inevitable, and productive. This technique can also be used to address role and power differences by recognizing power asymmetries and promoting shared decision making when possible. For example, health professionals can integrate principles of trauma-informed care or harm reduction by meeting individuals where they are, focusing on their self-identified needs, and emphasizing incremental gains built through trust, validation, and noncoercive interactions.\textsuperscript{35,36}

**Responding by dismantling structural stigma through action**

Once learners can recognize structural stigma, question their assumptions, and reframe clinical presentations, they can begin to reimagine structural interventions and respond through action. Responding requires learners to couple their structural-level knowledge with action to address structural inequities.\textsuperscript{22,37} Effectively responding to structural stigma may involve interventions within immediate, local, and broader contexts.

Responding can involve interventions at multiple levels. In both examples described above—the patient with the infected skin ulcer from intravenous drug use and the patient with a history of psychiatric treatment—an immediate response would involve validation, normalization, and explicit role modeling of a more empathic and less stigmatized framing of the individual’s condition. Both cases require appropriate clinical assessment and use of resources. They may also warrant further inquiry and advocacy regarding the different application of policy toward one patient or another. In addition, responding may also involve health professionals in championing broader structural changes within the system, such as changing how patient information is captured in electronic health records, modifying guidelines for pain management,
adopter trauma-informed approaches to communication, or establishing an explicit medical screening process for individuals with MHSU in acute care environments to mitigate the risk of diagnostic overshadowing.

At a structural level, responding might be improved by providing training in health advocacy. Health professionals can use their expertise and influence to advocate for structurally marginalized populations. \(^{32,37–39}\) Community-level advocacy may include considering authentic approaches to codesign or social innovation in which design and implementation take place outside of a traditional academic organization. \(^{18,38}\) In addition, advocacy could involve a quality improvement initiative or simply supporting a patient’s housing, economic, or social needs as part of their medical care.

**Developing structural humility**

In addition to the 4 R’s, structural humility is a vital component of developing structural competency. Structural humility is the ability to recognize the limitations of structural competency. \(^{20,40,41}\) Even when health care professionals are aware of structural factors in clinical encounters, there are limits to what they can accomplish with their authority, training, and expertise. Structural humility can be enhanced by using a patient-centered approach: listening to the voices and expertise of those with lived and living experience of suffering. \(^{33}\) Clinical teachers should foster structural humility throughout all aspects of structural competency. Putting structural humility into practice requires role modeling a more deferential and respectful approach toward patients. It also requires explicitly recognizing that power asymmetries influence which voices are prioritized and which perspectives inform the policy and legislative decisions that adversely affect some populations more than others.
Examples of Integrating Structural Competency Into Curricula

Quality improvement curricula

One way to build skills in recognizing and responding to structural MHSU stigma is to integrate structural MHSU stigma training and quality-of-care education. This approach would help learners identify structural forms of stigma as operationalized outcomes and performance deficits. For example, learners could be involved in an audit of clinical services for people suffering from MHSU disorders to identify structural inequities and other gaps in access. Teaching structural competency within the context of quality improvement would also encourage better integration of structural MHSU stigma measures in health systems performance, allowing for better tracking and understanding of how resource allocation and system design can produce inequities. Once such a structural disparity is made explicit, responding could focus on how to reallocate resources and foster system redesign, while foregrounding structural competency as a vital component of equity and, therefore, quality patient care.

Interdisciplinary learning

An interdisciplinary perspective is central to teaching and learning about structural competency. Teaching about health and including the lens of various disciplines, such as sociology, psychology, public health, economics, human rights, ethics, and mad studies, increase learner knowledge while promoting critical consciousness and critical reflexivity. These opportunities create a space for learners to reconceptualize health care, become more sensitive to patient experiences, reexamine relationships in terms of human interactions, and promote personal understanding. Existing forms of structural competency training are often interdisciplinary, include small group discussions, and improve communication skills through dialogue between and within teams.
Meaningful patient partnerships

When addressing structural MHSU stigma, involving patients as partners can foster a powerful and effective way of training health professionals. An example is a longitudinal course for psychiatry residents coproduced with individuals with lived experience of mental health challenges. During this course, patient partners served as advisors to resident physicians and fostered participants’ empathy and reflection. Such examples of coproduced education have improved students’ respect, empathy, and compassion for patients. At the same time, students are motivated to challenge structural MHSU stigma while recognizing the role of power imbalances in the doctor–patient relationship in reproducing health inequities. In the context of mental health training, coproduction of educational experiences also benefits mental health service users who often feel empowered after participating. Despite the potential for coproduction, educators must pay attention to challenges related to the potential for tokenism and exploitation.

Experiential community-based learning and partnerships

Experiential community-based learning helps learners apply classroom concepts in a real-world context, increasing awareness and identification of structural factors both within and outside a typical health care environment. One common form of experiential learning is engagement in community placements. Engagement with community-based organizations focused on mental health or substance use provides learners with opportunities to observe the influence of structural factors, such as poverty or precarious housing, on individual health and livelihood, thereby engendering iterative learning and increasing awareness. Observation, field notes, reflection, and facilitated dialogue may all be included in such experiential learning and may help
encourage learners develop innovative structural interventions that can be applied at various levels.

**Faculty development**

Efforts to integrate structural competency also require trained faculty to help with curricular design and implementation. Given longstanding gaps in faculty development in areas such as structural competency and structural inequity and stigma for MHSU, we draw upon existing literature to advocate for interdisciplinary professionals, including those from medicine, nursing, anthropology, social work, public health, criminology, and law. Facilitators should be trained to gain a deeper understanding of the principles being taught and the theory that informs the structural competency approach. Efforts to build capacity for clinical teachers also require explicit attention to how structural competency may be distinct from traditional approaches and include opportunities to practice and be coached by experts.

**Limitations of a Structural Competency Approach**

Structural competency is primarily an educational approach, targeting professionals, to improve care. Addressing structural stigma requires paying attention to learners at all levels of a system, including health professions leaders and decision makers. Therefore, further research is needed on how to apply structural competency to and integrate it with leadership competencies. Learners may have different prior knowledge that can be activated as well as biases that require critical reflection and unlearning as part of a structural competence approach. Another important limitation is a lack of robust evaluation for such approaches. Therefore, ensuring the relevance and effectiveness of a structural competency curriculum for a particular audience within their professional and organizational context is important for translating these approaches into a successful implementation. In addition, our approach is a preliminary one. We acknowledge that
our framework is simply one exploratory step in the application of structural competency education to structural MHSU stigma education.

Conclusion

A structural competency approach for targeted structural MHSU stigma education can provide a practical and evidence-informed framework for health professions learners. By enhancing knowledge and skills to recognize structural stigma, to reflect on one’s assumptions, to reframe language use, and to respond with actions, health professions learners can engage in meaningful and participatory approaches to dismantling structural stigma. Interprofessional learning and experiential learning can enhance teaching in this regard. Although such a framework targets practicing professionals, addressing structural stigma in a thorough manner also requires training and regulatory change for health care leaders and accreditation bodies.
References


Table 1

Proposed Educational Strategies to Mitigate Mental Health and Substance Abuse Stigma at the Structural, Interpersonal/Public, and Personal Levels

<table>
<thead>
<tr>
<th>Level of stigma</th>
<th>Educational strategies</th>
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| Structural                       | • Increasing awareness of the social, historical, cultural, and moral influences on the design and delivery of services  
• Fostering critical consciousness regarding structural forms of stigma within educational and health systems  
• Learning skills to recognize structural stigma and redesigning policies, rules, practices, and systems to improve equitable outcomes |
| Interpersonal/Public              | • Learning skills to challenge negative attitudes and misperceptions  
• Increasing awareness of how labeling and stereotypes lead to discrimination and inequitable outcomes  
• Fostering empathy and shifting attitudes through education based on social contact  
• Recognizing and managing biases |
| Personal (Self-stigma)            | • Increasing awareness of how stigma can be internalized and contribute to learned helplessness, self-blame, and shame  
• Learning skills to practice self-validation, self-forgiveness, and self-compassion |
Table 2

Proposed Framework for Addressing Structural Mental Health and Substance Use Stigma in Education for Health Professionals

<table>
<thead>
<tr>
<th>Component</th>
<th>Focus</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Recognize</td>
<td>Recognizing how structural stigma manifests during care processes</td>
<td>During rounds, when one patient is described as “drug seeking” while another is described as “pleasant,” the clinical teacher draws attention to the differences both in language use and in the perceived need to attend to the two patients’ pain, despite similar complaints.</td>
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</table>
| Reflect | Reflecting critically on how assumptions, values, and biases underpin systems of care | A clinical teacher assigns students to critically reflect on language use in a patient’s health record, challenging learners to consider the following:  
- How certain words transmit assumptions, values, and biases  
- How their assumptions and judgments might be different if they knew the patient’s full life story  
- How structural factors may have influenced the patient’s presentation and course  
These are examples of critical reflections:  
- How would the patient’s presentation differ if they had timely or equitable access?  
- Did the patient perhaps avoid care because of unsatisfying or unhelpful past clinical experiences, such as being treated poorly in previous encounters with the health care system or because they felt they would not be listened to or understood? |
| Reframe | Reframing situations to highlight structural components and enhance connection | The clinical teacher shifts from using diagnosis- to person-centered language. Reframing should incorporate how various structural determinants have influenced the patient’s status and symptomatic presentation, their orientation toward care and treatment, their relationship with care providers and institutions, and other experiences and realities.  
These are examples of reframing:  
- Reframing an individual from being a “schizophrenic” to someone with a “brain illness”  
- Recharacterizing a patient from “drug seeking” to “seeking relief from pain”  
- Shifting from asking “What’s wrong with you?” to “What happened to you?”  
- The clinical teacher debriefs conflict between the team and a patient by recognizing power asymmetries and differences in roles and responsibilities to promote shared decision making. |
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<th>Respond</th>
<th>Responding by role modeling structural humility and by advocating for structural change</th>
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<td></td>
<td>• The clinical teacher role models awareness of a patient’s individual behavior as symptoms of an underlying illness or traumatic experience.</td>
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<td></td>
<td>• Teams should encourage quality improvement initiatives to address structural vulnerabilities. For example, institute a standard clinical algorithm for medical clearance.</td>
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<tr>
<td></td>
<td>• Teams should support patients’ housing, economic, or social needs as part of their medical care. For example, write a letter to a landlord to address housing issues.</td>
</tr>
<tr>
<td></td>
<td>• Teams should advocate for structural change or for access to evidence-based care, such as harm reduction (safe consumption sites) within hospital settings.</td>
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