

Structural Stigma and Mental Illness

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INTRODUCTION

Structural stigma is the “societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatized populations” (Hatzenbuehler & Link, 2014, p. 2). It refers to the inequities and injustices inherent in social structures that arbitrarily restrict the means and freedoms of a specific population (Corrigan, Markowitz, & Watson, 2004; Kelly, 2006; Link & Phelan, 2001). Structural stigma related to mental illness is increasingly recognized as one of the most significant barriers to the wellbeing of people with mental illness (PMI). PMI encounter discrimination across their life course, including employment and housing discrimination; however, discrimination has mostly been documented and reported by PMI at the interpersonal level rather than the structural level (Baldwin & Marcus, 2006; Callard et al., 2012b; Corrigan & Lam, 2007; Glozier, 1998; Manning & White, 1995; Page, 1995; Stuart, 2006; Wahl, 1999). Nevertheless, interpersonal discrimination occurs within the broader context of structural stigma, whereby it is more likely to occur in the context of high levels of structural stigma. Structural stigma may contribute to or interact with interpersonal stigma, as well as operate independently of interpersonal stigma (Link & Phelan, 2001; Livingston, 2013).

This review will summarize the research examining the ways in which structural stigma related to mental illness (MI) has manifested and its impact on health for PMI. A search for literature was conducted on several databases, including PubMed, PsycInfo, Google Scholar, Web of Knowledge, and SocIndex, using keywords (e.g., ‘structural stigma’, ‘structural discrimination’, ‘institutional discrimination,’ ‘mental illness’). Colleagues in this field contributed suggestions for literature, and article references were also reviewed for additional publications. There is a dearth of MI literature that explicitly employs the concept of ‘structural stigma’; nevertheless, there is a meaningful body of work examining the structural barriers that affect PMI from which this review draws. A comprehensive summary of mental illness related structural stigma was previously completed by Livingston (2013) which included examples from around the globe, although with a specific lens towards Canada.

STRUCTURAL STIGMA AND LINKAGES TO DISCRIMINATION WITHIN PRIVATE AND PUBLIC INSTITUTIONS

One approach to operationalizing measurements of structural stigma has been through use of policies explicitly targeting PMI. A review of legislation in all 50 states found legal restrictions for PMI in the following five domains: serving on a jury, voting, holding political office, parental custody rights, and marriage (Burton, 1990; Hemmens, Miller, Burton, & Milner, 2002). A similar review of nearly 1,000 mental health-related proposed bills in 2002 found three percent were restricted liberties (e.g., allowed compulsory community treatment); one percent were discriminatory (e.g., restrictions on gun ownership, parental rights, placement of mental health facilities); and four percent reduced privacy (e.g., permitting disclosure of mental health information in special circumstances (Corrigan, Watson, Heyrman, et al., 2005). One of the major critiques of such legislation is the use of the broad, homogenous inclusion criteria - people

with any diagnosis of MI - rather than more precise metrics of cognitive or functional impairment or reduced capacity (Corrigan, Watson, Heyrman, et al., 2005; Hemmens et al., 2002). Such arbitrariness is the defining feature of structural stigma and reflects the stereotype that all PMI are dangerous or inadequate in some way and therefore deserving of fewer liberties and opportunities.

Structural stigma may also be measured by examining how PMI are protected from discrimination and the enforcement of their rights. The persistence of interpersonal discrimination, despite protections from the Americans with Disabilities Act (ADA) and the Fair Housing Act (Office of Disability Employment Policy, 2015; Stuart, 2006), reflects how stigma can continue to occur when structural interventions with the stated intention to diminish stigma are inadequately designed and implemented. For instance, the second most common discrimination charge filed under the ADA has been for mental disorders (Colker, 2001; Scheid, 1999; Scheid, 2005; Stuart, 2006); and PMI were likely to have poorer outcomes in employment discrimination suits compared to plaintiffs without MI (Burriss, Swanson, Moss, Ullman, & Ranney, 2006). Even with privacy protection laws for health records, forms of covert stigma may occur through institutional policies that stipulate the use of other proxies that strongly correlate with mental illness, including gaps of time in employment, disability as a source of income, and criminal records (Livingston, 2013; “Tanner and Vlake,” 2003). Structural stigma may also be seen in the inadequate enforcement of laws addressing interpersonal discrimination of PMI through under resourced legal aid services, and complex bureaucratic processes for receiving legal aid, or filing a lawsuit oneself (Callard et al., 2012b). An awareness of the existence of covert forms of structural stigma is useful for informing a research strategy that identifies manifestations of structural stigma that are not easily recognizable and understanding how structural stigma can be sustained even with structural interventions purported to protect stigmatized groups (Corrigan et al., 2004). Studies are also needed to examine how the different levels of PMI-related stigma, including structural and interpersonal, interact with each other, as well as operate independently.

Paternalism, reduced expectations, heightened scrutiny and coercion are embedded in many public agencies and service structures constituting another way structural stigma is manifest for PMI. For instance, case studies of employment assistance programs found that disincentives, bureaucratic obstacles, and stigma impeded commitment to the employment programs (Marrone, Foley, & Selleck, 2005). Mental health service users were counseled to take jobs despite being over qualified for the job in question (Wahl, 1999). PMI face increased scrutiny by social workers, educators, physicians, family court administrators and child protective services personnel (Dolman, Jones, & Howard, 2013; Jeffery et al., 2013). Within the educational system, students with mental disabilities experience inadequate or delay of supportive services, segregation, and harsher discipline compared to students without MI (Livingston, 2013; Losen & Welner, 2001; Skiba & Peterson, 2000; Wald & Losen, 2003). Some housing support programs have strict requirements for PMI to maintain housing assistance, including prohibition of family or visitors, and mandatory compliance with programming and medication regimes (Riley, 2011; Schneider, 2010). Segregated housing, some resembling psychiatric institutions (Byrne, 2000; Melnychuk, Verdun-Jones, & Brink, 2009; Metraux, Caplan, Klugman, & Hadley, 2007; Riley, 2011), and community-wide rejection of mental

health facilities, otherwise known as NIMBYism (Not-In-My-Backyard) (Piat, 2000), are two overt forms of structural stigma related to housing that have been well-documented (Callard et al., 2012a). As evidenced by these findings, mental illness-related structural stigma spans different life domains, even in sectors that seek to improve PMI-related outcomes. Analyses such as these have thus far predominantly been descriptive of PMI experiences within different systems; however, they represent objective measures of structural stigma that could be linked to health datasets to document how structural stigma affects individual-level outcomes among PMI (e.g., treatment utilization, chronicity/persistence of disorder), as has been done in research on other stigmatized groups (e.g., Hatzenbuehler, 2014; Hatzenbuehler et al., 2014).

HEALTHCARE & TREATMENT

The mental health treatment system is one of the most commonly cited sources of structural stigma for PMI. Such structural stigma is manifest in the low quality of services (Schulze & Angermeyer, 2003; Schulze, 2007), fragmented and byzantine bureaucracy for accessing treatment, coercive approaches to care, rejection of facilities by communities, and inadequate funding (Heflinger & Hinshaw, 2010; Schomerus & Angermeyer, 2008; Schulze & Angermeyer, 2003; Schulze, 2007). A review of studies on MH services by the Institute of Medicine showed that guidelines for care were often not specified resulting in low adherence to evidence-based guidelines and an overuse of coercive and punitive measures. (Institute of Medicine (U.S.). Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders., 2006). Quality measurements of mental healthcare amount to only a fraction of physical healthcare measures, and many are narrowly focused, poorly defined or lacking in evidence, validation, and meaningfulness (Kilbourne, Keyser, & Pincus, 2010). Mental health services in the US are not well integrated into primary care compared to other developed countries (Reilly et al., 2012) with only a small proportion of community health center patients receiving MH services (Cummings, Wen, Ko, & Druss, 2013). General practitioners are also failing to refer patients to appropriate mental health services as needed (Pescosolido, Martin, Lang, & Olafsdottir, 2008; Sartorius et al., 2010), or refer PMIs to appropriate physical health services like mammography, cardiovascular procedures, and pain management (Corrigan & Kleinlein, 2005) compared to individuals without MI.

The systematic de-prioritization and disparity of funding for mental health services and research compared to general physical health, despite the high prevalence of need and comparable return on investment, may also be a form of MI-related structural stigma (Kelly, 2006; Mark, Levit, Yee, & Chow, 2014). The unequal allocation of resources between mental health and physical health is patterned across the different strata of the health system. Mental health research receives less scientific funding relative to other health conditions (Aoun, Pennebaker, & Pascal, 2004; Brousseau & Hyman, 2009; Fineberg et al., 2013; Livingston, 2013; Pincus, 1992). Low reimbursements have arguably been a major contributor to the low insurance acceptance rates among psychiatrists (Bishop, Press, Keyhani, & Pincus, 2014) and provider shortage areas for MH services (Cummings et al., 2013). Lack of investment in MH care has also made it difficult to access appropriate, evidence-based services in safety net facilities (Cummings et al., 2013).

Even with the availability of providers and insurance coverage, insurance benefits have traditionally been more prohibitive of mental health services compared to physical healthcare with constraints like high deductibles, requirements for patients' MH status to deteriorate before treatment coverage can be allowed, or a rejection of behavioral health coverage completely (Angermeyer, Schulze, & Dietrich, 2003; Corrigan et al., 2004; Livingston, 2013; Muhlbauer, 2002). In the US, mental health parity laws have been a cornerstone policy for combating the structural inequity of mental health coverage and reducing coverage restrictions so that MH benefits are closer to being on par with benefits related to physical health services (Hernandez & Uggen, 2012; Sipe et al., 2015). Different mental health parity laws have been passed at the state and federal level in various forms to bring MH coverage more in line with physical health coverage. A review of empirical studies prior to and including 2011 was conducted by Sipe and colleagues (Sipe et al., 2015), identifying 30 quasi-experimental and observational studies, examining the association between parity laws and MH services access and health outcomes. For the most part, the studies have provided strong evidence of comprehensive parity improving MH service access. These studies, however, were conducted prior to the Patient Protection and Affordable Care Act of 2010 (ACA), which, in addition to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), is expected to have a major impact on MI-related structural stigma (Beronio, Glied, & Frank, 2014). In addition to easing the financial burden of MI services through more robust parity requirements, the ACA promises to improve care coordination and quality of services (Beronio et al., 2014). Projections estimate that utilization of MH services will increase by 40% across all income groups (Ali, Teich, Woodward, & Han, 2014). However, a 2014 study comprising a survey of PMIs and family members concurrent with an analysis of formularies offered by Qualified Health Plans indicates early hurdles in implementation and enforcement, including difficulty finding providers in their plan network; arbitrary denials of higher level care and lack of transparency in treatment approval process by plans; and inconsistent enforcement of plans to comply with mandates (Honberg, Diehl, & Douglas, 2014). The legislation as well as the institutional policies and practices of the insurance payers, and the enforcement agencies that regulate them, all contribute to forms of structural stigma surrounding mental illness.

Research is needed to clarify the role of these new policies in reducing health-related disparities among PMI and improving MH. Although one of the challenges is the ubiquity of the laws, there may be variation in implementation and enforcement across states. A rigorous study design is seen in Busch and Barry's (2008) quasi-experimental study which examined five states that had implemented parity laws fitting the study's criteria of moderately-strong parity laws and 13 other nonparity states to control for secular trends, during the study period of 1997 – 2002. They used cross-sectional interview data from the National Survey of America's Families (NSAF) at three time points to measure self-reported mental health status and service utilization. State's with parity laws experienced higher utilization of services among groups working for small employers, with low income groups having the strongest effect size. There was some evidence of an increase in service utilization among individuals with poor mental health. Further, states with parity laws compared to nonparity states had a lower prevalence of poor mental health and experienced a further decline post-intervention. The presence of parity laws, as measured by this study, however, does not reflect implementation or level of adherence by

employers and payees. Further, the use of population level rather than individual level outcome measures also makes this study design vulnerable to ecological fallacy. Such research limitations should be considered in future studies.

CRIMINAL JUSTICE

The criminal justice system is a notable area where there has been increasing concern regarding how PMI are disadvantaged compared to people without mental illness. Structural stigma is apparent in several areas related to the criminal justice system, including laws and policing policies that make PMI vulnerable to arrest; the adjudication processes that PMI are less equipped to navigate than people without MI; the lack of MH treatment services and support for PMI within the criminal justice system; and the decreased likelihood PMI face in being disentangled from the criminal justice system compared to people without MI (Livingston, 2013). The disproportionate representation of people with mental illness with criminal justice involvement (Sarteschi, 2013; Glaze & James, 2006) and their treatment within the criminal justice system may be indicators of how criminal laws are designed and enforced in such a way as to differentially target and adversely impact PMI significantly more than people without mental illness. Nationally, over half of jail and prison inmates in 2005, had a mental health problem; compared to incarcerated individuals without MI, PMI were more likely to have been arrested, and incarcerated multiple times; a third of people incarcerated in prison and about 17 percent of those in jail with mental health problems accessed treatment since their imprisonment; and approximately 22-23 percent of individuals incarcerated with MI received treatment within a year before their arrest (Glaze & James, 2006). Most states in the US have more PMI in prison or jail than the state-operated psychiatric hospital (Torrey et al., 2014). The proliferation of mental health oriented programs, including mental health courts and special police teams, is also considered by some scholars as problematic as it may promote the notion that MI is inherently intertwined with criminality, and detracts from more upstream interventions and investments (Livingston, 2013).

Within the corrections system, whether prison or jail, PMI compared to people without mental illness face higher rates of being abused by staff and inmates (Blitz, Wolff, & Shi, 2008; Human Rights Watch, 2015); receiving sanctions like solitary confinement (Cloud, Drucker, Browne, & Parsons, 2015; Glaze & James, 2006; Subramanian, Delaney, Roberts, Fishman, & McGarry, 2015); being given longer sentences; and being denied parole (Livingston, 2013) compared to those without MI. While under community supervision, PMI experience more intense supervision and face a higher likelihood of receiving technical violations, even though the rate of new offenses is similar between individuals with and without MI (Louden & Skeem, 2013).

Some of these patterns of disparities represent the systematic marginalization of PMI and could potentially be used to create indicators of structural stigma; however, much of this data has not been consistently collected. Furthermore, while the disproportionality of PMI involved in the criminal justice system compared to people without MI is compelling and has increasingly raised concerns of unfair treatment (Abramsky, 2015; Epperson & Pettus-Davis, 2015; Giliberti, 2015; Gingrich & Jones, 2015; NYT Editorial Board, 2014; Wisniewski, 2015), more research is

needed to disentangle confounding factors related to criminality and establish causal inferences between the indicators of structural stigma and both criminal justice and health outcomes. The few studies examining structural factors related to PMI and criminal justice indicators focused on the association between the decline of psychiatric institutions and incarceration rates, and have produced conflicting findings as to whether such an association exists (Kim, 2014; Lamb & Bachrach, 2001; Markowitz, 2011; Palermo, Smith, & Liska, 1991; Wierdsma & Mulder, 2009). One of the consistent design weaknesses in these studies is the absence of potentially confounding variables like outpatient service capacity and utilization patterns, or indicators of the policy or policing environment (Kim, 2014). Despite the need for further research, there is a growing consensus that the shunting of PMI into the criminal justice system constitutes a form of structural stigma.

MEDIA

Media influences the public perception of people with mental illness, and is also a primary source for information on mental illness among the general public (Edney, 2004; Granello & Pauley, 2000). Structural stigma in media occurs through the promotion of stigmatizing frames of mental illness (Klin & Lemish, 2008). Content analysis of media items, a common approach in examining mental illness stigma in media, has consistently found negative stereotyping and portrayals of PMI, often in a violent and sensationalized context that links PMI to dangerousness and crime (Klin & Lemish, 2008); depicts treatment as unhelpful or even harmful (Sartorius et al., 2010; Schulze, 2007); and displays pessimistic views of illness management and recovery (Schulze, 2007). There has also been a dearth of first-person accounts by PMI (Edney, 2004). A content analysis of a nationally representative sample of US news found that the association of PMI with dangerousness made up the largest proportion of stories at 39 percent (Corrigan, Watson, Gracia, et al., 2005). Treatment was discussed in 26 percent of stories but only 16 percent of these acknowledged recovery as an outcome.

Although commonly used, content analysis studies have been criticized for their lack of validity in assessing the prevalence of stigma in media at a structural level (Corrigan et al., 2004; Stout, Villegas, & Jennings, 2004). Others have critiqued the narrow frame of reference in the coding schemes, calling for analyses that capture more context and examine the valence of the terms and narratives (Corrigan et al., 2004; Knifton & Quinn, 2008). Also, studies often have limited samples of media items, usually only focusing on either newspapers or televisions, with only a few examining social media (Birnbaum, Candan, Libby, Pascucci, & Kane, 2014; Joseph et al., 2015; Reavley & Pilkington, 2014) or incorporating more than one media form at a time.

Research examining the effect of media stigma on individual and MH-related outcomes has been less robust than the content analysis research related to media stigma. Some cross-sectional, self-reported survey studies have shown that greater consumption of media is correlated with increased negative attitudes towards PMI and mental health treatment, and support for punishment and coercive responses towards PMI (Diefenbach & West, 2007). Using a nationally representative population survey in Germany, Angermeyer and colleagues (2005) found media consumption, particularly television and tabloids, to be associated with increased desirability for social distance from PMI (Angermeyer, Dietrich, Pott, & Matschinger, 2005).

Most other studies, which had similar findings, entailed small, non-representative samples in the US (Granello, Pauley, & Carmichael, 1999; Granello & Pauley, 2000; Vogel, Gentile, & Kaplan, 2008).

Experimental studies comparing attitudinal outcomes between participants randomly assigned to consume a particular media item (e.g. vignette, newspaper article, movies, commercial) have found exposure to be associated with a change in attitudes. For example, McGinty and colleagues (2013) found that participants who read a media item about a mass shooting involving a PMI experienced an increase in negative attitudes towards PMI versus participants with no exposure and whose attitudes didn't change. Similarly, using vignettes, McGinty and colleagues (2015) found that stories of recovery decreased prejudiced attitudes towards PMI and improved belief in treatment efficacy. However, such experiments are situational, failing to assess stigma in media at the structural level. Although, a study, using population-level data from a series of eight representative, cross-sectional surveys in Germany, found that, following a highly publicized, violent event, there was an increase in prejudicial attitudes towards PMI, particularly in the regions where the event occurred (Angermeyer & Schulze, 2001; Angermeyer & Matschinger, 1996). However, a major limitation of this study is the absence of a measurement for structural stigma in the media. Generally, more studies are needed to develop valid indicators of structural stigma in the media. Broad indicators like hours of television or newspaper exposure, which are commonly used, are limited. Further, many of these studies have restricted their scope to only assessing the general population with little attention to discrimination, health seeking behaviors, or mental health outcomes among PMI specifically.

Increasing efforts have been made to address mass media directly through MI anti-stigma initiatives. Key media-related strategies seen in these efforts include trainings; advocacy; and fostering PMI and providers to become media spokespeople (Campbell, Heath, Bouknight, Rudd, & Pender; Mental Health Commission, 2005). Evaluations across countries have largely focused on changes in the prevalence of positive and negative media stories, which have shown mixed results (Clement et al., 2013; Mental Health Commission, 2005; Stuart, 2003; Thornicroft et al., 2013). Evaluation of Australia's *beyondblue*, a comprehensive social marketing campaign to destigmatize depression, went even further and assessed changes in attitudes among the general public. The evaluation strategy entailed cross-sectional survey data collected prior to and following the intervention. States were codified as having either 'low' or 'high' exposure to the intervention, therefore strengthening the evaluation's ability to make causal inferences. Evaluations showed an increase in understanding of depression, awareness of discrimination, and self-reported use of MH treatment (Jorm, Christensen, & Griffiths, 2005, 2006).

CULTURAL CONTEXT AND ATTITUDES

Structural stigma and its various manifestations is a reflection of cultural norms, attitudes and beliefs. Many studies examined attitudes towards MI among specific groups and the general public, finding differences by socio-demographic variables (Parcesepe & Cabassa, 2013). Stigmatizing attitudes towards PMI are found among criminal justice authorities, including beliefs that they are more dangerous than others involved in the criminal justice system (Ruiz,

2004; Watson, Corrigan, & Ottati, 2004); and healthcare providers who were also viewed as being exclusionary of PMI in treatment planning and having low expectations (Deans & Meocevic; Heflinger & Hinshaw, 2010; Kingdon, 2004; Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Schulze & Angermeyer, 2003; Schulze, 2007; Suto et al., 2012). Attitudinal studies of actors within institutions may be indicative of a climate within the institution that tolerates, is complicit in, or even fosters stigmatizing attitudes and practices, even though the attitudes and practices are exercised at the individual level.

Mental illness-related public stigma – “the prejudice and discrimination endorsed by the general population” (Corrigan, Morris, Michaels, Rafacz, & Rüsich, 2012) – is found to be widespread, particularly beliefs of PMI as dangerous and less competent, and desirability for social distance from PMI (Parcesepe & Cabassa, 2013). Evans-Lacko and colleagues’ cross-national study of 14 European countries examining associations between public attitudes of MI and self-stigma among PMI was one of the few to examine health service related outcomes. MH consumers living in countries with higher self-reports of seeking MH services, feeling comfortable talking to PMI, and better perceived access to MI information experienced greater feelings of empowerment, lower levels of perceived discrimination, and lower rates of self-stigma (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012).

Few studies have examined the cultural mechanisms underlying public attitudes and other forms of structural stigma. Yang and colleagues (2014) sought to unpack the pathways and cultural context surrounding MI-related structural stigma through a mixed-methods study of Fuzhonese immigrants with severe MI. Findings illustrated how structural barriers which affect one’s ability to exercise cultural values, such as employment, can impact health outcomes and contribute to feelings of self-empowerment (Yang et al., 2014).

However, the link between attitudes and structural stigma is complex. For instance, Corrigan and colleagues found that people who endorsed stereotypes of dangerousness and violence were more likely to support coercive approaches to PMI and segregation, and less likely to endorse supportive services for PMI (Corrigan, Watson, Warpinski, & Gracia, 2004). However, in a separate study, using population surveys of German citizens, Angermeyer and colleagues found that between 2001 and 2011 there was an increase in level of support for funding depression related services, while desire for social distance remained the same. The investigators speculate that this change may be associated with the increase in media coverage surrounding depression, therefore raising awareness of depression as a health problem. This illustrates the distinction between attitudes related to individual discrimination and structural discrimination and therefore the need for different strategies to address the multiple forms of stigma.

IMPLICATIONS AND FUTURE RESEARCH FOR STRUCTURAL STIGMA RELATING TO MENTAL ILLNESS

People with mental illness face systematic disadvantage across all major social determinants of health, consistently experiencing poorer outcomes compared to people without mental illness including, higher rates of unemployment and underemployment (Stuart, 2006); housing instability and homelessness (Callard et al., 2012a); high school and college disruption

(Mojtabai et al., 2015); and criminal justice involvement (Glaze & James, 2006). While much of the literature and discourse has focused on dangerousness and violence of PMI, studies have found that PMI are at higher risk of victimization (Choe, Teplin, & Abram, 2008; Desmarais et al., 2014; Khalifeh et al., 2015; Wolff, Blitz, & Shi, 2007) and even poly-victimization (Listwan, Daigle, Hartman, & Guastafarro, 2014), as well as unfair treatment by authorities in attempting to report crimes (Pettitt et al., 2013) compared to those without MI. There have been mixed findings on the willingness of PMI to report and seek assistance from authorities (Khalifeh et al., 2015).

While the discrimination of people with mental illness has been documented and critiqued in different socio-economic domains like housing and education, there is a paucity of rigorous research examining the prevalence of these forms of structural stigma, the experiences of PMI as they interact with them, and the relationship between these structures and health outcomes among PMI. Structural stigma has been linked to many of these outcomes but there has been a dearth of studies supporting causality. Many studies have been descriptive of how structural stigma is manifested or prevalent, or focus on attitudinal outcomes. It is also difficult to disentangle the various confounding factors from stigma and identify the differential impact they have on PMI health and wellbeing. Further, many existing studies rely on subjective appraisals and how individual perceptions of stigma impact outcomes like care seeking. For instance, through focus groups and interviews, PMI have reported fear of discrimination and stigma, particularly related to employment and parenting, as a barrier to seeking MH care (Clement et al., 2012; Roeloffs et al., 2003). Patients and caregivers of PMI report that the climate of treatment settings can be in poor condition, demoralizing and communicates shame and lack of hope (Heflinger & Hinshaw, 2010). Media narratives and perceived coercion have been expressed by PMI as contributing to stigma of MI (Corrigan, Druss, & Perlick, 2014; Edney, 2004; Grinfeld, 1998; Livingston, 2012) and resistance in disclosing MI issues and seeking care (Dew et al., 2007; Swartz, Swanson, Hannon, 2007). Although useful and supportive of the link between stigma and care seeking, these studies lack objective measures of structural stigma.

However, structural stigma research is a burgeoning field of work in public health with a growing literature of innovative studies that MI related work can draw from to develop more diverse and objective ways of measuring structural stigma, and rigorous study designs from which to make causal inferences. For instance, studies related to structural racism (Hatzenbuehler, Keyes, Hamilton, Uddin, & Galea, 2015) and LGBT-stigma (Hatzenbuehler, 2014; Hatzenbuehler et al., 2014; Pachankis, Hatzenbuehler, & Starks, 2014) have operationalized state policies and public stigma as measures of structural stigma, and by incorporating different geographies to capture variance in the structural stigma measures, have found associations between the structural stigma measures and health outcomes at the individual level. Hatzenbuehler's study of same-sex marriage bans as structural stigma towards LGBT populations was able to go even further as a natural experiment where individual health outcomes were compared before and after the passage of such bans, therefore incorporating temporality along with geographic variation by state to support causation (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). The impact of structural stigma was also assessed for both LGBT and heterosexual individuals. Such a dynamic study design can inform future MI

structural stigma studies. Few studies have examined the differential impact of structural stigma on people with mental illness and people without mental illness. Literature differentiating the various types of MI and related stigma is also needed, along with the differential impact and associations MI stigma has on various subpopulations. Much of the literature reviewed here has addressed PMI as a homogenous group with little distinction between how the stigma of MI interacts with different groups.

The stigma of mental illness is embodied across the various structures that impact health and wellbeing. Addressing these various threads of stigma will require a comprehensive approach that addresses the various domains. Scholars have proposed that an effective strategy will require advocacy and political engagement (Corrigan, Roe, & Tsang, 2011; Corrigan, 2004). Countries have already begun to implement anti-stigma efforts for MI. In the US, current legislation can be useful to advance structural change. This includes the Americans with Disabilities Act, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Patient Protection and Affordable Care Act of 2010 (ACA), and the Fair Housing Act. However, even with these stigma diminishing and MH promotion strategies, more information will be needed on how they are implemented, enforced, under what conditions, how they are experienced by PMI, and their impact on behavior and health.

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