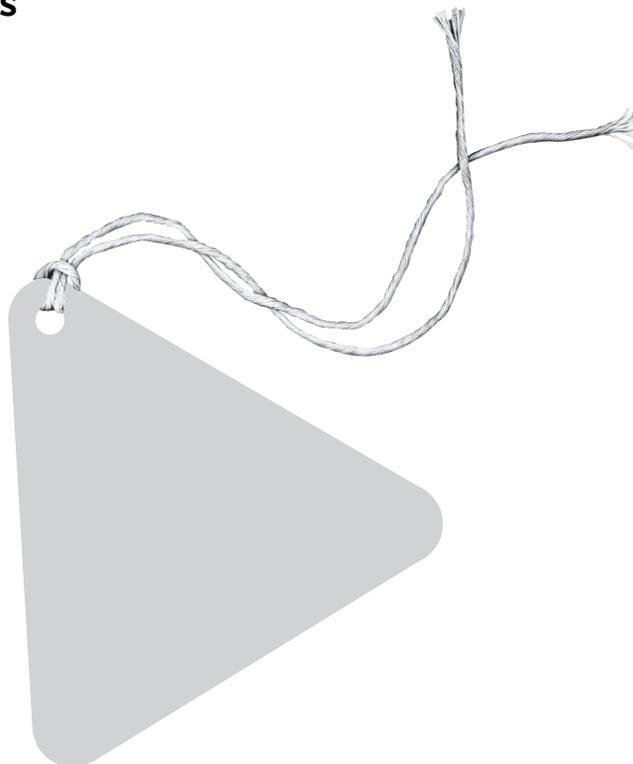


BEYOND THE LABEL

**An Educational Kit to Promote Awareness and
Understanding of the Impact of Stigma on
People Living with Concurrent Mental Health
and Substance Use Problems**



Beyond the Label
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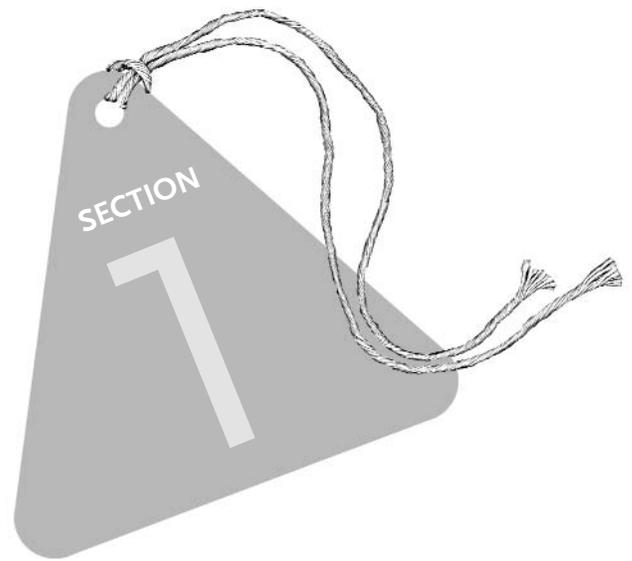
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INTRODUCTION



INTRODUCTION

BACKGROUND

Beyond the Label has evolved from research in the fields of stigma and concurrent disorders, and through the knowledge obtained from people living with concurrent disorders, their families and the professionals working closely with them.

These studies and conversations have uncovered one clear and consistent message: Despite the increased awareness about concurrent disorders, their prevalence, and the need for an integrated approach to treatment, the stigma attached to the label continues to be a significant barrier for people living with concurrent mental health and substance use problems. This often-unconscious social bias prevents people from seeking assistance, accessing services or, in many cases, continuing with the treatment programs that play a vital role in their recovery.

ABOUT THIS RESOURCE

Purpose

Beyond the Label has been designed to:

1. help service providers ensure that their services are accessible and supportive to people with concurrent mental health and substance use problems by examining stigma and the barrier it presents
2. provide mental health and addiction workers with concrete tools to use in their agencies and in the community, to raise awareness about the stigma associated with concurrent disorders.

Beyond the Label is not an information resource on concurrent disorders. This educational kit focuses on the stigma associated with concurrent mental health and substance use problems, and includes activities that:

- emphasize the impact of attitudes and beliefs on people with concurrent mental health and substance use problems
- highlight facts and dispel myths about concurrent disorders

- present positive stories showing people who have experienced concurrent mental health and substance use problems contributing to society
- present solution-focused approaches
- support addiction and mental health workers in their efforts to eliminate stigma, prejudice and discrimination.

Through this learning process, participants will build on their ability to understand stigma and its impact.

Intended audience

Those of us who provide addiction and mental health services have a critical role to play in addressing stigma. We know only too well the barrier that stigma creates when someone is trying to access treatment or support. Yet ironically, we often hold unexamined prejudices or misconceptions of our own. *Beyond the Label* is intended to support people working in the fields of mental health and/or addiction treatment by providing them with an interactive framework to discuss, learn, understand and reflect on the impact of stigma on people living with concurrent mental health and substance use problems.

Beyond the Label's easy-to-use format provides the facilitator with information and teaching tools to reach a variety of audiences, including:

- colleagues
- volunteers
- managers
- board members
- community agencies or coalitions
- and many more (see “Sample presentations,” on page 54).

What's inside

This educational kit features:

- 10 specially created group activities
- a presentation outline to set the stage for your workshop presentation
- master sheets, in print and CD format, to use as photocopy handouts or to make transparencies
- background information for facilitators on concurrent disorders and stigma

- presentation tips and information about how to use this material efficiently
- discussion points for group and individual dialogue
- facts and ideas to keep your presentation lively and focused
- examples of opportune times to use this kit in your community.

How to use this package

Finding a large block of time to organize and facilitate a group activity can be difficult, but don't worry. You can customize this material to suit your time frame, the number of participants in your session and your desired emphasis.

This resource has activities that can be used at staff meetings, training courses, brown bag lunches, rounds (in clinical settings such as hospitals and community health centres) and orientation sessions for new staff, volunteers or board members. It can also be used as a supplement to knowledge-based training about concurrent disorders. Some sample presentations are provided in Section 4: Tips for the Facilitator.

GUIDING PRINCIPLES

- The time frames suggested for each activity in this package are flexible. You may decide that you would like to allow more time for some activities in order to incorporate additional discussion points that might be relevant to your audience.
- Feel free to add your own stigma-busting activities that you have tried or seen others use.
- Having someone who has lived with a co-occurring problem act as facilitator or co-facilitator will enrich the presentation. Activity 9, "There's always another story," is a good activity to include in this instance.
- You don't have to be the expert! The participants will be equal partners in your stigma-busting presentation.
- Activities have been grouped chronologically to help you order your presentation in a way that is natural and logical.
- Include the information slides on concurrent disorders and stigma (Section II: Setting the Stage) to launch all presentations.
- We recommend ending your presentation on a positive, solution-focused note with Activities 8, 9 and 10.

A WORD ABOUT WORDS

Language can be a friend or foe when confronting the stigma associated with concurrent mental health and substance use problems. How people are labelled can actually affect the way we feel about them and how they feel about themselves. For example, terms like “junkie,” “psycho” and “drunk” perpetuate myths and stereotypes. This stigmatizing language is hurtful and can lead to prejudice and discrimination. Even terms like “alcoholic,” “schizophrenic” and “concurrent disorders” suggest that this particular characteristic is of prime importance, overshadowing the person’s other qualities.

Still, you may find that some people refer to themselves as “alcoholics” or “schizophrenics.” We must respect how people choose to identify themselves, even though society associates negative characteristics to certain terms. We may encourage people to refer to themselves in more affirming and inclusive terms, but it is important that we honour people’s life stories and listen carefully to their words.

Throughout this package, we have tried to use language that respects the client’s uniqueness as an individual but still allows us to refer to people as part of groups that reflect similar profiles. For example, we use the phrase “person with concurrent (or co-occurring) mental health and substance use problems” to denote “concurrent disorders.” We hope that this term, though lengthy, will cause the facilitator and the participants to reflect on the individual rather than the label.

SETTING THE STAGE



SETTING THE STAGE

The following is a suggested format for beginning your presentation and introducing key terms. We recommend that, at every workshop, you take 10 minutes to present the nine overhead slides in this section to “set the stage” for the workshop activities and group discussion to follow. These introductory slides will provide your audience with a basic understanding of concurrent mental health and substance use problems and an overview of stigma.

GETTING STARTED

1. Introduction and presentation overview

Welcome participants and introduce yourself, indicating your background, experience and interest in this topic. Depending on the group size, the participants could then introduce themselves and explain their interest in attending the presentation.

Present **OVERHEAD 1: Presentation overview**

Providing a brief overview of the presentation will reinforce to participants that this workshop will focus on the stigma related to concurrent disorders and not on concurrent disorders themselves.



NOTE TO FACILITATOR

For participants who are interested in learning more about concurrent mental health and substance use problems, a handout on concurrent disorders and a list of suggested resources are available in the appendices, and can be copied and distributed to participants.

2. Ground rules

Before starting the warm-up activity, **present OVERHEAD 2: A few ground rules**, or have the group establish their own ground rules.



3. Warm-up

Included in Section 3: Stigma-Busting Activities are two warm-up activities (“Just the facts!” and “Do you know . . . ?”) that will stimulate participants’ thinking about stigma and concurrent disorders. You can use one of these activities or choose one of your own.

A WORD ABOUT CONCURRENT DISORDERS

While the workshop presentation will focus on stigma, the following brief didactic presentation will ensure that everyone has a common understanding of concurrent mental health and substance use problems and their prevalence.

OVERHEAD

3

1. Present OVERHEAD 3: What are concurrent disorders?

OVERHEAD

4

2. Present OVERHEAD 4: However, 1 + 1 may equal 3, 4, 5 . . .

Suggested script

People who are living with co-occurring, or concurrent, substance use and mental health problems are said to have concurrent disorders. However it is not just $1 + 1 = 2$ but rather $1 + 1 = 3, 4, 5 . . .$ First, there may be more than one mental health problem (e.g., schizophrenia and depression) and more than one substance involved (e.g., cocaine and marijuana).

Second, the effects of one may compound the effects of the other, thus exacerbating symptoms and making the person's life more challenging. This in turn may put the individual at risk of losing his or her housing, job and perhaps social support networks. The person may also be at risk for medical problems such as HIV/AIDS, hepatitis C, diabetes and respiratory problems.

Are there any other factors at play?

3. Present OVERHEAD 5: Prevalence of concurrent disorders

OVERHEAD

5

Suggested script

Concurrent disorders are common in both the mental health and substance use systems. Studies have shown that between 40 and 60 per cent of people who have mental health problems will also have a substance use problem. These percentages are similar for people who seek help for their substance use.

Until recently, two separate groups of professionals treated substance use problems and mental health problems in different settings. Providers in the mental health system would say, “You need to deal with your substance use problem first,” and providers in the substance use system would say, “You need to deal with your mental health problems first.” People would be shuffled between these two systems and, as a result, would never receive appropriate treatment.

Best practices recommend a more integrated approach that addresses both problems concurrently. This is a work in progress. Training and education of service providers, along with consultation and collaboration with community agencies and other institutions, are some of the ways that will bring about the necessary changes for a more integrated system.

NOTE TO FACILITATOR

It is important to wrap up your brief presentation on “Concurrent disorders” before changing the workshop emphasis to “Stigma and concurrent disorders.”

Suggested script

The purpose of this brief presentation was to make sure we have a common understanding of the term “concurrent disorders.” If you would like to learn more about concurrent mental health and substance use problems, a handout, containing specific references and resources, will be available at the end of the presentation. Now, we are ready to start our stigma-busting journey.

A WORD ABOUT STIGMA

1. What is stigma?

The following activity is a good way to set the stage for your presentation on stigma. It opens up the discussion of stigma in a non-threatening manner.

Suggested script

You will be hearing the words stigma and discrimination throughout the presentation today, so we are going to do a short visualization exercise to set the stage for our discussions. I would like all of you to get comfortable and either close your eyes or look down at the floor for a few moments.

NOTE TO FACILITATOR

Now in your best dramatic voice, read the following passage. Use your own hair colour in the example (e.g., redhead, brunette, person with dark hair).

*“On ordinary streets, there is a disaster waiting to happen. There is a group of people among us who pose a threat to their neighbours and indeed to the whole community. Too often their potentially dangerous behaviour is ignored until it is too late. The public is angry about the alarming number of incidents in which **blondes** injure or kill innocent people. Hardly a day goes by without news of a murder or attack by a **blonde** leading many to question why they are allowed to live freely in the community. Even if, as some critics claim, it’s only a small minority causing the problem, it’s not always possible to know which **blondes** are dangerous. We must put the rights of the community first and keep **blondes** in secure but humane institutions for their own good as well as ours.”*

(Taken directly from the video by K. Mattison [Producer] & N. Platt [Director]. [1998]. *Myths about Madness: Challenging Stigma and Changing Attitudes*. Princeton, NJ: Mental Health Media.)

After reading this passage, ask participants to open their eyes.

Suggested script (continued)

*Suppose you had this negative stereotype about **blondes**. How do you think you would have reacted to me when you entered the room? (Pause or discuss.)*

It may seem a bit silly, but we need to ask ourselves, “Is it fair to judge a group of people based on the actions of just a few?” (Pause.) This is how people with mental health and substance use problems are often portrayed.

Before we continue our discussion of stigma and discrimination, let’s review the formal definitions of each of these terms.

Present **OVERHEAD 6: What is stigma?**

OVERHEAD

6

Present **OVERHEAD 7: What is discrimination?**

OVERHEAD

7**2. The multi-layers of stigma**

The stigma related to concurrent disorders is also not as simple as $1 + 1 = 2$. Some people will be further burdened by stigma because society also attributes negative stereotypes to other labels.

Present **OVERHEAD 8: Multi-layers of stigma**

OVERHEAD

8

After reading the list, you may want to ask participants if they can think of any other “layers.” Note that these multi-layers of stigma can create enormous barriers to people receiving the appropriate treatment and support.

3. The effects of stigma

Suggested script

When people are experiencing difficulty in their lives because of co-occurring substance use and mental health problems, it is often hard for them to reach out for help because of the stigma and discrimination associated with both of the co-occurring problems. They worry that people will learn about their situation and react negatively, perhaps as family and friends have, leading them to put a great deal of energy into keeping problems to themselves. People experience prejudice and discrimination because of the negative stereotypes associated with such labels as “alcoholic,” “addict,” “crazy,” “insane,” etc.

Ask participants: “What do you think are some of the effects of stigma?”

OVERHEAD

9

Present OVERHEAD 9: Effects of stigma

NOTE TO FACILITATOR

Listed below are some of the important areas to mention if the participants have not covered them in their answers.

Decent, affordable housing

If landlords discover that a prospective tenant has a history of substance use and/or mental health issues, they are less likely to rent to that person because of negative stereotypes.

Employment

If someone has a history of substance use and mental health problems, the employer and colleagues will likely be more watchful and look for the person to “slip up.” A gap in employment history due to ill health may be difficult to explain without disclosing the details.

Medical care

Often people with substance use and mental health problems are not seen as “urgent” in emergency departments and may be left waiting for hours on their own. They are also often faced with a blaming, “it’s your own fault” attitude.

In closing, you can note the following:

Stigma also has an impact on family and friends. Some family members have experienced:

- economic hardship
- social isolation
- physical and emotional stress
- stigma “by association”
- loss of leisure.

NOTE TO FACILITATOR

Now you can turn to the “Stigma-busting menu” in Section 3: **Stigma-Busting Activities** for a selection of activities designed to raise awareness about this important topic.

Presentation overview

We will explore:

- the facts and myths about concurrent disorders
- the power of language and how words can wound
- stigma, prejudice and discrimination as a barrier to recovery for people living with concurrent mental health and substance use problems
- ways you can incorporate anti-stigma practices into your work
- ways we can all be part of the solution.

A few ground rules

- Respect confidentiality, whether it's about our personal lives, out careers or observations from our work.
- One person speaks at a time and everyone will get a chance to contribute.
- Participants are encouraged to share ideas, but participation is voluntary.
- Participants are encouraged to express differences of opinion.
- Use “I” statements; the first person is more straightforward.
- Actively listen to others.
- No interrupting!
- Embrace religious, age, gender, sexual orientation, linguistic or cultural differences.
- Confront with care; challenge with respect.
- The facilitator is just that—not the “expert”!

What are concurrent disorders?

Concurrent disorders are any combination of mental health and substance use disorders.

Some examples are:

- an anxiety disorder and a drinking problem
- schizophrenia and cannabis dependence
- borderline personality disorder and heroin dependence
- depression and dependence on sleeping pills.

**However,
1 + 1 may equal 3, 4, 5 . . .**

**A combination of mental health and
substance use problems can create
more problems.**

Prevalence of concurrent disorders

Forty to 60 per cent of people who have mental health problems will also have a substance use problem during their lifetime.

These percentages are similar for people who seek help for their substance use.

Health Canada (2001). *Best Practices: Concurrent Mental Health and Substance Use Disorders*. Ottawa: Author.

What is stigma?

Stigma is:

- a complex idea that involves attitudes, feelings and behaviour
- a word referring to the negative “mark” attached to people who possess any attribute, trait or disorder that marks that person as different from “normal” people. This “difference” is viewed as undesirable and shameful, and can result in people having negative attitudes and responses (prejudice and discrimination) toward another person.

Adapted from O'Grady, C. (2004). Stigma as experienced by family members of people with severe mental illness: The impact of participation in self-help/mutual aid support groups. Unpublished doctoral dissertation, University of Toronto.

What is discrimination?

Discrimination is a prejudicial act, such as denying someone employment, housing, accommodation or other services because of the person's race, colour, citizenship, culture, ethnic origin, marital or family status, sexual orientation, disability, age, gender, economic situation and so on. It may be covert or systemic, intentional or unintentional. An act of discrimination is a violation of an individual's human rights and may be prosecuted under the Ontario Human Rights Code.

Multi-layers of stigma

People who are experiencing stigma as a result of their co-occurring mental health and substance use problems may experience additional prejudice and discrimination associated with their:

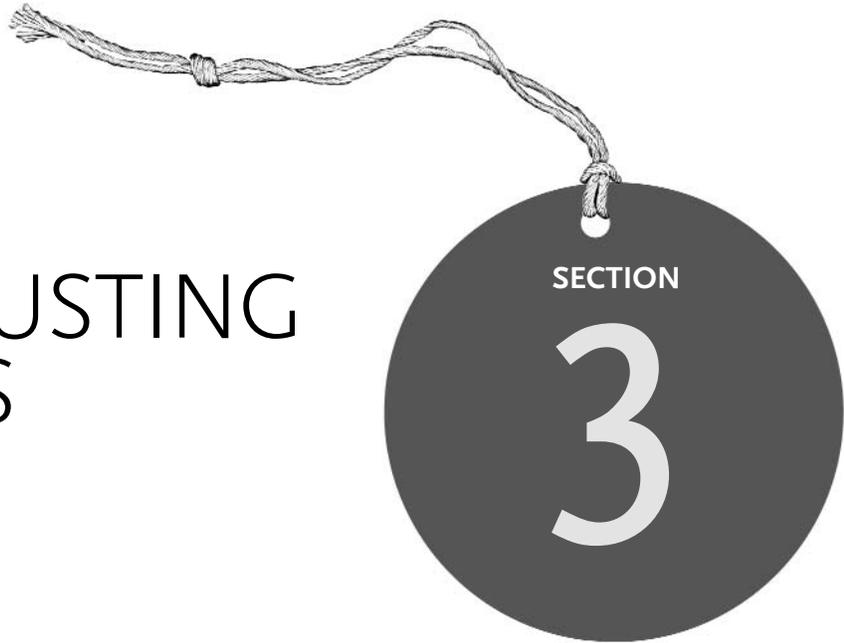
- ethnicity
- race
- religion
- sexual orientation
- invisible or visible disability
- gender
- economic status
- age.

Effects of stigma

- prejudice and discrimination (in medical care, housing, employment)
- negative feelings about self (self-stigma); for example, believing the negative stereotypes generated by society and media messages
- tendency to avoid seeking help, and to keep symptoms and substance use a secret
- social isolation and/or constricted social support network
- poverty
- depression
- loss of hope for recovery
- suicide.

Adapted from Pompili, M., Mancinelli, I. & Tatarelli, R. (2003). Stigma as a cause of suicide. *British Journal of Psychiatry*, 183(2), 173–174, and from Kittel Canale, M. (2001). *Stigma of Addiction: Final Report*. Toronto: Centre for Addiction and Mental Health.

STIGMA-BUSTING ACTIVITIES



STIGMA-BUSTING ACTIVITIES

In this section we have included 10 easy-to-use activities that will raise awareness about: 1) the impact of stigma on people with co-occurring substance use and mental health problems, and 2) how stigma can lead to prejudice and discrimination. You will also find some strategies for making everyone part of the solution.

THE STIGMA-BUSTING MENU

Warm-up

- Activity 1 “Just the facts!”
- Activity 2 “Did you know . . . ?”

The power of language

- Activity 3 “Rethinking ‘normal’”
- Activity 4 “Words can wound”

Keeping it personal

- Activity 5 “Who wears the label?”
- Activity 6 “Walk a mile in these shoes”
- Activity 7 “What’s your gut feeling?”

A solution-focused approach

- Activity 8 “Everyone has a part to play”
- Activity 9 “There’s always another story”

Wrap-up

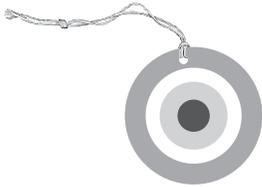
- Activity 10 “Closing activity: Ending on a positive note”

ACTIVITY 1

JUST THE FACTS!

This is a good warm-up exercise to start a presentation.

Many participants will be surprised by what they learn. Two of the main ingredients of stigma are ignorance and fear. People are influenced by what they see and hear in the media and by what they hear from others. Terms such as “alcoholic,” “addict,” “psycho” and “insane” are associated with negative stereotypes, which are based on myths and not on fact.



LEARNING GOALS

- to dispel myths concerning substance use, mental health and concurrent problems
- to raise awareness of the impact of myths and how they perpetuate stigma, prejudice and discrimination.



LEARNING ACTIVITY

MATERIALS

- n fact sheets 1 to 7
- n masking tape
- n flipchart paper and markers

TIME

- n 15–20 minutes

1. Before your presentation, photocopy the fact sheets and tape the photocopies on the walls around the room, leaving enough space to allow several people to gather.

Note: Blank templates have been provided in case you want to include your own fact sheets.

2. Ask participants to walk around the room, read each of the fact sheets and, when they have finished, stand beside the one that is the most surprising to them (or that they think would be the most surprising to other people).

3. Ask the participants who have chosen the *same* fact to:
 - introduce themselves to each other
 - discuss why they were drawn to this fact (or why other people might be surprised by this piece of information)
 - have one person in the small group summarize the feedback.
4. With the entire group, go around the room and have people introduce themselves. Have one person from each small group read the fact and summarize the thoughts of the group.
5. Ask the group if there is anything they would like to add to what was said already.

KEY MESSAGES

- Having the facts about concurrent disorders will help dispel the myths.
- Myths about substance use and mental health problems contribute to stigma resulting in prejudice and discrimination.

“Just the facts!” was adapted from an activity created by the Staff Development team, Education & Publishing, Centre for Addiction and Mental Health.



MYTH

People with concurrent mental health and substance use problems are less likely to seek treatment than people with only one problem.

FACT

People with concurrent disorders are more likely to actively seek treatment than people with only one problem.¹ They are also more likely to be stigmatized and excluded from existing services.²

¹ Health Canada (2001)

² Rassool 92002)

MYTH

People with co-occurring mental health and substance use problems can benefit from substance use treatment (or mental health treatment) if integrated services aren't available.

FACT

Engaging and working with people at either point of entry is crucial but “if one of the co-occurring problems goes untreated, both usually get worse and additional complications often arise.”

Substance Abuse and Mental Health Services Administration
(2002)

MYTH

Most people living with concurrent mental health and substance use problems are homeless.

FACT

While it has been estimated that 40 to 60 per cent of people who are homeless have concurrent disorders, co-occurring problems affect people of all social and economic backgrounds.

MYTH

Most people living with co-occurring mental health and substance use problems have trouble fitting in with the rest of society.

FACT

The stigma associated with concurrent mental health and substance use problems makes it difficult for people to be open with friends, family and colleagues, leaving many people to incorrectly believe that all people with co-occurring problems are homeless or living in poverty.

MYTH

Most people with mental health problems do not have a problem with substance use.

FACT

Forty to 60 per cent of people with a mental health problem will also have a substance use problem sometime in their life.

Health Canada (2001).

MYTH

Treatment first: People who are homeless and living with concurrent mental health and substance use problems need to be stabilized before housing arrangements can be successful.

FACT

Housing first: Studies show that people who are homeless and living with mental health and substance use problems are more likely to address their problems and become more stable if they have decent affordable housing.

Note: Supportive housing does not require clients to be free of the symptoms of their mental illness but often does require them to be free of the symptoms of their substance use problem.

MYTH

There is a tendency for people with severe mental illness to become violent.

FACT

In a 2001 study, researchers calculated that about three per cent of violent offences could be attributed to mental illness and another seven per cent to substance use problems; theoretically, only one in 10 crimes could be prevented if these disorders did not exist.

Arboleda-Florez & Stuart (2001).



SECTION 3
STIGMA-BUSTING ACTIVITIES

ACTIVITY 1
JUST THE FACTS!

A large, empty rectangular box with a black border, occupying most of the page. It is intended for students to write their responses to the activity.



SECTION 3
STIGMA-BUSTING ACTIVITIES

ACTIVITY 1
JUST THE FACTS!

A large, empty rectangular box with a thin black border, occupying most of the page. It is intended for students to write their responses to the activity.

ACTIVITY 2

DID YOU KNOW...?

LEARNING GOALS

- to learn some important facts about mental health, substance use and co-occurring problems
- to identify some misconceptions and stereotypes that contribute to stigma.



LEARNING ACTIVITY

MATERIALS

- n pencils
- n Handouts 1 and 2, “Did you know . . . ?”

TIME

- n 10–15 minutes



1. Give out Handout 1 (the “True or false” questionnaire) and ask participants to mark “true” or “false” beside the statements on the sheet. Tell participants that no one else will see their answers.
2. Review the correct answers using the answer sheet provided.
3. Ask participants: “Were you surprised by some of the answers? Why?” (Discuss.)
4. Ask participants: “How can some of these misconceptions lead to stigmatizing attitudes?” (Discuss.)
5. Give out a copy of Handout 2 (the correct answers) to participants.

KEY MESSAGES

- It is important to know the facts about mental health, substance use and concurrent disorders.
- Myths and misconceptions can lead to stigma, which in turn can be a barrier for people trying to access appropriate treatment and support.



True or false?

	TRUE	FALSE
1. Most people with concurrent mental health and substance use problems need to hit “rock bottom” before they have a chance to recover.	<input type="checkbox"/>	<input type="checkbox"/>
2. If you use an integrated approach to treatment for people with concurrent disorders, the mental health problem and substance use problem will always be treated at the same time.	<input type="checkbox"/>	<input type="checkbox"/>
3. People living with concurrent mental health and substance use problems are less likely to seek treatment than people living with only one problem.	<input type="checkbox"/>	<input type="checkbox"/>
4. Stigma prevents people from seeking help for their mental health and/or substance use problem.	<input type="checkbox"/>	<input type="checkbox"/>
5. People with schizophrenia find that their hallucinatory and delusional symptoms have the greatest impact on their lives.	<input type="checkbox"/>	<input type="checkbox"/>
6. You can't help people with concurrent mental health and substance use problems until they are abstinent.	<input type="checkbox"/>	<input type="checkbox"/>
7. You don't fully “recover” from substance use and mental health problems; you just learn to cope with them.	<input type="checkbox"/>	<input type="checkbox"/>
8. Some professionals working in mental health and substance use treatment hold stigmatizing views of their clients.	<input type="checkbox"/>	<input type="checkbox"/>
9. The stigma associated with concurrent disorders can be as problematic as the symptoms.	<input type="checkbox"/>	<input type="checkbox"/>
10. Suicide causes more deaths in Canada each year than traffic accidents.	<input type="checkbox"/>	<input type="checkbox"/>

“True or false” answers

1. **False.** Mental health and substance use problems can be treated at any stage. Not treating these problems until they are affecting every aspect of life puts the client at greater risk.
2. **False.** While concurrent treatment is believed to be most effective for some co-occurring problems (e.g., eating disorders and substance use), sequencing (addressing one problem and then the other) is recommended in other cases (e.g., when treating mood disorders and substance use, it is best to address the substance use first) (Health Canada, 2001).
3. **False.** People living with concurrent disorders are more likely to seek treatment than are people with only one problem.
4. **True.** A 1996 Israeli study by Ben Noun found that 80 per cent of patients who were referred to a psychiatrist by their doctor refused the referral because of the stigma of receiving psychiatric care (BC Partners for Mental Health and Addictions Information, 2005).
5. **False.** In a 2001 Schizophrenia Society of Canada study, people with schizophrenia reported that social withdrawal had a “great impact” on their lives, and that hallucinations and delusions had the “least impact” on their lives, thanks to advances in treatment (BC Partners for Mental Health and Addictions Information, 2005).
6. **False.** Although total abstinence is recommended for many people with concurrent mental health and substance use problems, *harm reduction* strategies—which allow for reduced use—is a more realistic goal for some.
7. **False.** Recovery is a realistic goal for people living with mental health and/or substance use problems. Early interventions, modern medications and newer psychotherapies have improved possibilities for remission or recovery.
8. **True.** People who work in the mental health and substance use field share many of the same attitudes and beliefs as the rest of society. They may also develop negative attitudes toward clients with substance use and mental health problems, due to:
 - misperceptions
 - the complexity of problems presented by people with concurrent mental health and substance use problems
 - personal feelings of inadequacy, frustration and disappointment (Ritson, 1999).
9. **True.** The strongest theme that emerged from focus groups with people with concurrent disorders was the additional and severe stigma associated with having both problems (Health Canada, 2001).
10. **True.** Suicide is a bigger killer than traffic accidents involving drivers and pedestrians alike. In 1999, Statistics Canada reported 4,073 suicides, compared with 2,969 traffic fatalities the same year (Canada Safety Council, 2004). Studies indicate that as many as 90 per cent of people who complete suicide are experiencing depression, a substance use problem or another diagnosable disorder when they take their own lives (BC Partners for Mental Health and Addictions Information, 2003).

ACTIVITY 3

RETHINKING “NORMAL”

LEARNING GOALS

- to identify the negative stereotypes attributed to the labels “addiction” and “mental illness”
- to explore the impact of stereotypes on people with concurrent mental health and substance use problems
- to be aware that people can be given many stigmatizing labels that can lead to prejudice and discrimination
- to explore how subjective terms like “normal” and “abnormal” perpetuate stigma.



LEARNING ACTIVITY

MATERIALS

- n markers and pens
- n masking tape
- n flipchart paper and lined paper

TIME

- n 15–20 minutes



1. Ask participants to form groups of two, three or four. Provide each small group with paper and pen.
2. Divide the groups into two sections: One section will take on the label “addiction” and the other section will take on the label “mental illness.”
3. Ask the small groups that were assigned the label “addiction” to write down all the negative stereotypes (words or phrases) that society attributes to this label (e.g., through media, etc.). Ask the other groups to do the same for the label “mental illness.”
4. Ask participants how they felt about doing this exercise. It will be important to acknowledge that it may feel uncomfortable and difficult to see and hear these words. Remind participants that, by the end of the presentation, they will walk away with some strategies designed to stamp out this stigmatizing language.

5. Ask a representative from each small group that was assigned the term “addiction” to give three words or phrases that his or her group came up with. Write them out on the flipchart. After all the “addiction” groups have had a turn, ask if there were any more terms to add to the list. Repeat this step with the small groups that were given the term “mental illness.” Mix up the “addiction” and “mental illness” terms on the flipchart page.
6. As the participants are viewing the list, use the following script to guide discussion:

Suggested script

Can you imagine leaving your home every day knowing that this is what people are thinking about you? (Pause.)

What do you think are some of the challenges and barriers that people with concurrent mental health and substance use problems face because of these negative stereotypes? (Discuss.)

Society also attributes negative stereotypes to people based on race, gender, sexual orientation, disability, immigration status, being overweight, etc.

Imagine the additional challenges and barriers that people with concurrent mental health and substance use problems face if they also experience stigma and discrimination related to these other areas. These labels and stereotypes indicate that a person is somehow “abnormal.” Yet when we think of all the layers of stigma that society has created through negative stereotypes, it makes you wonder who actually falls into the category of “normal.”

Ask participants to comment on the concept of “normal.”

Pose the following questions:

1. *Who gets to say what’s “normal” and what’s not?*
2. *What does it mean to be “abnormal”? Does it mean average or above/below average?*

In conclusion

“Normal” can differ from family to family, from neighbourhood to neighbourhood and from individual to individual. “Normal” is a purely subjective term. It has the power to exclude people, resulting in stigma and discrimination.

KEY MESSAGES

- Stigma = discrimination.
- People living with concurrent mental health and substance use problems experience a double stigma.
- Other factors can result in multi-layers of stigma, prejudice and discrimination for people living with concurrent mental health and substance use problems.
- “Normal” and “abnormal” are subjective terms that exclude people and perpetuate stigma.



ACTIVITY 4

WORDS CAN WOUND



LEARNING GOALS

- to understand the power of language and how it can perpetuate stigma
- to realize the negative effects of labelling people with substance use and mental health problems.



LEARNING ACTIVITY

MATERIALS

- n Overhead 10:
The limits of my language
- n Activity card 1
- n overhead or LCD projector
- n flipchart and markers
- n masking tape

TIME

- n 15–20 minutes

Before the presentation, make activity cards by printing or photocopying the “Activity cards” template provided and cutting out the “cards.”

OVERHEAD

10

1. Present **OVERHEAD 10: The limits of my language.**

Suggested script

This quote refers to the power of language to discriminate and exclude. Labels such as “alcoholic,” “addict,” “mental case” and “insane” contribute to stigma because of the negative stereotypes society attributes to them. Using these labels discriminates and excludes people, and reduces their ability to live, work and recover in the community.

2. Hand out one activity card to each participant (or small group).
3. Have each participant (or small group representative) read the label out loud and list some of the negative stereotypes attributed to this label.
4. Ask the entire group what limits or barriers this might present for someone.

NOTE TO FACILITATOR

To further illustrate the impact of labels, you could write down the label on a flipchart, list the responses and then tape the flipchart paper onto the wall to give a visual representation.

5. Pose the following question: “Imagine if you were someone who had to wear several of these labels at once.” (Discuss.)

NOTE TO FACILITATOR

To illustrate the multi-layers of stigma, you could collect the cards and then select one “addiction label,” one “mental illness” label and a third (or even fourth) label, and ask participants to discuss the additional challenges and barriers someone with all of these labels might experience in his or her daily life.

6. Ask participants to suggest words or phrases to replace some of the labels.
7. In closing, note to participants that other “limits of language” can include low literacy levels, English as a second language and the use of jargon.

KEY MESSAGES

- Stigmatizing labels create barriers and lead to prejudice and discrimination.
- Language can hurt emotionally and psychologically.
- The stigma associated with concurrent mental health and substance use problems can prevent people from seeking help.



“The limits of my language . . .
mean the limits of my world.”

—Ludwig Wittgenstein (1963)



Addict

Alcoholic

Junkie

Schizophrenic

Insane

Handicapped

Elderly

Single Mother

Immigrant

Homosexual

Homeless

Psycho

ACTIVITY 5

WHO WEARS THE LABEL?

People living with a substance use and/or mental health problem often feel ashamed, embarrassed and fearful of being judged. These feelings come from being stigmatized by society's negative stereotypes and by labels like "alcoholic," "addict," "psycho" and "mentally ill." For example, the terms "crackhead" and "psycho" often conjure up images of violence. This stigmatization can lead to prejudice and discrimination, creating barriers for people to seek the help they need.

People who live with a substance use and/or mental health problem want society to know that they are so much more than the label that has been attributed to them. "I'm a human being. These are just some of my warts—but we all have them" (Kittel Canale, 2001).

With this activity, participants can witness the immeasurable contribution that these famous people, who have lived or are living with a substance use and/or mental health problem, have given to society.

LEARNING GOALS

- to understand that substance use and mental health problems know no bounds and can enter someone's life anywhere at any time
- to realize that people with substance use and mental health problems can and do recover, and continue to enrich society with their contributions.

LEARNING ACTIVITY

MATERIALS

- n Overhead 11: Famous people with mental health and/or substance use problems
- n Handout 3: "Who wears the label?"
- n overhead or LCD projector
- n flipchart and markers
- n masking tape

TIME

- n 10–15 minutes



OVERHEAD



1. **Present OVERHEAD 11: Famous people . . .** and have participants look over the list of famous people. You can present this as a handout as well.

Ask participants to identify the name of someone they recognize and tell the group what talents or accomplishments that person has given to society. The answers can be written on the flipchart and then taped up around the room.

2. Ask the group to identify some of the barriers these people may have had to overcome because of stigma. (Discuss.)
3. At the end of the exercise, distribute Handout 3, which lists the famous people and their accomplishments, so the participants will be able to pass on this information to others.

NOTE TO FACILITATOR

Point out to participants that although you have given examples of famous people who have lived with mental health and/or substance use problems, most people living with these challenges are not in the public eye—they are someone’s mother, father, daughter or son.



KEY MESSAGES

- People living with substance use and/or mental health problems make many important contributions to society.
- People can recover from co-occurring substance use and mental health problems.
- Society must learn to look beyond the label and see a person with strengths, talents and wisdom.

Famous people with mental health and/or substance use problems

LUDWIG
VAN BEETHOVEN

JOHN NASH

Ted Turner

PATTY DUKE AGTIN

EMILY CARR

ROBERT DOWNEY, JR.

HOWARD HUGHES

Oprah Winfrey

VINCENT
VAN GOGH

JUDY GARLAND

NICOLAS CAGE

WINGSTON CHURCHILL

Elizabeth Manley

ERNEST HEMINGWAY

MATHEW PERRY

“Who wears the label?”

People who have lived with substance use and/or mental health problems

MENTAL HEALTH PROBLEMS

Depression

Buzz Aldrin (astronaut)

Ron Ellis (NHL hockey player)

Abraham Lincoln (American president)

Elizabeth Manley (Olympic figure skater)

Tennessee Williams (writer)

Virginia Woolf (writer)

Bipolar disorder

Patty Duke Astin (actor)

Winston Churchill (former British prime minister)

Ted Turner (founder of CNN)

Ludwig van Beethoven (composer)

Vincent van Gogh (Dutch post-impressionist painter)

Anxiety disorder

Roseanne Barr (actor/comedian)

Nicolas Cage (actor)

Shayne Corson (NHL hockey player)

Aretha Franklin (singer)

Howard Hughes (tycoon)

Ricky Williams (NFL football player)

Oprah Winfrey (actor/talk show host)

Schizophrenia

Emily Carr (artist)

John Nash (scientist—portrayed in movie *A Beautiful Mind*)

Eating disorder

Karen Carpenter (singer)

Mary-Kate Olsen (actor)

SUBSTANCE USE PROBLEMS

Drew Barrymore (actor and director)

Robert Downey, Jr. (actor)

Judy Garland (actor and singer)

Jack Kerouac (beat generation writer)

Sir Elton John (musician)

Edgar Allan Poe (writer)

Cole Porter (composer of Broadway scores)

Leo Tolstoy (writer of *War and Peace*)

Mathew Perry (actor from *Friends*)

Jann Arden (singer)

Ernest Hemingway (writer)

Note: Given the prevalence of concurrent disorders, it is likely that 40 to 60 per cent of these famous people have lived, or are living, with co-occurring mental health and substance use problems.

For example, actor and director Drew Barrymore talks about her substance use problem and depression in the book *Beyond Crazy*, by Scott Simmie and Julia Nunes (2002). And biographical accounts of Winston Churchill and Judy Garland indicate that they were also living with concurrent mental health and substance use problems.

ACTIVITY 6

WALK A MILE IN THESE SHOES

LEARNING GOAL

- to understand the impact of stigma on the quality of life of people living with concurrent mental health and substance use problems.



LEARNING ACTIVITY

MATERIALS

n none

TIME

n 10–15 minutes



Before you begin this activity, encourage participants to get comfortable and close their eyes or look down at the floor.

Visualization 1

- Invite the group to envision the following scenario using the script below:

“What would it be like if everyone in the room decided to move in together and share a house, with the males sharing bedrooms with the males, the females sharing bedrooms with the other females, and only one kitchen and one common living room. Because of the limited number of bedrooms, there might be as many as four people sharing a room.”

- Give the participants a few moments to think about this and then point out the following:
 - Many people discharged from hospital, jail or residential treatment will end up living in this type of accommodation.
 - Many of the people living in boarding homes or recovery homes will have a history of abuse, suicide attempts and/or experience with the criminal justice system, and will be living in poverty because their only source of income is social assistance.

3. Ask participants the following question:

“What do you think some of the challenges would be for people trying to recover after being discharged from a hospital, jail or a treatment program under these circumstances?” (Discuss.)

Suggested script

Stigma can be a barrier for people trying to break out of this cycle. Society’s attitudes toward people with co-occurring substance use and mental health problems can have an impact on their ability to access decent housing and meaningful employment. Stigma can also contribute to relapse and can feed the belief that recovery is an impossible goal to attain.

Visualization 2

1. Ask the group to do the following:

“Consider all the friends you have (close friends, acquaintances, co-workers, sports team members, etc.), along with all of your relatives (children, partners, parents, cousins) and neighbours—everyone who you are socially connected to. This is your social network. In times of stress or transition, we can potentially draw on any of these people.” (Pause.) People who have been living with concurrent mental health and substance use problems for a long time may have lost some, or all, of their social support network. For some, their social network consists mostly of paid professionals, such as a doctor, nurse, case manager or therapist.

2. Ask participants the following question:

“What challenges might people with chronic co-occurring problems face in developing a new social network?”

Note: Below are some points you can make if participants do not mention them in the discussion.

- The stigma associated with concurrent disorders can create a barrier to people making friends.

- Some symptoms of concurrent mental health and substance use problems may affect a person’s social skills, making it difficult for him or her to engage with other people.
- Appearance may also be affected (e.g., weight gain from medication, tremors from medication side-effects, personal hygiene) and may not fit into what society considers “acceptable.”
- Other barriers include myths about concurrent disorders, such as “These people are violent” or “Recovery is not possible.”
- This marginalization contributes to loneliness and isolation, and a sense of disconnection from society.

KEY MESSAGES

- The stigma associated with concurrent disorders has a negative impact on people’s quality of life. It can contribute to relapse and interfere with recovery.
- The stigma associated with concurrent mental health and substance use problems affects people’s access to decent, affordable housing, job opportunities and social networks, and can also influence their personal dignity.



Visualizations 1 and 2 were originally developed by Steven Hughes, Organizational Development and French Language Services, Centre for Addiction and Mental Health.

ACTIVITY 7

WHAT'S YOUR GUT FEELING?

This exercise provides participants with an opportunity to reflect on their own attitudes and beliefs.



LEARNING GOALS

- to explore our own attitudes and beliefs about people living with concurrent mental health and substance use problems
- to understand the effects of stigma related to concurrent mental health and substance use problems.



LEARNING ACTIVITY

MATERIALS

- n envelopes
- n cut-out scenarios

TIME

- n 15–20 minutes

1. Cut out the scenarios for this activity and place them in an envelope. You may want to use some of your own scenarios depending on your audience. If you have a larger group, some people may have the same scenario.
2. Suggested script

In this activity, we are going to have an opportunity to check out our own attitudes and beliefs about concurrent mental health and substance use problems. All the scenarios are from real-life situations. I am going to pass around an envelope and ask that you take out one piece of paper and read the scenario to yourself.

Pass around the envelope and give the participants a couple of minutes to read their scenario.

Suggested script

Of course not all family members, service providers, social workers, doctors or friends hold these attitudes and beliefs. However, it is important to acknowledge that some people do attribute negative stereotypes to concurrent mental health and substance use problems, and this can have an impact on a person's capacity to reach out for help. Before the end of this workshop, you will be hearing about some solution-focused approaches that will help all of us play a part in addressing stigma.

Would any of you like to share your initial reaction to your scenario? (Discuss.)

Ask the person to read his or her scenario out loud. After the person has commented, you might ask the group:

Does anyone else want to comment on this scenario?

If no one volunteers to read his or her scenario, then you could choose a few, read them out loud and ask participants to comment. The following questions can be used as prompts for discussion:

What are some of the issues related to stigma in this scenario?

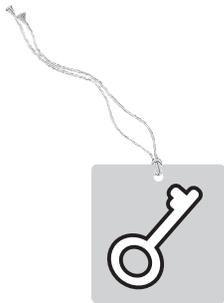
What are some of the barriers that stop this person from getting the help he or she needs?

What might be some of the ways that the person could better support someone with a concurrent mental health and substance use problem? What could the person do? What could he or she say?

NOTE TO FACILITATOR

If the group does not detect a co-occurring problem in Scenario 8, it will be important to note that the father may, for example, have depression and is using alcohol as a way to cope with his feelings. Depression in older persons often goes undetected or untreated and people will say, “Of course he is depressed. He’s getting old and everyone around him is dying.”

Remember, if you’re not sure how to respond to any of the comments, you can always turn the discussion back to the group and ask: “What do others think about this?”

**KEY MESSAGES**

- Faulty beliefs and misconceptions about people living with concurrent mental health and substance use problems can be a barrier to people getting the help they need.
- It is important to learn the facts about concurrent mental health and substance use problems, and recognize that recovery is possible.

Angela Tse, Hong Fook Mental Health Association, Toronto, originally developed the activity “What’s your gut feeling?”

✂

1. **From a friend:** It's okay for your daughter to come to our holiday party, but I think it's better for everyone's sake that your son not attend. You said yourself that you think he has some mental problems and that he might be using drugs. We don't want to take a chance.

✂

2. **From a mental health agency staff person:** I am sorry but we can't work with you any more because your drug use is interfering with your treatment. You need to get some help for your drug use, and then we can deal with your mental illness.

✂

3. **From an addiction agency staff person:** I am sorry but we only work with people who have an addiction. We are not trained to deal with the complex issues related to your mental illness. You will have to see a psychiatrist first and maybe get a mental health worker.

✂

4. **From a co-worker (in the lunchroom at work):** Mary's off sick again. She's always taking time off, especially on Mondays. You know, I've smelled alcohol on her breath sometimes, and she always seems to be in a bad mood. She's going to get fired if she doesn't watch herself.

✂

5. **From a family member:** He has to move out. My mother-in-law is coming to visit and she does not know he has a mental illness, not to mention the fact that he also drinks too much. Everybody else in our family is a high achiever, except him. I don't want her to look at me differently.

✂

6. **From a neighbour to her daughter:** I don't want you going over to Fatima's house. I heard that her mother just got out of hospital because of some nervous breakdown. If she's crazy, you never know what she might do.

7. **From a friend:** I felt sorry for Walter when he found out that he has schizophrenia. It's not his fault because he was born with it, but now he's smoking marijuana and getting into all kinds of trouble. He should know better. It's bad enough his family has to live with his mental illness.

8. **Son to his spouse:** I know my dad drinks a little too much, but come on, he's 75 and it's one of his last pleasures in life. Most of his friends are dying, so it gives him a little comfort. It probably helps him sleep.

9. **From a landlord:** As long as she takes her meds and doesn't drink, she'll have a place to live. I can't deal with drug addicts or alcoholics.

10. **From a social worker:** No treatment, no social assistance. Sorry.

11. **From a client:** I think he should be kicked out of the support group. He's borderline, still using, and he keeps monopolizing the conversation.

12. **From a family member:** Alcohol is taboo in our culture. There's been some acceptance of his bipolar disorder, but if our friends and relatives find out that our son is drinking, we're doomed.

13. **From a consulting psychiatrist:** His substance abuse leaves little hope for recovery.



14. **From a family member of a client with concurrent mental health and substance use problems:** It is just so hideous a behaviour. Normal people just don't cut themselves.



15. **From a manager of a concurrent disorders program:** We don't treat cutters or burners here.

ACTIVITY 8

EVERYONE HAS A PART TO PLAY

This activity dramatically illustrates the role that everyone can play in addressing stigma. We recommend using this activity along with Activity #9, “There’s always another story,” to further illustrate a solution-focused approach to addressing stigma.

LEARNING GOALS

- to understand that everyone can have a role in breaking down the barrier of stigma
- to learn the factors that help people make change.

LEARNING ACTIVITY

MATERIALS

- n overhead or LCD projector
- n Overhead 12: What works in therapy

TIME

- n 20–25 minutes

1. Start the activity by saying:

“I am about to show you proof that everyone in this room can play an important role in helping someone move along in the process of change.”

2. Present **OVERHEAD 12: What works in therapy**

NOTE TO FACILITATOR

Emphasize that the pie chart is based on research. Dr. Michael Lambert states that the research base for this interpretation of the factors was extensive and spanned decades. He refers to these “big four” as “common factors” that lead to change in someone’s life, regardless of the therapeutic model used by the therapist or counsellor.



OVERHEAD

12

Before explaining the pie chart, you could ask the participants:

*“What comes to mind when you hear the word therapy?”
(Discuss.)*

Suggested script

The purpose of this brief discussion is to demystify the term “therapy” or “therapist.” Therapy is simply about people trying to make changes in their lives with the help of a trained professional. There is often a mystique surrounding this term.

This pie chart illustrates that the counsellor or therapist is not the only one that can make a difference in people’s lives as they struggle to make a change related to co-occurring substance use and mental health problems. As the person is going through this process of change, she or he may come in contact with many people in different systems: housing workers, employment workers, welfare workers, shelter workers, CAS workers, probation and parole officers, psychiatrists, physicians, nurses, intake workers, receptionists and others.

The following is an explanation of the slide that you can present to the group. After each brief explanation of a section, ask participants if they have something to add.

Relationship factors—30 per cent

Research has shown that regardless of which counselling model is used, it is the warmth, empathy, caring and non-judgmental attitude that the counsellor brings to the relationship that can make the difference. This holds true whether the relationship is with a therapist, probation officer, housing worker or the receptionist in a doctor’s office. For example, imagine what it is like for a person seeking help for the first time. He or she has to go to a place where everyone will know the reason for the visit. People may be fearful, ashamed or embarrassed because of the stigma related to concurrent substance use and mental health problems. A receptionist greeting the person with warmth, caring and a non-judgmental attitude will help to make that person feel comfortable and welcome. It will increase the likelihood that the person will come back

and continue to seek help. However, if that person is treated with disrespect and is discounted, the person will likely not feel understood and may not return. We all have a window of opportunity to show respect and treat people with dignity. This can go a long way toward breaking down the barriers of stigma.

Extratherapeutic factors—40 per cent

Extratherapeutic factors refer to the client's circumstances outside of therapy and what the person brings to the counselling session that can contribute to recovery. These factors include client strengths, supportive elements in the environment and even chance events. Examples of factors that can contribute to successful outcomes are persistence, faith, a supportive grandmother, a mutual support group sponsor, membership in a religious community, a new job, a decent affordable home or a crisis successfully managed (Hubble et al., 2001).

NOTE TO FACILITATOR

This would be an excellent time to brainstorm a few other possible factors with the group.

A client may attend a counselling appointment once or twice a week, but the rest of the time is spent getting on with life. Outside of counselling sessions, the person will come in contact with other people, whether the housing worker, the rabbi, the server at his or her favourite restaurant, or friends and family members. These people have that same window of opportunity to break down the barrier of stigma by treating the person as an individual and not as a stereotype. A warm, caring and non-judgmental attitude can help a person feel good about himself or herself, and instill hope that change is possible.

Hope and expectancy—15 per cent

Hope and expectancy refer to the belief that things can and will get better. This belief can come from the client feeling supported and respected in the relationship with the therapist, and the many extratherapeutic factors that can contribute to recovery (e.g., a home, a job, a friend).

Model and technique—15 per cent

Although model and technique are important to effecting behaviour change, we often focus too much on this aspect of the change process. As we can see, there are many opportunities related to extratherapeutic factors through which people can make a difference. The therapist can be

an important member of the team that supports someone living with concurrent substance use and mental health problems.

Suggested script

As you can see, there are many opportunities for us to have a role in supporting people as they try to make changes. With this in mind, what might you do (or do differently) in your work? (Discuss.)

3. Ask participants if they have a personal story they would like to share of how a simple act of kindness or a good deed made a difference in someone's life. You may have a story to share as well.

Here are two examples:

- Quote from *New Yorker Magazine* (Friend, 2003).

Dr. Jerome Motto had a patient who committed suicide from the Golden Gate in the seventies. "I went to this guy's apartment afterward with the assistant medical examiner," he told me. "The guy was in his thirties, lived alone, pretty bare apartment. He'd written a note and left it on his bureau. It said, 'I'm going to walk to the bridge. If one person smiles at me on the way, I will not jump.'"*

- Quote from June Callwood, author and social activist (Allemang, 2004).

"And I thought, floating up there, 'This is what it is all about.' It's kindness. Not top-down kindness, giving toonies [coins] to a street person and treating them like a slot machine, but stopping and talking to them. If people can behave well to each other, that's all that there is."

* While the author used the term "committed" suicide, we prefer "died by suicide" as "committed" suggests committing a crime, and has its roots in history, when suicide in fact was considered to be a crime.

Ask participants if they can think of an example in their own lives or something they have heard or read that they would like to share.

NOTE TO FACILITATOR

If you are going to use Activity 9, “There’s always another story,” you could lead into the activity by saying: “As we continue our solution-focused approach to addressing stigma, I am going to share an anti-stigma model with you.”

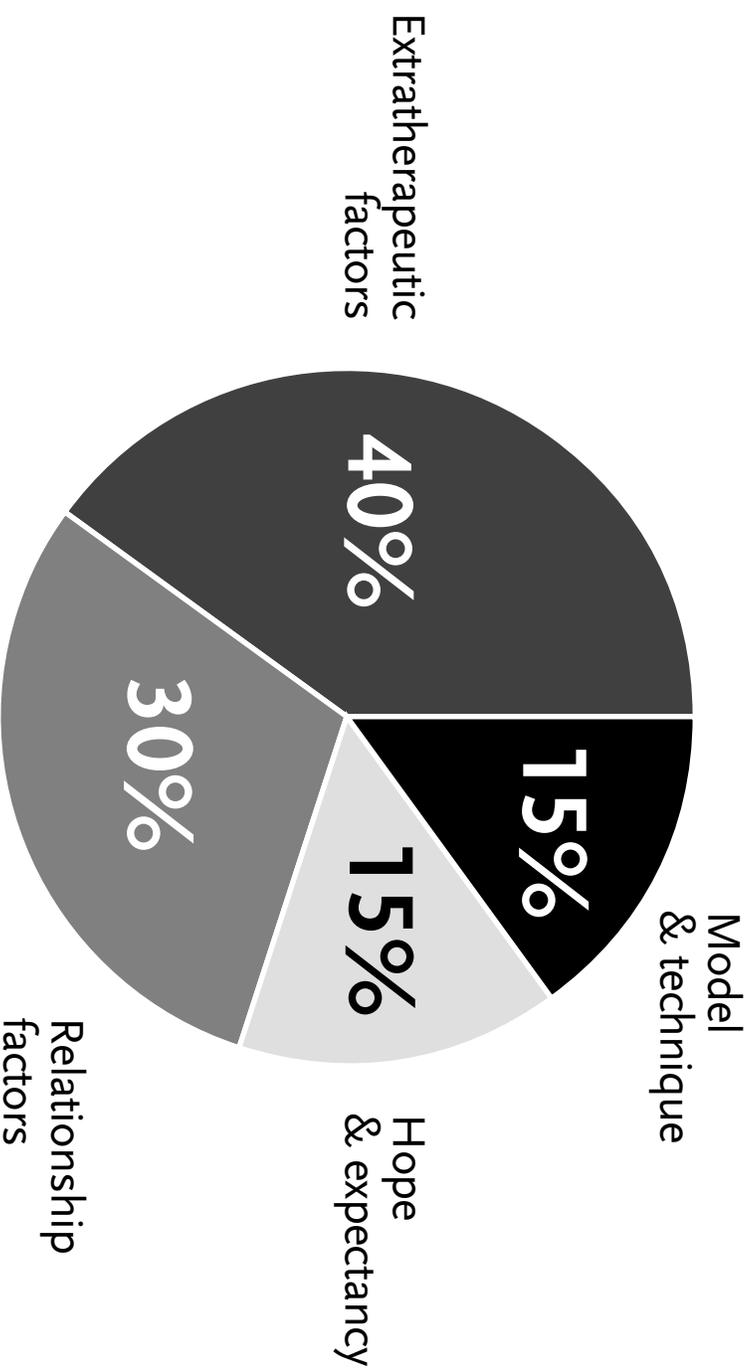
KEY MESSAGES

- You don’t have to be an expert in concurrent disorders to help someone struggling with concurrent substance use and mental health problems.
- Many factors contribute to how someone is able to make changes.
- A warm, caring and non-judgmental person can break down the barrier of stigma that prevents people from seeking help or accessing services.



What works in therapy

Making sense of 40 years of outcome data



Dr. Michael Lambert, Brigham Young University

ACTIVITY 9

THERE'S ALWAYS ANOTHER STORY

This exercise is based on the principles of narrative therapy. The concept is easy to teach to any audience when used as an anti-stigma model.

LEARNING GOALS

- to see the person as separate from the problem
- to learn about the stories beyond the label
- to consider a person's view of himself or herself
- to understand the term “social context” and its importance.

LEARNING ACTIVITY

MATERIALS

- n overhead or LCD projector
- n Overhead 13: The other story
- n Overhead 14: Social context

TIME

- n 20–25 minutes



LARGE GROUP ACTIVITY

OVERHEAD

13

1. **Present OVERHEAD 13: The other story**, using the following script to guide you:

Suggested script

When people have come forward to get help for substance use and mental health problems, the system sometimes responds from a disease and/or problem perspective. The person is treated as a “presenting problem,” so it is the problem that walks through the door and the person’s life story and strengths can get buried in the telling of the problem story. (Point to the top circle.) The person comes to a place that deals with problems and is being counselled as if he or she is a problem with no other identity.

To change this thinking, we first need to address the person and not the problem. (Point to the bottom circle.) By externalizing the problem, we can shift the conversation from the “problem story” to the person’s life story, which contains his or her strengths, abilities and successes that will help to fight against the problem.

OVERHEAD

14

2. **Present OVERHEAD 14: Social context**, using the following script to guide you:

Suggested script

To explain this concept, we use an analogy of a person carrying two invisible suitcases. When people come to an agency or hospital for help, they are coming with these two suitcases that hold the story of their lives. These stories not only contain their strengths, abilities and successes but also contain other aspects of their identity, such as their ethnocultural background, their sexual orientation, their beliefs or world view and their current reality.

We need to join with the people and help them unpack these suitcases to acknowledge the social context and help them create a new story that does not support or sustain the problem. Each person will have a different story that often is not told because a label like “depressed alcoholic” diverts people’s attention away from the details of the person’s life. If we don’t take the time to open the suitcases, then we will never really know the person. The “presenting problem” is not the whole story of the person’s life.

In conclusion, there are three elements to seeing beyond the label:

- **Externalize the problem**—this can help eliminate the stigmatizing and discriminating effects of labelling and self-stigma (e.g., not “depressed alcoholic” but rather “person living with depression and a substance use problem”).
- **Consider the other story**—ask questions about and listen to a person’s story. It contains information about their strengths, abilities and successes.
- **Take into account the social context**—this is everything in the two suitcases. We need to understand the person’s world in order to engage in the helping process. This is true in any relationship, no matter what our role is.

NOTE TO FACILITATOR

This might be a good time to give a personal example of “another story” beyond the label. This could be your own story, a story of a friend or relative, or a story you might have heard in the media. For example, you might have a sibling who has substance use and mental health problems but is also an artist, social activist or scientist.

Talk about barriers that person had to overcome and some of the things that helped him or her with these challenges.

During the pilot testing of this package, the facilitators who chose to talk about their own personal experience with concurrent mental health and substance use problems elected to share their “other story” with participants during this activity, rather than as part of the introduction. This is a powerful demonstration of this model (See “In the first person” in Section 4: Tips for the Facilitator).

SMALL GROUP ACTIVITY

The purpose of this exercise is to have people talk about their strengths and talents that may not be revealed in their day-to-day working lives. It is part of their “other story.”

1. Break the group into pairs or threes, and ask each small group to share with each other a positive story about themselves that does not reflect how people usually view them. It could be a special achievement, a hobby, a good deed or an interesting experience.

NOTE TO FACILITATOR

Participants often find this challenging because they are not used to being asked to talk about themselves. You may have to walk around and encourage them to “brag” a little.

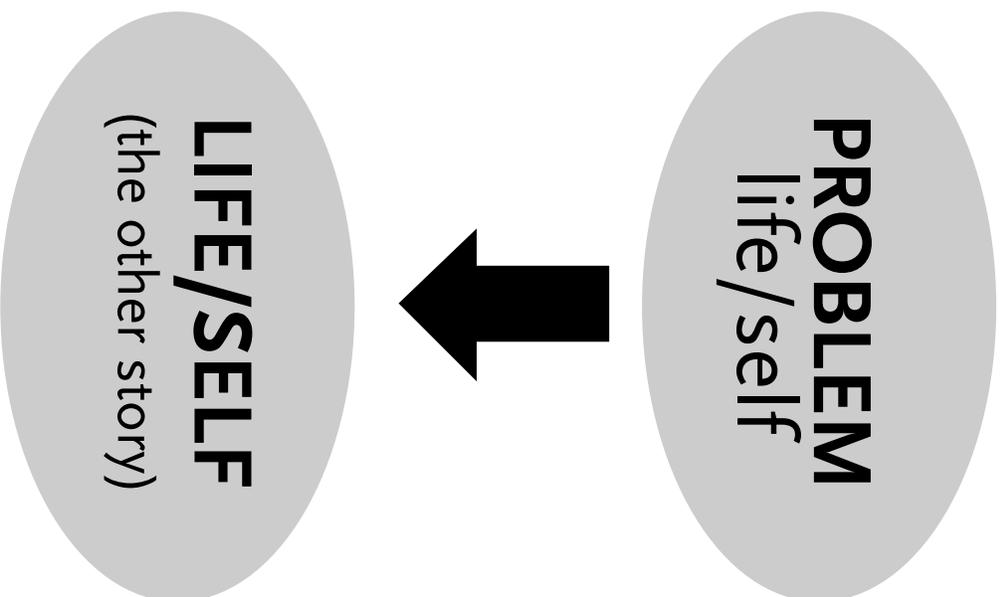
2. Give the groups about 5–10 minutes and then bring everyone back together.
3. In the large group, ask participants how they felt about telling something positive about themselves, and about the reactions of the other people to their story.

KEY MESSAGES

- Language is powerful. By externalizing the problem, we speak of the problem as outside of the person, rather than as something that defines the person.
- Everyone has another story, which contains his or her strengths, abilities and successes.
- It is critical to consider people’s view of themselves and their social context in order to understand how you can work together.

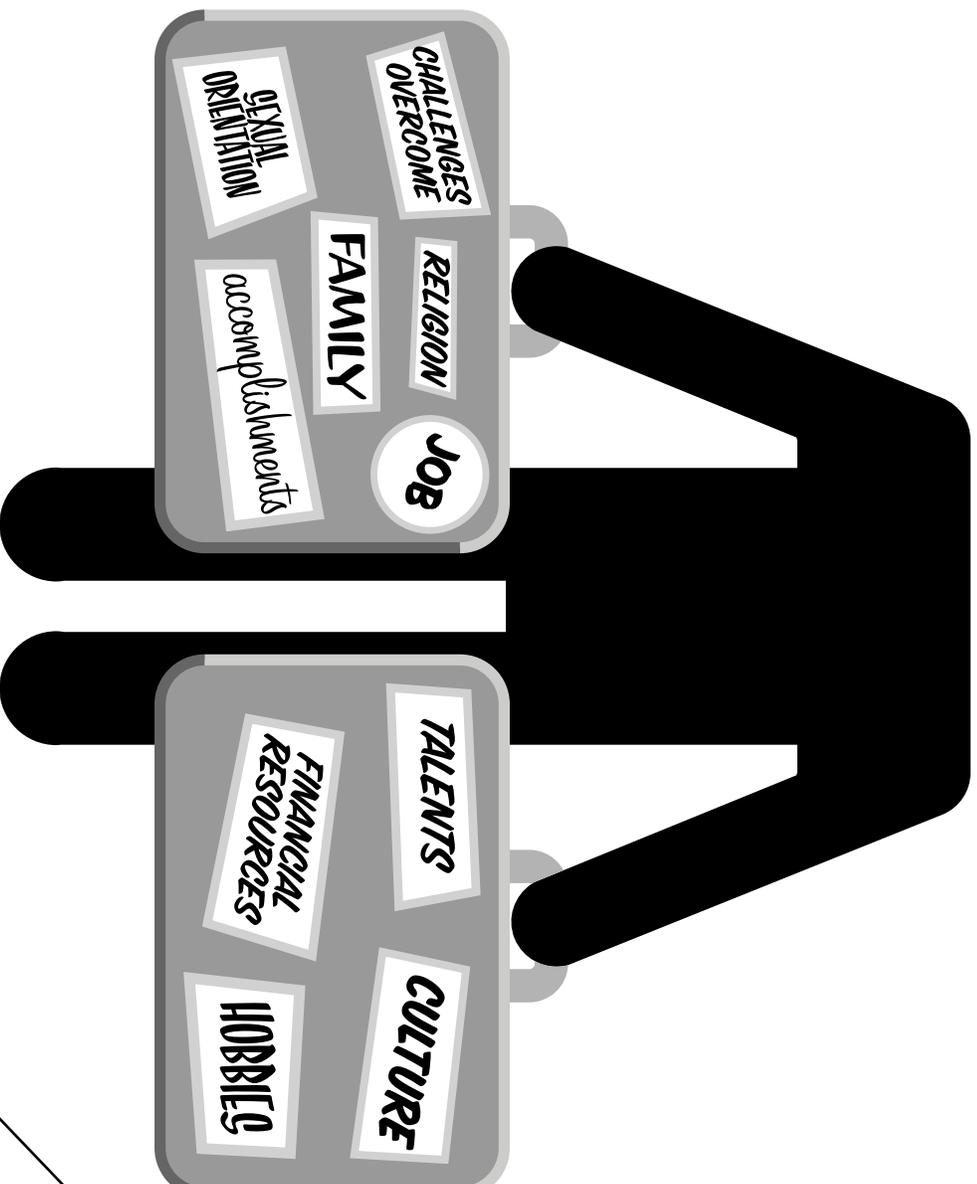
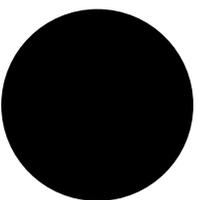


The other story



PROBLEM

SOCIAL CONTEXT



ACTIVITY 10

CLOSING ACTIVITY: ENDING ON A POSITIVE NOTE

This brief activity does just what the title suggests!

LEARNING ACTIVITY

MATERIALS

- n Overhead 15: Things you can do to stamp out stigma, and Overhead 16: What is stigma?
- n overhead or LCD projector
- n Handout 4, “Things you can do to stamp out stigma” and Handout 5, “We must speak out”

TIME

- n 10–15 minutes



1. Suggested script

We hope that by experiencing this presentation, people will want to join the “stigma-busting” team. It is probably a lifelong commitment but well worth the effort.

2. Before putting up the overhead, ask participants to name one thing they are going to do to help stamp out stigma.
3. **Present OVERHEAD 15: Things you can do to stamp out stigma.**
4. Ask participants if they have anything to add.
5. Give out copies of **Things you can do to stamp out stigma** and **We must speak out** handouts.
6. Check in with the group to find out if there are any lingering thoughts or feelings that they would like to discuss before ending the session.



OVERHEAD

16

7. As a final summary of the workshop, **present OVERHEAD 16: What is stigma?**

Suggested script

We have spent the last (number of hours) together talking about the stigma related to concurrent mental health and substance use problems because stigma prevents people from seeking help, it impedes recovery and it can be eliminated. We are leaving here today with some ideas of how we can help stamp out stigma. The one key message I leave with you is that stigma is not just about hurting someone's feelings. Stigma is about prejudice, discrimination and violating a person's human rights.

Things you can do to stamp out stigma

1. Acknowledge the prevalence of concurrent mental health and substance use problems.
2. Try to “walk in the shoes” of a person who is stigmatized.
3. Watch your language.
4. Monitor media and openly critique stigmatizing material.
5. Respond directly to stigmatizing material with a letter to the editor.
6. Speak up about stigma to friends, family and colleagues.
7. Be aware of your own attitudes and judgments.
8. Provide support for organizations that fight stigma.

What is stigma?

STIGMA

=

**PREJUDICE
+
DISCRIMINATION**

Things you can do to stamp out stigma

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3. Watch your language.
4. Monitor media and openly critique stigmatizing material.
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8. Provide support for organizations that fight stigma.

We must speak out

Seven steps to writing an effective letter of complaint to the media:

1. OPEN WITH YOUR PURPOSE AND EXPRESS YOUR FEELINGS

- The purpose of this letter is to . . .
- let you know . . .
- suggest . . .
- express my disappointment with. . .
- protest . . .
- condemn . . .

2. DOCUMENT THE SOURCE OF YOUR COMPLAINT

- Your editorial . . .
- Your article . . .
- Your television program . . .
- Your film . . . *that appeared on (date) under the title of (name of the editorial, article, program or film)*

3. SAY WHO YOU ARE

- As a reader/viewer/fan who has a mental health and/or substance use problem . . .
- As the family member of a wonderful young woman who has a . . .
- As the administrator of a program for people who . . .

4. SAY WHAT UPSET YOU AND THE HARM IT DOES

I can tell you that . . .

- your joke made me cry from pain and anger . . .
- your headline made my blood boil . . .
- you are misleading the public about . . .

5. ADD SOME INFORMATION ABOUT MENTAL HEALTH AND/OR SUBSTANCE USE PROBLEMS

I can also tell you that . . .

- negative stereotypes profoundly affect attitudes toward people with mental health (or substance use) problems. A 1990 study found that two out of three people surveyed get their information about mental illness from the media—not from doctors or other professionals.

6. SAY WHAT YOU WANT DONE

I implore you to stop . . .

- the slurs and jokes . . .
- the sensational headlines . . .
- the exploitation . . .

You can address any harm done by accurately reporting . . .

7. EDUCATE!

I enclose . . .

- educational material about . . .
- information about our program . . .
- an article about . . .

Adapted from Arnold, J. & Weinerth, N. (2001). *Challenging Stereotypes: An Action Guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

TIPS FOR THE FACILITATOR



TIPS FOR THE FACILITATOR

We recognize that facilitators using this package come from different settings, disciplines and agencies with their own individual time constraints. This section is designed to aid the facilitator by providing:

- facilitator guidelines
- a basic checklist for workshop preparation and delivery
- answers to difficult questions
- tips for first-person presentations
- sample presentations and scenarios showing how the package can be used.

FACILITATOR GUIDELINES

We all know from experience that some people facilitate workshops on their own, while others prefer co-facilitating. The activities in this resource kit lend themselves to co-facilitation for a number of reasons: they require people with a balance of mental health and substance use experience, a balance between content knowledge and process knowledge, and a second pair of eyes and ears to monitor how the group and/or individuals are doing. We recommend that people only facilitate on their own if they have lots of experience.

While the activities in this resource kit are not designed to elicit strong reactions or conflict within the group, stigma, prejudice and discrimination are sensitive subjects. Care and concern for the participants and their feelings should always be a priority for the facilitator(s). Whether you are co-facilitating or facilitating on your own, the following recommendations are designed to help you create a safe, respectful and positive learning environment for everyone.

Before the workshop

Discuss with your co-facilitator:

- your facilitation style and what you consider to be your strengths
- how you will process each activity in detail
- what you will do if an activity is not working as you had hoped (plan B)
- how you will develop ground rules with workshop participants
- how you will handle conflict or difficult reactions if they occur
- how you will communicate with each other.

During the workshop

Incorporate opportunities for the following:

- ways for people to get to know each other, even if they work together (e.g., icebreakers).
- discussion about what people need to feel safe and successful (see Overhead 2: A few ground rules). Sometimes it's useful to ask people what experiences have made past workshops unsuccessful for them, and then come to an agreement about how people will participate.
- a check-in on energy levels; if people are losing focus, change the pace, take a break or shift gears.
- group discussion and processing of thoughts, ideas and feelings.
- plan B (E.g., if an activity takes more time than you expected, know what you will cut out or, alternatively, what you might add or switch.)
- ways for methodical thinkers to provide their ideas. Brainstorming can be useful; however, it favours "fast thinkers" and verbal people. Asking people to write their thoughts on sticky notes or on a piece of paper can even the playing field.
- different groupings (People will always gravitate toward people they already know. Switching groups allows for new energy and new ideas to emerge.)
- closure (Even if you are running out of time, be sure to include a closing activity.)
- occasions for humour and fun!

After the workshop

- Invite people to stay behind if they need more information or if they need to talk. Rather than immediately talking with your co-facilitator or packing up, wait until everyone has left.

- Debrief with your co-facilitator once participants have left (while your memories are still fresh and before you review feedback from participants). Take note of anything that you've learned, identifying things that went particularly well, checking personal perceptions, etc.
- Take the opportunity to reconnect with participants after the workshop; provide a summary of the feedback, offer a list of additional resources that might have been mentioned during the workshop, and invite them to contact you for more information. Brief contact by e-mail, fax or phone can reinforce learning and retention.
- Celebrate your accomplishment!

PRESENTATION CHECKLIST

It's often useful to review the basic ingredients of effective presentations prior to planning and holding a session. Here is a checklist to keep in mind:

- n Make sure that you have booked a space that is big enough to accommodate your group size, with private space or extra rooms for small group discussions if needed.
- n Provide refreshments if the proceedings are to take an hour or more. At the very least, make sure water is available. Start coffee ahead of time.
- n Have enough handouts for everybody; and make a few more so people can take an extra copy if they wish.
- n Make the font large and easy to read on all handouts and overheads.
- n Have flipcharts, paper, markers and pens available.
- n Check the temperature in the room.
- n Reserve audiovisual equipment and ensure that it is working properly at least 30 minutes before events begin. Have a backup plan just in case.

BE PREPARED FOR QUESTIONS

It can be difficult and intimidating to broach the topic of stigma with colleagues—especially with people who are likely to have come across other anti-stigma materials and who themselves may combat stigma through their work. Below are a few questions that may come up as you present the material.

POTENTIAL QUESTION: Why bother talking about stigma? Isn't it just always going to be a problem?

Suggested script

Several studies have shown that anti-stigma programs work. For example, a recent mental health training intervention with the police force in England left most of the participants “more informed and more confident to support people in mental distress” (Pinfold et al., 2003). One study (Coates et al., 2003) shows that the stigma of post-traumatic stress disorder has been reduced considerably in New York City following the 9/11 attacks. This shows that sharing stories can reduce stigma. Raising awareness through educational tools or communication campaigns leads to changing attitudes and media depictions, which reduces stigma and makes life easier for those who are affected. Information destigmatizes!

POTENTIAL QUESTION: I work with clients who have concurrent disorders and I know the extra burdens they carry. Why should I spend time going over and over what I already know?

Suggested script

Most of us hold certain beliefs or stereotypes that, upon reflection, are not entirely accurate. Bringing to light our own unconscious feelings or biases is an important part of understanding how stigma works and how we can overcome it. In this workshop, we have included some solution-focused approaches that you might find useful in helping others understand how stigma affects your clients.

POTENTIAL QUESTION: I know of a situation in which a neighbour with substance use and mental health problems became aggressive and

threatening. In that situation, many of the ideas and fears we have about violence and mental illness were accurate. How can we change attitudes when there are some situations where the behaviour of someone does warrant concern?

Suggested script

While there are isolated instances in which people with concurrent disorders are violent and where intervention is needed, unfortunately, the stigma associated with mental illness and addiction perpetuates the myth that these situations are common and that all people with mental health and substance use problems are dangerous and should be feared. Quite contrary to this, a study by Arboleda-Flórez & Stuart (2001) revealed that about three per cent of violent offences can be attributed to mental illness and another seven per cent to substance use problems; theoretically, only one in 10 crimes could be prevented if these disorders did not exist. Because media portrayals often reinforce the myth that all people with mental health or substance use problems are a danger to the public, distorted media images need to be challenged.

POTENTIAL QUESTION: I thought we were going to learn more about concurrent disorders in this workshop. Isn't it more important to learn about best practices in treatment than to explore stigma?

Suggested script

Concurrent disorders have become a priority in both research and clinical settings; however, little attention has been paid to the impact of stigma or the real benefits of incorporating anti-stigma practices into our work. In this workshop, we want to raise awareness about the burden that stigma places on people living with concurrent mental health and substance use problems. We have put together a list of references and resources in case you are interested in finding out more about best practices in concurrent disorders.

Remember! You are not expected to be the expert. Sometimes it's helpful to acknowledge the complexity of this topic and ask the group: "What do others think about this?"

IN THE FIRST PERSON

Research has shown that although education reduces fear and increases knowledge, it does not single-handedly eradicate stigma. Drawing on your own experience, where relevant, is an excellent way to bring home the message. It can be powerful for group members to apply the theoretical ideas to an actual person, and identify with that person.

If you do not have personal experience with concurrent problems, or if you prefer not to share them at the workshop, you may wish to invite a guest speaker to share his or her story with the group. A client, a family member or anybody else who has had trouble with mental health and/or substance use could speak.

If you are inviting a guest speaker to your presentation, here are some tips:

- Connect with your guest speaker in advance via phone or in person rather than merely e-mailing or faxing the essentials.
- Explain the learning outcome of the presentation and why you have asked him or her to speak.
- Offer brief training on public speaking and on managing questions from participants.
- Discuss with the presenter the risks and benefits of speaking publicly. The decision to speak is the presenter's, and his or hers alone.
- Offer a couple of potential presentation dates.
- Tell the speaker how long you want the talk to last, and how much question and discussion time there will be.
- Discuss payment. Is there an honorarium?
- Call your speaker again a week or so before the set date to ask if he or she needs anything.
- When your speaker arrives, make him or her feel welcome.
- Introduce the speaker to the group.
- Remind the group to respect the guest speaker's confidentiality.
- Lead applause after the speaker has finished; publicly say "thank you."
- Ask the group if anyone has comments or questions.
- Present the guest speaker with an honorarium, or a small gift if possible, before he or she leaves.
- Send a thank-you card after the event; make sure you've spelled the guest speaker's name correctly.

TIPS FOR GUEST SPEAKERS

The following is a list of tips and recommendations for guest speakers who accept an invitation to share their personal experiences (or a family member's experience) with mental health and/or substance use challenges.

- Ask to meet with the event organizer to find out what you want to know about the audience, the location, the length and the purpose of your presentation.
- Know your audience. If the audience is a group of service providers, for example, you may want to emphasize your experiences with concurrent disorders.
- Consider your message. Remind yourself of the kinds of messages you want the audience to take away when you are preparing your presentation.
- Explore with someone you trust the potential risks and benefits of speaking publicly about your experience with concurrent mental health and substance use problems. Others need to respect your decision not to speak if you do not feel it is in your best interest to do so.
- Plan what you want to say. Think about what, and how much, you want to share with the audience. It is up to you what you include and what you leave out. Write out your presentation on cue cards or paper. You can refer to these notes during the presentation.
- Anticipate the sorts of questions you might be asked. If a particular question that you don't want to answer comes up at the presentation, it is okay to say so.
- Involve others. Practise your presentation with a friend or family member and ask that person for feedback.
- Confirm the presentation time, location and travel arrangements the day before your presentation.
- Congratulate yourself! Your willingness to share your personal experience will do a great deal to destigmatize mental health and substance use problems

Adapted from CAMH (2001). *Talking about Mental Illness: Community Guide*.
Toronto: Author.

SAMPLE PRESENTATIONS

Here are several examples of scenarios in which this package can be used effectively. We recommend that you present the Section 2: Setting the Stage information about concurrent disorders and stigma in every presentation.

SCENARIO 1: HALF-DAY WORKSHOP FOR SERVICE PROVIDERS

Moira is a psychiatric nurse in a Northern Ontario community where there has been a recent increase in solvent use by teens. She has been asked to host the next half-day staff retreat, which family physicians, nurses, managers and support staff will attend. Two or three mental health clients are usually invited to attend the retreat too. Using this package, she creates a half-day of exercises and discussion, and distributes one handout for the group to take away with them. She supplements the information sharing and group work with a 20-minute talk by an invited speaker.

Moira plans the following half-day agenda:

15 minutes: Activity 1: Just the facts!

10 minutes: Section 2: Setting the Stage

15 minutes: Activity 3: Rethinking “normal”

20 minutes: Activity 7: What’s your gut feeling?

15 minutes: Break

20 minutes: Speaker (the mother of a youth with concurrent mental health and substance use problems); question-and-answer session

20 minutes: Activity 8: Everyone has a part to play

25 minutes: Activity 9: There’s always another story

05 minutes: Activity 10: Closing activity: Ending on a positive note

SCENARIO 2: ONE-HOUR PRESENTATION FOR SERVICE PROVIDERS

Paolo is an addiction counsellor who works full time at a withdrawal management centre in a large urban community. He’s started to realize that many of the clients he works with are facing a complex array of emotional and interpersonal difficulties in addition to substance use, and that mental health problems are making recovery much more difficult. When he spends time with colleagues in other settings, he’s begun to notice that many of them seem to hold misconceptions or make sweeping statements about mental health problems. He offers to hold a half-day

workshop on concurrent disorders for other addiction workers in his area during their next informal get-together, and decides to dedicate an hour-long part of the event to the stigma of concurrent mental health and substance use problems.

After reading through the facilitator guide, Paolo develops his own one-hour agenda:

10 minutes: Section 2: Setting the Stage

10 minutes: Activity 2: Did you know . . . ?

15 minutes: Activity 3: Rethinking “normal”

15 minutes: Activity 5: Who wears the label?

10 minutes: Activity 10: Closing activity: Ending on a positive note

Once you have tried a few of these activities in your presentations, you will start to discover many more awareness-raising opportunities in your community. The following are just a few!

SCENARIO 3: STAFF MEETING

A staff meeting (or a meeting including managers, and executive directors or agency volunteers) is an excellent opportunity for both clinical and non-clinical staff to explore their own values and attitudes related to people living with concurrent mental health and substance use problems. This example takes 60 minutes.

10 minutes: Section 2: Setting the Stage

20 minutes: Activity 4: Words can wound

20 minutes: Activity 8: Everyone has a part to play

10 minutes: Activity 10: Closing activity: Ending on a positive note

SCENARIO 4: BROWN BAG LUNCH OR GRAND ROUNDS

Think of a catchy title to advertise this one-hour presentation on stigma and concurrent mental health and substance use problems.

10 minutes: Section 2: Setting the Stage

15 minutes: Activity 3: Rethinking “normal”

10 minutes: Activity 6: Walk a mile in these shoes

25 minutes: Activity 9: There’s always another story

SCENARIO 5: ORIENTATION SESSION FOR NEW STAFF AND VOLUNTEERS

This material could be a valuable addition to staff orientation sessions.

10 minutes: Section 2: Setting the Stage

15 minutes: Activity 2: Did you know . . . ?

10 minutes: Activity 5: Who wears the label?

20 minutes: Activity 8: Everyone has a part to play

25 minutes: Activity 9: There's always another story

SCENARIO 6: RESIDENTIAL SETTINGS

(i.e., treatment programs, supportive housing programs)

During the pilot test phase of *Beyond the Label*, workshop participants indicated they would like to use the information with client groups. People living with concurrent mental health and substance use problems will sometimes experience “self-stigma” and internalize negative stereotypes attached to labels (Kittel Canale, 2001). You may find some of the activities useful in helping individuals understand that self-stigma is not about them but rather the way people are socialized to hold these negative attitudes about mental health and substance use problems. The following is a sample presentation that demonstrates the root of stigma and discrimination.

10 minutes: Section 2: Setting the Stage

15 minutes: Activity 4: Rethinking “normal”

25 minutes: Activity 8: Everyone has a part to play

25 minutes: Activity 9: There's always another story

REFERENCES



REFERENCES

Arboleda-Flórez, J.E. & Stuart, H.L. (2001). A public health perspective on violent offenses among persons with mental illness. *Psychiatric Services*, 52, 654–659.

Allemang, J. (June 26, 2004). “‘I was in bad shape for a long time,’ she says. ‘It took me years to stop being angry, and I’m not over being hurt yet.’” *The Globe and Mail*, F1.

Arnold, J. & Weinerth, N. (2001). *Challenging Stereotypes: An Action Guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration Center for Mental Health Service, U.S. Department of Health and Human Services.

BC Partners for Mental Health and Addictions Information (2003). Stigma and Discrimination around Mental Disorders and Addictions. Retrieved January 19, 2005 from www.heretohelp.bc.ca/publications/factsheets/stigma.shtml.

BC Partners for Mental Health and Addictions Information (2003). Suicide: Following the Warning Signs. Retrieval January 19, 2005 from www.heretohelp.bc.ca/publications/factsheets/suicide.shtml.

Brands, B., Sproule, B. & Marshman, J. (Eds.) (1998). *Drugs & Drug Abuse* (3rd ed.). Toronto: Addiction Research Foundation.

Canada Safety Council (2004). www.safety-council.org.

Centre for Addiction and Mental Health (2001). *Fundamental Concepts in Mental Health*. Toronto: Author.

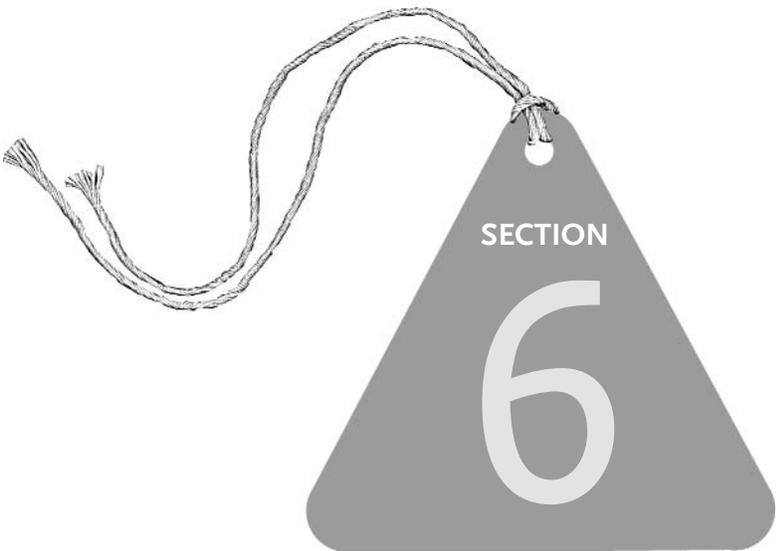
Centre for Addiction and Mental Health. (2003). *Challenges & Choices: Finding Mental Health Services in Ontario*. Toronto: Author.

EmployAbilities: EMPLOYment Resources for Persons with disABILITIES. Frequently Asked Questions—What is a disability? Retrieved January 18, 2005 from www.employabilities.ab.ca/faq.htm#quest1.

- Friend, T. (October 13, 2003). Jumpers: The fatal grandeur of the Golden Gate Bridge. *The New Yorker*.
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.
- Health Canada. (2001). *Best Practices: Concurrent Mental Health and Substance Use Disorders*. Ottawa: Author.
- Hubble, M.A., Duncan, B.L. & Miller, S.D. (Eds.) (2001). *The Heart and Soul of Change: What Works in Therapy*. Washington, DC: American Psychological Association.
- Kittel Canale, M. (2001). *Stigma of Addiction: Final Report*. Toronto: Centre for Addiction and Mental Health.
- Leavey, J.E. (2003). *The meaning of mental illness to youth: Exploring the psychosocial effects of mental illness on identity and life cycle development in youth aged 17–24*. Doctoral dissertation, University of Toronto.
- Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C. & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health & Social Behavior*, 38(2), 177–190.
- Mattison, K. (Producer) & Platt, N. (Director). (1998). *Myths about madness: Challenging stigma and changing attitudes*. Mental Health Media. North American Distribution: Films for the Humanities and Sciences, Princeton, NJ.
- Narrative Therapy Centre of Toronto. Retrieved January 18, 2005 from www.narrativetherapycentre.com/index_files/Page378.htm.
- O’Grady, C. (2004). *Stigma as experienced by family members of people with severe mental illness: The impact of participation in self-help/mutual aid support groups*. Unpublished doctoral dissertation, University of Toronto.
- Penn, D. & Martin, J. (1998). The stigma of severe mental illness: Some potential solutions for a recalcitrant problem. *Psychiatric Quarterly*, 69(3), 235–247.

- Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H. & Graham, T. (2003). Reducing psychiatric stigma and discrimination: Evaluating an educational intervention with the police force in England. *Social Psychiatry & Psychiatric Epidemiology*, 38(6), 337–344.
- Pompili, M., Mancinelli, I. & Tatarelli, R. (2003). *Stigma as a cause of suicide*. *British Journal of Psychiatry*, 183(2), 173–174.
- Rassool, G. (2002). Substance misuse and mental health: An overview. *Nursing Standard*, 16(50), 46–52.
- Reiger, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L. et al. (1990). Co-morbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiological Catchment Area (ECA) study. *Journal of the American Medical Association*, 264, 2511–2518.
- Ritson, E.B. (1999). Alcohol, drugs and stigma. *International Journal of Clinical Practice*, 53(7), 549–551.
- Schechter, D.S. (2003). Intergenerational communication of maternal violent trauma: Understanding the interplay of reflective functioning and posttraumatic psychopathology. In S.W. Coates, J.L. Rosenthal & D.S. Schechter (Eds.), *September 11: Trauma and Human Bonds* (pp. 115–142). Hillsdale, NJ: Analytic Press.
- Simmie, S. & Nunes, J. (2002). *Beyond Crazy: Journeys through Mental Illness*. Toronto: McClelland and Stewart.
- Skinner, W.J., O’Grady, C.P., Bartha, C. & Parker, C. (2004). *Concurrent Substance Use and Mental Health Disorders: An Information Guide*. Toronto: Centre for Addiction and Mental Health.
- Stuart, H. & Arboleda-Flórez, J. (2001). Community attitudes toward people with schizophrenia. *Canadian Journal of Psychiatry*, 46(3), 245–252.
- Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the Prevention and Treatment of Co-occurring Substance Use Disorders and Mental Disorders*. Washington, DC: Author.

GLOSSARY



GLOSSARY

Abstinence means non-partaking of a substance or behaviour.

Addiction is a state of dependence on a drug, in which the person continues substance use despite significant substance-related problems that may include harm to physical and/or mental health, social well-being and/or economic functioning (Brands, Sproule & Marshman, 1998).

Bipolar disorder is a cycle of depressed mood, “normal” mood and mania.

Borderline personality disorder is characterized by intense, chaotic relationships with fluctuating and extreme attitudes toward others, self-destructive behaviours, emotional instability and impulsiveness, and an unclear sense of identity. The person can also be chronically angry or depressed, and may experience psychotic symptoms when using alcohol or other substances (CAMH, 2001).

Concurrent disorders refers to any combination of mental health and substance use problems.

Depression is a low, unhappy mood accompanied by symptoms such as loss of interest or pleasure in life; irritability; sadness; difficulty sleeping or sleeping too much; decreased or increased appetite; lack of concentration; a sense of worthlessness; guilt; and in some cases, thoughts of suicide.

Disability is “a functional limitation or restriction of an individual’s ability to perform an activity. Disabilities can be visible (can be seen) or invisible (cannot be seen). Visible disabilities include physical disabilities such as paralysis, amputation, or mobility issues, and sensory disabilities such as blindness, visual impairment, deafness or hearing impairment. Invisible disabilities include developmental delay, mental health issues, learning disabilities, and/or medical conditions such as diabetes and epilepsy” (EmployAbilities, 2005).

Discrimination means a prejudicial act, such as denying a person employment, housing, accommodation or other services because of the person’s race, culture, sexual orientation, disability, age, gender, economic situation, etc. It may be covert or systemic, intentional or unintentional.

Harm reduction is a policy or program directed toward decreasing the adverse health, social and economic consequences of substance use without requiring abstinence (although abstinence can be one of the strategies).

A **Mental health problem** is a disturbance in thoughts and emotions that decreases a person's capacity to cope with the challenges of everyday life.

Myth means a belief that is not based in fact.

Narrative therapy "is a respectful, non-blaming, collaborative approach to counselling and community work. In essence, within a narrative therapy model, the focus is not on "experts" solving problems . . . it is on people discovering, through conversation, the hopeful new, preferred and previously unrecognized and hidden possibilities contained within themselves" (Narrative Therapy Centre of Toronto, 2005).

Prejudice is a state of mind; a set of attitudes held by one person or group against another person or group, which casts the other in an inferior light despite the absence of legitimate or sufficient evidence.

Recovery may historically have slightly different connotations within the context of mental health and addiction treatment. Recovery is a journey, not a destination. People in recovery develop new meaning and purpose in their lives as they grow beyond the effects of mental health and/or substance use problems. It is a way of living a satisfying, hopeful and creative life, even with limitations caused by illness.

Relapse is the return of symptoms of a mental health problem and/or the return to problematic substance use.

Schizophrenia is a complex mental disorder involving delusions, hallucinations, disturbances in thinking and communication. Delusions are false beliefs or misinterpretations of situations and experiences. Hallucinations involve seeing, hearing, feeling, tasting or smelling something for which there is no external cause. Schizophrenia is also associated with a deterioration of a person's ability to function at work, at school and/or socially.

A **Stereotype** is a false or generalized conception of a group of people, which results in an unconscious or conscious categorization of each member of that group without regard for individual differences.

Stigma refers to the negative “mark” attached to people with mental health and/or substance use problems, stemming from and leading to prejudice and unfair discriminatory behaviour.

Substance use is a broad term describing the wide range of use of alcohol and other drugs, from moderate use to problem use.

APPENDICES: BACKGROUND INFORMATION ON CONCURRENT DISORDERS AND STIGMA



The following information on concurrent disorders and stigma can be used as a resource for the facilitator and as handouts for workshop participants.

STRAIGHT TALK ABOUT CONCURRENT DISORDERS

The following information on concurrent disorders has been taken from *Concurrent Substance Use and Mental Health Disorders: An Information Guide* (Skinner et al., 2004) and adapted for this resource.

WHAT ARE CONCURRENT DISORDERS?

“Concurrent disorders” is a term used in Canada to denote any combination of mental health and substance use disorders. Concurrent disorders can include combinations such as:

- an anxiety disorder and a drinking problem
- schizophrenia and cannabis dependence
- borderline personality disorder and heroin dependence
- depression and dependence on sleeping pills.

Serious substance use may be diagnosed as a “substance use *disorder*” while serious mental health problems may be diagnosed as a “mental health *disorder*.” However, symptoms or problems can range from mild to serious. Milder problems may not lead to a diagnosis of a disorder, but they can still affect a person’s life. The term “concurrent disorders” describes any combination of mental health and substance use problems.

Concurrent disorders are also sometimes called “dual disorders” or “dual diagnosis.” In Ontario, the term “dual diagnosis” is used when a person has an intellectual disability and a mental health problem.

HOW COMMON ARE CONCURRENT DISORDERS?

A person with a mental health problem has a higher risk of having a substance use problem, just as a person with a substance use problem has an increased chance of having a mental health problem.

A large American study (Reiger et al., 1990) found the following rates:

- 30 per cent of people diagnosed with a mental health disorder will also have a substance use disorder at some time in their lives. This is close to twice the rate found in people who do not have a lifetime history of a mental health disorder.
- 37 per cent of people diagnosed with an alcohol disorder will have a mental health disorder at some point in their lives. This is close to twice the rate found in people who do not have a lifetime history of substance use disorder.
- 53 per cent of people diagnosed with a substance use disorder (other than alcohol) will also have a mental health disorder at some point in their lives. This is close to four times the rate found in people who do not have a lifetime history of substance use disorder.

The most common combinations are:

- substance use disorders and anxiety disorders
- substance use disorders and mood disorders.

Anxiety disorders

- In general, 10 to 25 per cent of all people will have an anxiety disorder in their lifetime.
- Among people who have had an anxiety disorder in their lifetime, 24 per cent will have a substance use disorder in their lifetime.

Major depression

- In general, 15 to 20 per cent of all people will have major depression in their lifetime.
- Among people who have had major depression in their lifetime, 27 per cent will have a substance use disorder in their lifetime.

Bipolar disorder

- About one to two per cent of adults have bipolar disorder.
- 56 per cent of people with bipolar disorder will have a substance use disorder in their lifetime. This is over three times the average rate.

Schizophrenia

- One per cent of the population has schizophrenia.
- 47 per cent of people with schizophrenia will have a substance use disorder in their lifetime. This is nearly three times the average rate.

There is no simple cause of concurrent disorders. Each person's situation is different. Some people who have a mental health problem may use substances to feel better. For other people, biological factors may come into play. An event causing emotional or physical trauma could also precede concurrent disorders.

People often ask, "Which came first, the mental health problem or the substance use problem?" This is a hard question to answer. Often it is more useful to think of them as independent problems that interact with each other.

HOW DOES EACH PROBLEM AFFECT THE OTHER?

Mental health and substance use problems can affect each other in several ways:

- Substance use can make mental health problems worse.
- Substance use can mimic or hide the symptoms of mental health problems.
- Sometimes people turn to substance use to "relieve" or forget about the symptoms of mental health problems.
- Some substances can make psychiatric medications less effective.
- Using substances can make people forget to take their medications. If this happens, the mental health problems may come back or get worse.
- When a person relapses with one problem, it can trigger the symptoms of the other problem.

A person with concurrent disorders will often have more serious medical, social and emotional problems than if he or she had only one condition. Treatment may take longer and be more challenging, but recovery is possible.

HOW ARE CONCURRENT DISORDERS TREATED?

People who have concurrent disorders often have to go to one service for mental health treatment and another place for addiction treatment. Sometimes the services are not connected at all.

However, concurrent substance use and mental health problems are often related, and they affect each other. Clients have the best success when both problems are addressed at the same time, in a co-ordinated way. The treatment approach usually depends on the type and the severity of the problems. A person might receive psychosocial treatment, biological treatment or often both.

Clients with severe mental health and substance use problems may need *integrated treatment*. Integrated treatment is a way of making sure that treatment is smooth, co-ordinated and comprehensive for the client. It ensures that the client receives help not only with the concurrent disorders, but also in other life areas, such as housing and employment. Ongoing support in these life areas helps clients to:

- maintain treatment successes
- prevent relapses
- ensure their basic life needs are being met.

Integrated treatment works best if the client has a stable, trusting, long-term relationship with one *case facilitator*. The facilitator is a health care professional, such as a case manager or therapist. Even though one person is responsible for overseeing the client's treatment, the client may work with a team of professionals, such as psychiatrists, social workers or addiction therapists.

If all the treatment services are not in one location, two or more programs may work together to co-ordinate treatment. For example, a therapist in a substance use program might ask new clients questions to see if they also have mental health problems. If the clients do, the substance use program could either treat the mental health problems, or refer clients to a mental health agency and work with that agency. Therapists at both agencies would keep in touch about the clients' progress.

TREATMENT GOALS

In the past, substance use and mental health treatment services have had different ways of treating problems. They have also had different ways of thinking about problems. Clients who received treatment from both systems might have been confused by the differences. For example:

- Many addiction services agree that reducing substance use is a realistic goal for clients at the beginning of treatment. This is called harm reduction. As the client moves through treatment, the long-term goal may or may not be abstinence. However, some mental health programs ask clients to completely stop using alcohol or other drugs before they can get treatment.
- Many mental health problems benefit from treatment with medications. However, some substance use programs may try to help the client stop taking all drugs, including those used to treat mental health problems.

Fortunately, staff in mental health and substance use programs are beginning to work more closely together. As a result, clients may see fewer differences like the ones described above.

The ultimate goal of treatment is for clients to:

- decide what a healthy future means for them
- find ways to live a healthy life.

For more information on concurrent disorders, refer to Appendix D: Suggested Resources.

STRAIGHT TALK ABOUT STIGMA

WHAT IS STIGMA?

“Stigma” is a socially constructed label that refers to negative attitudes people hold toward others whom they deem “different” or “other” to themselves. It is manifested in bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance. It can lead others to avoid living, socializing or working with, renting to, or employing people who carry this denotation (Penn & Martin, 1998).

Stigma is part of a cycle: it both leads to, and results from, prejudice and discriminatory behaviour. Stigma is the “mark” (stemming from its original meaning of a visible mark on the skin); prejudice is the attitude leading to and stemming from stigma; and discrimination is the behaviour associated with stigma.

In this package, you will find the terms “stigma,” “prejudice” and “discrimination” used to denote attitudes and behaviours that hurt, undermine or oppress those living with mental health and substance use problems.

WHO DOES STIGMA HURT?

Stigma affects everyone who is branded by its labels. Prejudice and discrimination that affect other groups—such as ethnocultural groups, people with physical disabilities and the gay, lesbian, bisexual and transgender communities—have been more effectively counteracted in the past four decades than have prejudice and discrimination against those with mental health and/or substance use problems. Mental health and substance use problems are one of the few last frontiers of generally acceptable prejudice.

Stigma affects not only the person with the label but also those who love, or care for, someone with the label, and children who might still depend on that person for the necessities of life. Therapists, social workers, personal support workers, mental health and addiction nurses, parents, friends, neighbours, teachers and children of someone with concurrent disorders may all feel the effects of prejudice and discrimination directly or indirectly. American sociologist Erving Goffman (1963) called this phenomenon of stigma-by-association “courtesy stigma.”

WHY DOES STIGMA EXIST?

Sociologist Erving Goffman described stigma as an “attribute that is deeply discrediting” (1963). The person with the attribute is “reduced in our minds from a whole and usual person to a tainted, discounted one.” There are various explanations as to why people with concurrent disorders are stigmatized:

- **Fear**, in this case stemming from the misperception that those with co-occurring substance use and mental health problems are more dangerous than other groups. “Losing one’s mind” is a common terror, and seeing this loss of control in another person is a profoundly distressing experience that may cause a blaming or distancing reaction as a way of coping. Another cause contributing to fear of people with mental health and substance use problems is the fact that the nature and effects of mental illness, substance use and concurrent disorders are still not well understood, even in specialized research circles.
- **Disruptions in social interaction**, caused by the fact that some symptoms of concurrent mental health and substance use problems may affect the social skills, dignity or appearance of the person, so that others may feel the person is “difficult to relate to” or “untrustworthy.”
- **Attribution of responsibility**, blaming, and assuming that discipline, will power and desire to get better are all lacking in people living with co-occurring substance use and mental health problems.
- **Perception of poor prognosis**, the pervasive myth that most mental illness and substance dependency is incurable and that the outlook is thus hopeless.

WHO STIGMATIZES?

All of us are guilty of some form of stigmatization, whether we do it consciously or unconsciously. Media portrayals can create stigma and they also reflect it. Cinema, television, books and magazines, for adults and for children, continually reinforce negative stereotypes. Rather than being seen as having painful, complex health concerns, people with substance use and mental health problems are often portrayed as blameworthy, dangerous or funny.

Ritson (1999) notes that the general public often stigmatizes people with mental health and substance use problems. He suggests that within the helping professions, negative attitudes toward clients can arise for several different reasons. Some may be based in misperceptions, but others may result from feelings of inadequacy, frustration and disappointment that arise when professionals are working with clients with complex needs. These last three factors, along with education and training needs, need to be addressed to assist service providers working in the area of concurrent disorders.

HOW DOES STIGMA HURT?

Stigma is not merely a problem of “hurting people’s feelings.” Stigma interferes with the person’s full participation in society, can lead to and/or increase mental health and substance use problems, and can provoke the person to withdraw from relationships and services that could be helpful. Stigma can seriously hamper matters such as holding a job, having a home, accessing services and participating in social relationships.

A research study (Leavey, 2003) of Toronto-area youth with mental health problems showed that most youth surveyed “felt stigmatized and labelled, and experienced multiple losses of identity [touching on] family, career choices, and educational and social standing (p. 225).”

Canadian researchers surveyed public attitudes toward people with schizophrenia (Stuart & Arboleda-Flórez, 2001). The resulting study showed that one in five thought he or she would be unable to maintain a friendship with a person with schizophrenia, half thought they would be unable to share living quarters with a person with schizophrenia, and three-quarters thought they would be unable to marry a person with schizophrenia.

Researchers in the United States (Link et al., 1997) interviewed people who had experienced concurrent mental health and substance use problems. Respondents reported the following examples of discrimination:

- six per cent were denied medical treatment
- 16 per cent were denied an apartment
- 24 per cent were paid lower wages due to their history of substance misuse.

People who experience stigma often talk about feelings of shame, anxiety, frustration, depression, helplessness, fear and hurt. Over time, people with concurrent disorders may start to see themselves in terms of the negative stereotypes of their problem, internalizing a sense of hopelessness or shame rather than blaming the system. It is therefore not surprising that many other studies show a strong link between stigma and depression. In fact, a British study (Pompili et al., 2003) linked stigma with an increased risk of suicide.

STRAIGHT TALK ABOUT STIGMA AND CONCURRENT DISORDERS

STIGMA AND CONCURRENT DISORDERS: A TRIPLE BURDEN

People living with either a mental health or a substance use problem often report feeling that they carry a “double burden”: their illness and its stigma. The stigma that affects those facing concurrent disorders is especially debilitating, and clients can be said to carry not a double, but a triple burden. People living with concurrent mental health and substance use problems face increased stigma for the following reasons:

- a perception that people living with a mental health or a substance use problem are dangerous—and that those with both problems are even more dangerous
- the view that people who misuse substances are law-breakers and don't deserve mental health treatment
- the view that using substances implies a lack of self-control
- the fact that certain substance use can increase a person's likelihood of contracting certain conditions such as HIV/AIDS and hepatitis C
- a belief that a mental health problem will make recovery from concurrent disorders impossible
- the fact that because care is often fragmented, treatment for mental health and substance use problems often takes place in different settings, with a different set of professionals who do not communicate with each other
- the fact that each problem may compound and intensify the effects of the other, which may compromise the person's social skills and add to more visible symptoms.

Diagnosing and naming concurrent disorders is in itself often beneficial because it leads to recognition of these problems as real and treatable illnesses. Yet if used insensitively, it can lead to “labelling” people and deepening the effects of stigma. For many people, this new label or diagnosis can add another layer of stigma to their already complex lives.

“WEARING” MULTIPLE “LAYERS” OF STIGMA

Everyone is unique, so diagnostic categories can never capture individual experiences. The category of concurrent disorders is useful as a broad concept, but a person who lives with mental health and substance use problems—like everyone in society—will very likely also live with other problems, identities and ongoing challenges.

Living with concurrent disorders does not mean that other “labels”—such as sexual orientation, ethnic or cultural group, physical disability or economic status—fail to have their own significant impact.

In research that led to her doctoral thesis, CAMH staff person Caroline O’Grady interviewed several people about how cultural factors have complicated their experiences of mental health or substance use problems. Many spoke of how specific cultural taboos related to their problems hampered their ability to reach out to their friends and family. These interviews also revealed that, in support groups, more educated, wealthier or non-visible minority members may dominate, making such groups tough places for many people to feel “at home.”

For more information on stigma, refer to Appendix D: Suggested resources.

SUGGESTED RESOURCES

This appendix lists a range of resources in various media, which you may find useful. The fact that the resource list focuses mainly on the stigma of mental health problems indicates that more research and advocacy is being done in this area compared with the stigma of substance use and/or concurrent disorders.

WEBSITES

ADS Center: Resource Center to Address Discrimination and Stigma
www.adscenter.org

BC Partners for Mental Health and Addictions Information
www.heretohelp.bc.ca

Centre for Addiction and Mental Health
www.camh.net

Chicago Consortium for Stigma Research
www.stigmaresearch.org

Double Trouble in Recovery
www.doubletroubleinrecovery.org

Faces and Voices of Recovery
www.facesandvoicesofrecovery.org

Global Business and Economic Roundtable on Addiction and Mental Health
www.mentalhealthroundtable.ca

Harvard Medical School Center for Mental Health and Media
www.mentalhealthandmedia.org

The National Mental Health Consumers' Self-Help Clearinghouse
www.mhselfhelp.org

National Alliance for the Mentally Ill (U.S.)
www.nami.org

NIMHE Anti Stigma and Discrimination Programme
www.nimhe.org.uk

Royal College of Psychiatrists (U.K.)
www.rcpsych.ac.uk/campaigns/cminds/index.htm

Schizophrenia—Open the Doors
www.openthedoors.com

We All Belong
www.weallbelong.ca

ORGANIZATIONS

Canadian Mental Health Association, Ontario Division
180 Dundas Street West
Suite 2301
Toronto, ON M5G 1Z8
Tel: 416 977-5580 / Toll-free (in Ontario): 1 800 875-6213
Website: www.ontario.cmha.ca

Centre for Addiction and Mental Health
33 Russell Street
Toronto, ON M5S 2S1
Infoline: 1 800 463-6273 / In Toronto: 416 595-6111
Website: www.camh.net

Mood Disorders Association of Ontario
40 Orchard View Boulevard
Suite 222
Toronto, ON M4R 1B9
Tel: 416 486-8046 / Toll-free: 1 888 486-8236
Website: www.mooddorders.on.ca

REPORTS

Fulton, R. (2001). *Stigma of Substance Use and Attitudes of Professionals: A Review of the Literature*. Toronto: Centre for Addiction and Mental Health.

Health Canada. (2001). *Best Practices: Concurrent Mental Health and Substance Use Disorders*. Ottawa: Author.

Kittel Canale, M. (2001). *Stigma of Addiction: Final Report*. Toronto: Centre for Addiction and Mental Health.

Scheffer, R. (2003). *Addressing Stigma: Increasing Public Understanding of Mental Illness*. Toronto: Centre for Addiction and Mental Health.

Scheffer, R. (2003). *Stigma and Mental Illness: A Literature Review and Environmental Scan*. Toronto: Centre for Addiction and Mental Health.

BOOKS

Corrigan, P. & Lundin, R. (2000). *Don't Call Me Nuts! Coping with the Stigma of Mental Illness*. Chicago: Recovery Press.

Philo, G. (Ed.) (1996). *Media and Mental Distress*. The Glasgow University Media Group. New York: Addison Wesley Longman.

Simmie, S. & Nunes, J. (2002). *Beyond Crazy: Journeys through Mental Illness*. Toronto: McClelland and Stewart.

Simmie, S. & Nunes, J. (2002). *The Last Taboo: A Survival Guide to Mental Health Care in Canada*. Toronto: McClelland and Stewart.

Wahl, O. (1995). *Media Madness: Public Images of Mental Illness*. New Brunswick, NJ: Rutgers University Press.

Wahl, O. (1999). *Telling Is Risky Business: Mental Health Consumers Confront Stigma*. New Brunswick, NJ: Rutgers University Press.

BOOKLETS AND RESOURCE PACKAGES

Challenging Stereotypes: An Action Guide

U.S. Substance Abuse and Mental Health Services Administration

www.mentalhealth.org/publications/allpubs/SMA01-3513/Default.asp

A guide to decreasing the barriers of prejudice and discrimination toward people living with mental illness

Talking about Mental Illness

Centre for Addiction and Mental Health

www.camh.net/pdf/TAMI_CommunityALL.pdf

www.camh.net/pdf/TAMI_TeachersALL.pdf

A guide for developing an awareness program for youth.

Reaching Out: The Importance of Early Treatment

The Schizophrenia Society of Canada

Toll-free: 1 888 772-4673

info@schizophrenia.ca

An educational resource for youth.