

An Inquiry into Stigma within Mental Health Care Policy

By

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Abstract

Stigma is a major obstacle in the lives of people living with mental illness. This research uses a critical discourse analysis to examine instances of stigma embedded within mental health care policies in one Canadian mental health and addictions program. Drawing on the work of Foucault, Bourdieu and Goffman, this study focuses on the social power, domination and inequality that exist and become perpetuated within the social and institutional hospital environment. This example is used to explicate themes that are relevant for considerations of stigma in mental health care more generally. Three themes that emerged from the policy analysis are: paternalism, deviance and social exclusion. Overall recommendations for policy development are: 1) avoid over-generalization, 2) involve people with lived experience, 3) explicitly examine draft policies for the presence of potentially stigmatizing language and policy directives, and 4) emphasize the importance of the therapeutic bond when evaluating policy for stigma.

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List of Abbreviations

ACT	Assertive Community Treatment
CBC	Canadian Broadcasting Corporation
CC4MH	Community Coalition for Mental Health
CHANNAL	The Consumers Health Awareness Network Newfoundland and Labrador
CMHA	The Canadian Mental Health Association
CPA	Canadian Psychiatric Association
CTO	Community Treatment Order
CTUMS	Canadian Tobacco Use Monitoring Survey
DSM	Diagnostic and Statistical Manual of Mental Disorders
EHPAC	Eastern Health Policy Advisory Committee
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Queer Community
MH&A	Mental Health and Addictions
NL	Newfoundland and Labrador
NRT	Nicotine Replacement Therapy
RHA	Regional Health Authority
WHO	World Health Organization

Introduction

Maybe the target nowadays is not to discover what we are, but to refuse what we are.

-Michel Foucault in Dreyfus and Rabinow, 1983, p.216

Stigmatizing ideas about mental illness exist within society, in both covert and overt ways.

These ideas can permeate a person's beliefs and behaviours in subtle ways, and can show up in forms of discourse and communication within society. Such ideas are inadvertently purveyed and reinforced in the meanings associated with being mentally ill. Assumptions about mental illness continue to be perpetuated within the community through our institutions and through the day to day interactions between individuals.

The overall negative assumptions associated with mental illness give rise to the power and persuasiveness that legitimize the ways that the mentally ill are misunderstood and treated. In health care, one example of how stigmatizing ideas may be inadvertently purveyed and reinforced can be seen in the meanings associated with being mentally ill, that are implicit in health care policies. This thesis represents my efforts to look at select mental health care policies, in Newfoundland and Labrador's (NL) Eastern Health district, to reveal the hidden aspects of stigma within them. Specifically, this research has sought to answer the following questions: (1) to what extent do mental health care institutional policies convey and perpetuate ideas about mental illness that may be inaccurate and stigmatizing?, and (2) what are the provincial and national initiatives to reduce stigma.

The first chapter seeks to define stigma using sociologist Erving Goffman's theoretical writings. There is also an attempt to show the existence of stigma in the local NL context, in Chapter 1. As well, the standard definitions of mental illness are included, along with some statistics of its prevalence. My motivation for this thesis and epistemological stance are outlined in Chapter 2. Having a personal history with depression and anxiety, I was motivated to bring to light the hidden existence of stigma within our society. A literature review is included in Chapter 3, which gives an overview of the key areas needed to form the basis for the context and background that helped to shape this policy analysis. This chapter also provides an overview of the history of the Waterford Hospital, Eastern Health's psychiatric hospital, and the stigma associated with it. The third chapter also includes statistics that demonstrate the prevalence of stigma in our society. Chapter 4 explains the efforts that have been made in Canada and in the province of Newfoundland and Labrador to combat mental health stigma.

In particular, this research focused on the mental health and addictions programme within the largest health region of Newfoundland and Labrador, Eastern Health. The critical policy analysis in Chapter 5 aims to show how aspects of stigma work through policy and on patients, as an extension of the power that stigma exerts within society. Following a lengthy and in-depth analysis, three themes emerged from the policy analysis, which are: paternalism, deviance and social exclusion. Chapter 6 includes the final discussion of the overall recommendations to reduce the impact of stigma within policy development. Limitations of this thesis work are discussed, and recommendations are made for future research on the

existence of stigma of mental illness within the healthcare system. The chapters of this thesis display the efforts of a critical discourse analysis which sought to uncover stigma in a layered approach, revealing how engrained stigma is in society. Such a multifaceted methodology is helpful to provide a rich, in-depth analysis of stigma in social discourse.

Chapter 1: Mental Illness and Stigma

The word stigma can be tracked back historically, to its use in early Greek society (Goffman, 1963). At that time, stigma referred to a mark intentionally placed on a person's body. This mark would signify to the rest of society that this individual possessed some socially unacceptable moral trait or behaviour. In Christianity, a stigma could represent a bodily physical disorder, while ambiguously at the same time it could also represent a holy grace (Goffman, 1963, p.1). In contemporary society, the disgrace associated with a stigma still exists regardless of whether there is an obvious physical mark. Today we have psychiatric labels, which can draw similar discrediting attention to individuals.

This chapter will discuss mental illness, including how it is defined and the prevalence of it within society. There is a further discussion of what stigma is, and the local context of stigma in NL. In addition, there is also some discussion on the increasing awareness of mental illness within society.

1.1 Stigma and Society

Erving Goffman, a Canadian-American sociologist and writer, has done much research into understanding what stigma is and how it impacts the individual. In his book "*Stigma: Notes on the Management of Spoiled Identity*" (1963), Goffman explains that the power of stigma lies in the elements of the process of stigmatization and social distancing¹, which together can make

¹ Social distance is a concept that describes how comfortable a person is with associating with a particular type of person or group of people. This is discussed in more detail in section 5.1.3.

the stigmatized seem less than human. Goffman defines stigma as some aspect or behaviour that causes what he calls “normal” people to reject or discredit a person, instead of accepting them under the “normal” stereotype. There are certain assumptions made about the stigmatized, which create a perceived anticipation in society about how a stigmatized person will behave in typical social and professional settings. Furthermore, there is much discourse within society (i.e. media, stories, novels, shows, gossip) that helps to shape how society will view a stigmatized person. This information may be negative and add to the internalized proof to discredit the identity of the stigmatized individual; this stigma creates a social disconnect with others. The impact of this discourse is that it is internalized within each person, and the ramifications of a discredited identity can have a major impact on the individual’s sense of self. The result can be to silence a person by lowering their self-value, or to impact them by silencing their voice within society.

Goffman researched stigmatized persons and was able to see a pattern in the perceptions of how the stigmatized persons saw themselves within society, which he referred to as their “moral career²” (1963, p.32). He categorized four broad “moral careers”: 1) There is inborn stigma, which describes a person who was born into their stigma, and so they learn about life of a “normal”, along with learning about how they do not measure up to this standard; 2) A family or a neighbourhood may provide a protective shield against stigmatizing comments and therefore help to manage the discrediting information; 3) A person may become stigmatized

² The moral career is used to explain the internal ideas of self and external societal position that exists for a patient, prior to hospitalization, during hospitalization and after hospitalization. Thus, the moral career is specific to hospitalization. (Goffman, 1963).

later in life and have to learn to manage this new identity; in this way they learn that they have always been discreditable and have never measured up to what is considered normal; and 4) A person is socialized by a group that is outside normal society. In terms of the impact of the third pattern, learning about one's stigma later in life can lead to a major shift in one's identity. This shift can make a person question life choices as well as renegotiate the way in which their life has been constructed (Goffman, 1963, p. 35).

In his book *Asylums* (1961), Erving Goffman further analyses stigma within the context of how the identity of the mentally ill person is impacted upon hospitalization for a mental illness. While Goffman wrote this book many years ago, his findings are still relevant today. It is important to note that Goffman is describing patients who are coerced or forced into the hospital, so the work has limited applicability to understanding the situation for voluntarily hospitalized patients. Goffman does acknowledge that only a small portion of patients will go into the hospital willingly; most are coerced by family or friends who want them to get help. Coercion is also a major part of helping those with mental illness to access treatment, as there is often a lack of insight when a person is struggling with an episode of illness.

Goffman also outlined how hospitalization has historically impacted the identity of individuals with mental illness. He explains that this aspect of the patient's moral career consists of three phases: the time before entering the hospital, the pre-patient phase; the time in the hospital, the inpatient phase; and the time after the hospital, the ex-patient phase (Goffman, 1961, p.125). Goffman describes the first two phases in *Asylums*. He discusses the

pre-patient phase as having periods of coercion where there are often many instances of attempts or actions towards a person to help or intervene in the health of a person with mental illness, leading up to hospitalization (Goffman, 1961, p.125). There is a process by which something in the person's behaviour signifies to the friends of family or to the person themselves that they are losing control or capacity to cope with their lives. The pre-patient phase is highlighted by periods of feeling "abandonment, disloyalty and embitterment" due to the process that has occurred with family, friends or other members in society to bring them to hospitalization (Goffman, 1961, p.125). There can be stress associated with hospitalization because the patient "starts out with relationships and rights, and ends up, at the beginning of his hospital stay, with hardly any of either" (Goffman, 1961, p. 125). During the inpatient phase, the patient often has to come to terms with being placed in a locked ward, which might seem like punishment for previous behaviour. At this stage, Goffman explains, the patient might start to understand why they are at the hospital and begin to accept that they need psychiatric help (Goffman, 1961, p. 125). The inpatient also has to orient themselves to the ward, the rules and the forced loss of some rights. They may often tell the perceived history of their hardships to try to explain their behaviour that brought them to the hospital, to explain that they are really not at fault for their behaviour, as Goffman's quotes from research participants explain (1961, p. 125):

"I was going to night school to get an M.A. degree, and holding down a job in addition, and the load got too much for me."

"I got here by mistake because of a diabetes diagnosis, and I'll leave in a couple of days. [The patient had been in seven weeks.]"

In the ex-patient phase, the patient returns to community and needs to live with the new label, of mental illness, placed upon them as well as the stigma that goes along with that label. They also need to face the relationships with friends and family members who may have coerced them to seek treatment.

Goffman has outlined how those with a stigmatized condition can function well within society and manage the impact of stigma (1963, p. 73). There is a difficulty, though, in trying to manage social interactions and deciding whether to disclose information about having a mental illness. Goffman explains that when individuals with mental illness reveal their condition to others and receive a reaction (fear, for example) that is stigmatizing, then this reaction has the effect of “spoiling” the recipient’s identity through a process that ultimately discredits them as an individual. The effect of discrediting prevents the person from reaching full social acceptance. There are also social challenges in living with a stigmatizing condition. This stigma can also be passed on to discredit those individuals who are associated with the stigmatized person, such as family members. A way of coping with stigma may be to manage the information about them and only disclose what they are comfortable revealing (Goffman, 1963, p. 105). Some people may choose to deal with stigma by avoiding intimacy altogether. One of the most difficult aspects of living with a mental illness is to somehow balance psychiatric treatment with social stigmatization.

Goffman argues that, given the opportunity, stigmatized people will try to “pass as a normal” (Goffman, 1963, p. 73). A stigmatized individual may go to great lengths to conceal their condition or they may sometimes disclose their stigma in a more socially acceptable

manner. Goffman gives an example of those who choose instead to rely on symbols to help disclose for them, such as “Jewesses who wear a Star of David as a necklace” (1963, p. 123). Another example Goffman gave was that of a blind person who may purposely commit a clumsy act so as to disclose their blindness without having to go through the awkwardness of discussing it (1963, p. 103). Those belonging to a group for which there is no symbol have to use other means to show their stigma, such as verbally disclosing it, which can be very difficult. For mental illness, there is no visual image³ that can aid with trying to explain the difficulty one lives with.

1.2 Local Context of Stigma

It is important to provide some local context to the stigma of mental illness within Newfoundland and Labrador, when conducting a policy analysis such as this. In NL, the Waterford hospital itself is associated with stigma. The name The Waterford⁴ conjures up much stigma and ridicule and is often the punch line of jokes, such as “I’m heading to the Waterford, and I really need it!”. Breakwater Books Limited is a local publisher that worked with the Canadian Mental Health Association to produce the book *Out Loud* (2010), a collection of essays that includes individual stories from Newfoundlanders and Labradoreans whose lives have been impacted by mental illness. Unfortunately, there are many examples of how stigma

³ While there are ‘insider’ symbols that are emerging to convey that someone is living with mental illness (e.g., Project Semicolon [<https://projectsemicolon.com/>]) an individual has to choose to publicly declare their status as mentally ill. For the most part, mental illnesses are invisible.

⁴ The Health Science Centre and Janeway Children’s Hospital also have psychiatric wards, and the Waterford provides care beyond mental illness (for example, dialysis) as a means of trying to reduce the stigma. But historically, and still today, the Waterford is known as “the” mental health hospital.

has impacted individual lives in the province. The following are excerpts that help to provide some insight into the perception of mental illness in Newfoundland and Labrador. In this province, as in the rest of Canada and elsewhere, those who suffer from mental illness feel excluded from society and as if they are to blame for their illness:

“Often, the mentally ill are meant to feel “wrong”, as if it’s their fault they’re mentally ill and they’ve done something in their life to bring it onto themselves” (Bauld, 2010, p. 89).

Often times when one suffers from a physical injury there is no hesitation in offering condolences to the individual or their family. However, with mental illness there is a perceived social distance, as explained by one *Out Loud* contributor:

“When my son had to leave school he was gone for months. No one called. I believe if my son had any other illness, even cancer, there would have been lots of calls” (Kavanagh, 2010, p. 84).

There is an awareness of the social distance felt with mental illness, and so when a person finds that they themselves have to manage a personal mental illness, they are at a loss as to how to explain it to others. Another *Out Loud* contributor recounts her experience of a diagnosis and hospitalization with depression:

“I spent three days in the hospital to get started on medication, and to rest. I told my family I was there for high blood pressure, and when I left with my new prescription I left even more determined to hide the truth. I couldn’t imagine telling my family and friends that I had depression: that would be wrong for me to have something like that” (O’Halloran, 2010, p.163).

The difficulty of worrying about meeting societal expectations can provide many obstacles within social settings. For example, it can prevent youth with mental illness from finishing their

education. This is a quote from one such person who explained this difficulty and why they chose not to return to school:

“I found it was too stressful and worried so much about what other people thought of me” (Penney, 2010, p. 98).

The pain of feeling left behind while your peers advance in their life is a very real loss and is often the impact of stigma. One respondent remembers how it impacted him:

“I cannot describe to you the feeling of standing by and watching your friends continue to march to adulthood as you stand paralyzed” (Kavanagh, 2010, p. 83).

Donna Kavanagh quoted Mark Gruchy, a former student of hers and a local politician, who was able to overcome this barrier and later became a lawyer and eventually the president of the Canadian Mental Health Association in Newfoundland and Labrador.

1.3 Defining Mental Illness and its Prevalence

One of the challenges associated with mental illness is that it is very hard to define. Since we all fall somewhere on the wide continuum of mental states, it can be difficult to summarize in a neat concise way just what is considered mentally ill. Here are some commonly referenced definitions of mental illness:

The World Health Organization (2015) defines mental disorder as follows:

“Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, mental retardation and disorders due to drug abuse. Most of these disorders can be successfully treated.”

The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric

Association, 2000) defines mental disorder as:

“a clinically significant disturbance in cognition, emotion regulation, or behavior that indicates a dysfunction in mental functioning that is usually associated with significant distress or disability in work, relationships, or other areas of functioning”.

The NL Mental Health Care and Treatment Act (2006) defines mental disorder as:

“a disorder of thought, mood, perception, orientation or memory that impairs (i) judgment or behaviour, (ii) the capacity to recognize reality, or (iii) the ability to meet the ordinary demands of life, and in respect of which psychiatric treatment is advisable.”

For the purposes of this thesis, I emphasise the social construction of what it means to be mentally ill within society, and how stigma impacts the individual. These definitions are helpful for accessing healthcare or other supports, though they can also be damaging when they bring with them a heavy stigma.

1.4 Increased Awareness of Mental Illness

The World Health Organization (WHO) lists mental illness, specifically depression, as one of the major causes of disability worldwide. It is estimated that about 400 million people across the world suffer from depression, with more depression being diagnosed in women than men (WHO, 2015). WHO is invested in improving mental health and as such has developed a mental health action plan for 2013 – 2020, and developed programs such as the Mental Health Gap

Action Programme (WHO, 2015), aimed at improving mental health services internationally.

Actions such as these help to increase the awareness of mental illness around the world.

Bell Canada, Canada's largest telecommunications company, has initiated the national “Let’s Talk” campaign, which has raised both funds and recognition of stigma towards mental illness across the nation. The Canadian Mental Health Association (CMHA) also has held many events and has developed many programs that bring attention to stigma around mental illness across Canada. For example, the local Newfoundland and Labrador branch (CMHA-NL), holds an annual art exhibit called “Mindscapes”, which showcases art created by people with lived experience with mental illness (CHHA-NL, 2017). There have been celebrities such as Olympian Clara Hughes, comedian Robin Williams, singer Matthew Good, and the mother of Canada’s current Prime Minister, Margaret Trudeau, who have all helped to raise awareness around mental illness, through publicly disclosing their own battles. Having well known and respected people speak about their personal experience with mental illness helps to normalize it, through breaking down barriers and reframing stigmatizing assumptions (Sartorius et al., 2010; Rusch et al., 2008; Reinke et al., 2004; Abbey et al., 2011). The act of speaking out about one’s experiences helps to bring lightness into a once dark place and helps to make mental illness more human and less fearful.

Locally, there are groups in Newfoundland and Labrador that work towards raising awareness and decreasing stigma around mental illness. Local groups include: The Canadian Mental Health Association NL branch (CMHA-NL); The Consumers Health Awareness Network

Newfoundland and Labrador (CHANNAL), a peer-run support network for mental health; the local Schizophrenia Society; and the Eating Disorder Foundation of NL. These organizations frequently organize events and invite the community to learn more about mental illness in an effort to reduce stigma. For example, in the second week of March 2015, CHANNAL held a Stigma Awareness week, which included a variety show at a local church. Several local NL musicians and celebrities were actively involved to help raise awareness.

This chapter provided an overview of what stigma is and how it has been defined within society. The excerpts from a collection of essays by local NL individuals living with mental illness provided some local context of stigma. Finally, some standard definitions of mental illness were provided, and national and local efforts to combat stigma were described. The next chapter will give a detailed description of the methodology used to conduct the policy analysis for this research.

Chapter 2: Method

This chapter describes the methodology that was used to analyse the mental health care policies of Eastern Health. It gives a short overview of what critical discourse analysis is and the theory that was used to form the conceptual framework for the analysis. Lastly, there is a short overview of how this project observed requirements for rigour throughout the research process.

This project sought to answer questions about stigma and mental illness in Newfoundland and Labrador. The key questions asked were: (1) to what extent do mental health care institutional policies inadvertently convey and perpetuate ideas about mental illness that may be inaccurate and stigmatizing; and (2) what are the provincial and national initiatives to reduce stigma.

Critical discourse analysis was chosen because it is a research method that looks at the different and complex elements of power and how it is experienced or exercised within societal institutions. Critical discourse analysis (van Dijk, 2005) was developed by social linguists and political theorists seeking to examine complex issues such as racism and gender inequality. Like racism, stigma may sometimes be overt but it is mostly hidden. It has remained embedded in everyday culture through repeated references over time throughout society and history. Much of current public discourse has managed to normalize the assumptions and behaviours that dominate with respect to the stigma around mental illness. The accumulation of negative messaging about the mentally ill can result in a powerful impact on the individual. The messaging can create obstacles because the power relations hidden within day-to-day

interactions can cause additional obstacles, beyond those associated with dealing with an illness.

Using a critical discourse analysis method, I have been able to take into account the broad and complex environment in which mental health policies are developed, to understand how stigma is hidden. To reveal the hidden nature of stigma it was necessary to trace the roots of how mental illness was socially constructed and how the treatment of it has been normalized within our present day society. The nature of uncovering something hidden requires a long process of looking closely at, around and near the subject itself. This topic, then, required reading various theoretical works which would give me the tools to help deconstruct the ideology of what it means to be mentally ill within society, including the works of Goffman (1961-1963), Foucault (1961-1975), and Bourdieu (1977). It was also necessary to take into account how those living with mental illness describe the impact of stigma on their lives (e.g., Dearing, 2010; Jamison, 2004; Jamison, 2006), and to examine how the perception of those with mental illness is shaped by all forms of media (Baun, 2009; Edney, 2004). Additionally, it was important to consider that the nature of stigma around mental illness in NL has been influenced by the political, social and cultural history of this province. This required in-depth examination of the works of local writers focusing on mental illness (Dearing, 2010) and scrutiny of the key news media sources of the province, most particularly the province's leading newspaper, The Telegram, and The Canadian Broadcasting Corporation (CBC) local news.

My intention for this thesis was to complete a critical discourse analysis of mental health care policy in order to uncover hidden aspects of stigma. This meant that I had to look closely at the whole complex environment that interacts with the varied and intricate nature of what a mental illness diagnosis means under various frames; not just what it means as a label, but what the potential impact is given the heavy rhetoric that we live with, with respect to mental health. Using critical discourse analysis, I analyzed Eastern Health's mental health care policies to uncover hidden aspects of stigma.

2.1 Epistemological Positioning

As a part of my methodology, I as the researcher have a personal lens through which I view and interpret the world. This positioning is the lens that guided me through the analysis and understanding of the selected mental health care policies. As such, my own epistemological positioning has helped to shape and inform my stance on the issues in the research area of mental health. I have a personal history with anxiety and depression, which began in my teenage years. Throughout the research process, I have gained a deeper understanding of how my experience has impacted my identity, growth, and personal development within society. There can be pros and cons to using a personal lens in research; for example, in this case a person could be too sensitive and see stigmatizing messages where there are none. However, this positioning has given me a unique skill-set, as a person with lived experience, to study the complex area of the stigmatization of mental illness.

2.2 Critical Discourse Analysis

Critical discourse analysis is a specific research method used to focus on the existence of abuse of social power, domination and inequality within a social and/or political environment (van Dijk, 2005). This was a good fit for analyzing mental health care policies, as the mentally ill have historically been marginalized. Those living with mental illness, as a group, often suffer from a lack of social power and have been subject to many instances of inequality and misunderstanding.

While conducting my analysis, there were some guiding principles that helped my analytical process. These principles were: a) Critical discourse addresses social problems; b) Power relations are discursive; c) Discourse constitutes society and culture; d) Discourse does ideological work; e) Discourse is historical; f) The link between text and society is mediated; g) Discourse analysis is interpretative and explanatory; h) Discourse is a form of social action (van Dijk, 2005). There is a relationship between society and language that has evolved together over time. Society and language both shape each other; society is shaped by language and language is also influenced by society (van Dijk, 2005). There are certain ideas, attitudes, biases and a basis for the knowledge about mental illness that is constructed via the social environment. This discourse becomes accepted as “the truth” when repeated, believed and carried throughout society. It can make up the social environment, in the sense that it can shape the opinions and attitudes that can also represent beliefs (van Dijk, 1998). These ideas become so engrained in our way of being that we no longer stop to question their origins

(Bourdieu, 1977; Foucault, 1961). In keeping with the post-structuralism of Foucault and Bourdieu, it is likely that these ideologies, specifically, the ideologies about mental illness, may very well impact the way in which the policies that govern the mentally ill are developed. This is the central concern of my thesis. These ideas about mental illness are not based on facts but are built on perception as well as bias, so they are quite dangerous to those living with a mental illness diagnosis, because this knowledge is used for the assertion of power. These ideologies also impact the discourse around the formulation of policies as well as the manner in which these ideologies are maintained. Specifically, the ideologies about mental illness impact the way in which the policies that govern the mental ill are developed.

There is a wide range of techniques and tools used to classify and treat mental disorders, including the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM), mental health legislation, mental health care policies and medical training (American Psychiatric Association, 2000). These all wield power, prestige and respect within our society and to a large extent dominate our understanding of what mental illness is. The medical profession and its associated legislation create and uphold specific well defined labels and boundaries for society. If someone is ill, then the nosology, or classification of diseases, within medicine describes a well-constructed list of symptoms and methods. As a society, we put great faith and trust in the classification of disease. Persons with a mental illness may at some point in their life find themselves being treated for their behaviours either through legal or medical means. For individuals living with mental illness, the implication of punishment for one's actions (a notion that will be expanded on in section 5.1.2 of this thesis) often relates to

the power imbalance that is seen within society. This can be seen between those labeled as mentally ill and those in positions of power to define their behaviour, label and “treat” it. The treatment is in itself the action of power over the other’s body (which is vulnerable); under the guise of paternalism, where much can be done without hesitation.

My critical discourse analysis included an examination of the history of mental illness and its treatment. It was important to retrace the steps to how we arrived at how we see mental illness today. The social construction of illness through our discourse is powerful because it shapes the reality of the world that we live in. Therefore, in order to have a good understanding of this process, I reviewed the history of the Waterford dating back to the 1800s (O’Brien, 1988). I also looked at historical sources of how mental illness has been understood over time from the European renaissance period of 14th–17th centuries in Europe to present day understandings (Foucault, 1961). There has, of course, been much change in the conceptualization and treatment of mental illness over time. There have been advances relating to scientific research; but many ideas remain unchanged and form the underpinnings of how mental illness continues to be understood and treated today. In particular, this thesis will draw on the work of Foucault (1961-1975) to illustrate how long-standing assumptions about deviance continue to shape the way mental illness is understood and treated today (Jamison, 2006; Jost, 2009).

More recently in history, and in the local context of NL, there were various social and political events that shaped the way that mental illness is understood and managed. In

particular, two deaths related to mental illness garnered wide attention in the media and were subject to formal inquiries. The Luther Inquiry, which was overseen by Judge Donald Luther, describes the events leading up to the deaths of Norman Reid and Darryl Power. This was a local tragedy that prompted a subsequent evaluation of the Newfoundland and Labrador Mental Health Act, which had not been updated since 1971 (Luther, 2003). Both of these men suffered from mental illness and were shot by police under tragic circumstances in the year 2000. Norman Reid, 43, was from Bonavista, NL and had had recurring visits to the Waterford Hospital for treatment for schizophrenia. Shortly after discharge from the hospital there was an incident whereby he threatened police officers with an axe and was shot dead on August 26, 2000. Darryl Power, 23, was also a recently discharged psychiatric patient, from Western Memorial Regional Hospital. Leading up to his death, Darryl reported being suicidal on numerous occasions. In one instance, he stated that getting shot by a police officer would be one method of doing this. After a call to the police the night of October 16, 2000, Darryl was shot while he was coming towards an officer with a knife in his hand, outside of his mother's house in Corner Brook (Luther, 2003). Darryl's death was later deemed to be a "suicide by police officer." The tragic deaths of these two men brought attention to the need for a change within the mental health care system within NL. There seemed to be a breakdown in the continuity of care that these men received, which led to instances where the system might have been able to help, but failed to reach these men (Luther, 2003).

Local social advocacy efforts, such as *Out Loud* (as mentioned earlier, a partnership between the NL chapter of the Canadian Mental Health Association and local publisher

Breakwater Books Ltd.) were important both in communicating the rising tide of resistance against the way that mental illness was treated in the province, and reshaping the local context. In this thesis, I use the personal stories in *Out Loud* to give local examples of stigma around mental illness in NL; using the language of local people helped to frame how mental illness is experienced and understood locally. To deepen my understanding of the local context, I also attended several local events and initiatives that raise awareness around mental health. In addition, I participated in local research groups with the NL Centre for Applied Health Research, as well as in mental health and addiction committee discussions.

For the analysis of the policies themselves, I met with hospital representatives, who were my key informants, and received copies of the policies. I asked for any older versions of these policies in order to understand how they developed over time. The director of the Waterford's Mental Health and Addictions (MH&A) program was particularly helpful, meeting with me in an extended in-depth and open ended interview to provide me with an overview of the policy development process. Additionally, I was provided with several documents that aided in my understanding of Eastern Health's policy development process. Those documents included a *Policy Writing Handbook (2010)*; *Policy Development Checklist (2010)*; *Policy Development Template (2010)*; *Policy Development Framework (2010)*; *Policy Approval Process (2012)*; and *MH&A Program Policy and Procedure Advisory Committee Policy Feedback Template (2012)*.

To gain an understanding of the process used to shape the mental health policies, interviews were conducted with those who helped to create and implement these policies. The

interviews were meant as a source for discussion to contextualize the analysis of the mental health care policy documents. Purposive sampling was used to recruit those who had a significant role in policy development and therefore had the experience and insight for contextualizing the policy discourse analysis. Five key informants who are health professionals that work in these hospital programs, and who could offer insight in the policy development, were identified and were invited to participate (see Appendix A). All people accepted this invitation and were very helpful. These key informant interviews were used to support the analysis of the chosen policies. Questions were framed around clarification of the purpose and history of issues that had led to the development of the health policies (Appendix B). The five key informants included program managers, nurse educators, and policy and program coordinators from the Waterford psychiatric hospital and the Janeway Children's Health and Rehabilitation Centre (Janeway Hospital), within Eastern Health.

Considering the number of policies that were discussed with key informants, it was sometimes necessary to hold the interviews over two separate time-periods (of 1 to 1 ½ hours each) in most cases, as these key informants were professionals with busy schedules. The interviews were recorded, transcribed and analyzed for information to support the analysis. Each key informant was also sent a copy of their transcript and they provided me with any edits or updates to information given.

In addition to meeting with program managers and a policy coordinator, I also spoke with clinical educators about the orientation program at the Waterford and Janeway Hospitals. The

orientation program is for new mental health nurses. All new nurses are provided an extensive orientation at the Waterford. Those who work at the Janeway Hospital have an additional orientation to the child and youth psychiatric unit. I was advised that the orientation process included education around stigma, as well as a discussion around suicide, aggression, self-mutilation, and psychiatric rehabilitation. In an interview with a clinical educator from Eastern Health, I was told that specific questions answered as part of the orientation are: “What is stigma?” “Why are mental health patients stigmatized? What effect does stigma have on patients?” and “As health care professionals, what is our role in eliminating stigma?”. In addition, the article “Cloaked in Secrecy and Shame”, by Jane Kenny (2001), is distributed and discussed. Kenny has developed mental health services for children through the Children’s Services Network in Toronto. The “Cloaked in Secrecy and Shame” article describes stigma in fairly plain language and is meant to help train staff to understand how stigma impacts their patients. It describes the fear of judgement from a moral standpoint as well as a general feeling of being devalued by society (Kenny, 2001). In addition, I was informed that there is ongoing education on mental illness for staff working with both the adult and pediatric mental health programs. Through ongoing education, nurses are provided with up to date information about the community groups that support persons with mental illness. This process of ongoing education for staff was noted to be particularly important for staff working with the pediatric population. At the Janeway Hospital, nurses and clinical educators often have to educate patients and parents about stigma and how they can manage it. In addition, the Janeway Hospital has prepared additional take-home sheets of information describing various mental

illnesses that provide additional means of mitigating potential misunderstandings about the nature and implications of living with a mental illness.

As noted, the key informant interviews were used to frame the context of mental illness treatment within NL and to decide which policies I would examine more closely. I began with a list of 29 policies and initially conducted a cursory analysis of all policies, including conducting national scans and literature reviews relevant to each policy. That preliminary analysis enabled me to identify the themes that were the most relevant to examine how stigma is embedded within policy. My critical analysis of the hospital policies focused on the language used to discuss patients. This was done with the goal of examining and understanding the operation of power and knowledge production that emerged in the use of language (following Lupton, 1992). I read and re-read each of the policies, taking note of statements that seemed to convey stigma, and paid attention to the words being used. I then combined like ideas together and through arranging and re-arranging statements, I increasingly narrowed down the categories of types of statements and, in the context of the literature on mental illness and stigma, specific themes emerged. These major themes are paternalism, deviance and social exclusion. Using these themes, I narrowed down the analysis to six policies, which were deemed to be the best fit for a further, more in-depth analysis of hidden aspects of stigma within hospital discourse.

2.3 Conceptual Framework

My methodology has been informed by a social constructionist and critical theoretical perspective. A social constructionist approach is based on the idea that there is not one reality

but rather many different realities, which are individually constructed based on personal experience and circumstance (Green & Thorogood, 2009). Specifically, this thesis is looking at the social construction of mental illness. In relation to this perspective, the meaning of mental illness is constructed socially from the culture in which one lives and experiences life; furthermore, policy decisions are based upon these socially constructed values.

If there is stigma within society about people with mental illness, then it is likely to be, implicitly, part of policy, due to the simple fact that people living in society are also the people who create policy. This can be understood with reference to the concept of “habitus” by Pierre Bourdieu, meaning a system of internalized dispositions that mediate between social structures and practical activity, being shaped by the former and regulating the latter (1977, p. 72). Following Bourdieu, I argue that assumptions about people with mental illness lie in the realm of the taken-for-granted; they are hidden in the habits of everyday life and regenerated through repetitive, everyday acts. Implicit stigmatizing ideas are so normalized and naturalized that they are never noticed or questioned.

My research begins with the premise that long-standing culturally rooted assumptions about mental illness are subtly embedded in contemporary health care policy. The stigmatizing assumptions are hidden and are not often overtly expressed. The work of three main theorists has influenced this discourse analysis: Bourdieu (1977), Michel Foucault (e.g., 1973) and Erving Goffman (e.g., 1963). Their post-structuralist framework provided me with a deeper understanding of how ideas permeate society and work through subtle ways internally, as well

as through social structures externally, to impact the identity of an individual. The following is a brief overview of the major concepts from each theorist that contributed to the framework for my analysis.

Michel Foucault was a French philosopher who produced various works of research on the social structures within society and also outlined methods to analyze power relations within them. He traces the history of ideas to examine how the concepts have come to be understood as they are in present day. In this way he tries to uncover how ideologies can become embedded within our culture. This method of inquiry aids in building an argument that power is ascribed to belief systems and ideologies, which often work through institutions to exert their influence over people within them. Foucault's theory has given the basis for me to challenge contemporary normative assumptions about mental illness that have been shaped throughout history. Specifically, his work in *Madness and Civilization* (1961), *The Birth of the Clinic: An Archaeology of Medical Perception* (1973), *Discipline and Punish* (1975) as well as Hubert Dreyfus and Paul Rabinow's text *Michel Foucault: Beyond Structuralism and Hermeneutics* (1983), were used to help shape the critical framework for this analysis.

Pierre Bourdieu is a French sociologist who developed theory around the culturally accumulated and symbolic forms of power within society. Specifically, his theory within *Outline of a Theory of Practice* (1977), was used to help with uncovering how hidden notions within society can be maintained throughout history and, although covert, these notions can wield much power. Bourdieu describes how cultural capital operates within a society, such that

individuals socialized within that society tend to share ideas and perceptions that are embedded, and that will guide the way members of society think about things. The continual reinforcing of ideas and behaviour around the social structures within society is what Bourdieu termed “habitus” (1977, p. 72). These notions are trained, in a sense, through the socialization process, whereby the norms and beliefs of a culture are also embedded within each person. There are unwritten rules in society about mental illness that fall under the type of power that Bourdieu calls “doxa” (1977, p. 159). These ideas help to form a natural social order and alignment; doxa explains how power and domination can occur in social settings where the embedded ideas of how to act and think dominate a person and guide their everyday interactions. He uses the concept of “orthodoxy” to explain the written rules of society, such as discourses that are directly giving guidance on how to act and think within a social setting; policies are one such example of orthodoxy. A very useful aspect of Bourdieu’s theory is that it can help to understand social change, as he has uncovered a way of looking at the micro level social interactions, which to a large extent form the subtle forms of resistance in any social movement. For example, a subtle way to resist would be to conform in order to remain invisible. Bourdieu’s ideas can also help to understand embedded ideas within internal change while trying to develop an approach to influence external change on a broader level. His theory can help to give some tangible perspective on the individual’s ability for agency and what might propel them to make choices within different contexts, societies, or institutional settings.

Erving Goffman was a Canadian sociologist who produced much work in the area of the self and identity, in terms of how symbolic interactions within society help to form and reform

one's identity. Specifically, for this thesis I have relied on his work in *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961), and *Stigma: Notes on the Management of a Spoiled Identity* (1963). Goffman's work has provided much in the way of insight into the social setting of an institution and how it can impact the perception of oneself. This experience of a hospitalization can have a larger impact on self-stigma, as well as on the development and cohesive social adjustment back into society.

2.4 Rigour

Critical discourse analysis was chosen for the mental health care policy analysis. The development of policies for the mentally ill impacts the management of mentally ill persons; as well it shapes the subtle power that becomes exerted on persons on a day to day basis. This method takes into account the social and political environment, and how it impacts the interpretation of discourse, such as policy (van Dijk, 2005). Since critical discourse analysis is an interpretive method of analysis, it was important to follow a previously established framework, as outlined in van Dijk (2005) and described in Section 2.2. Following van Dijk's framework added reliability and reproducibility to the study design. For example, this thesis included a brief history of stigma around mental illness, a focus on language and its power in stigma, and a discussion about the attitudes that have existed and still exist in subtle ways today. In addition, this research process has been transparent; the research tools used in the recruitment of key informants are in the appendix. There was also a triangulation process followed, as there were two methods, interviews and textual analysis, used to answer the questions put forth

(Anderson, 2010). Representatives from within the health care system, most knowledgeable about the policies, were interviewed during the interpretation of the mental health policies to aid with the analysis.

This chapter gave an overview of the critical discourse analysis method used for this research. There was also a discussion for the reasoning behind the method selected to answer the research questions about stigma of mental illness within society. In addition, there was a brief overview of the theorists Foucault, Bourdieu and Goffman, whose work was used to influence and build the foundation of my conceptual framework for this research project. Finally, there was a short discussion of rigour in this research. The next chapter will give an overview of some of the history of the Waterford Hospital and review the literature on the impact of stigma within society. There is also some discussion of the media portrayal of mental illness, and a review of the Mad Pride movement to combat stigma.

Chapter 3: Literature Review

We've still got the Waterford. Oh I know, it's not the mental hospital anymore. It's a residential care facility for people with mental illness... and a diabetes clinic. I think they threw in the diabetics to try and soften the image. "Yeah, sure b'y I'm off to the Waterford to get my dose of dialysis." Makes it sort of normal sounding. But for a certain generation of Newfoundlanders the Waterford was a lunatic asylum. A place to be feared. A leper colony of sorts, right on the edge of town. Outside the camp.

-Crawford, 2010 (p.93)

This chapter begins with a discussion of the history of the Waterford Hospital, a key institution in the Newfoundland and Labrador context of mental health. It then provides an overview of the literature on stigma and mental illness, including an overview of the statistics related to the stigmatization of mental illness in society, as well as some examples of stigma from the media. Lastly, this chapter describes the recent broad movement to reduce stigma, known as the Mad Pride movement.

3.1 The Waterford Hospital

In Canada's oldest city of St. John's, Newfoundland and Labrador (NL) there is an old historic psychiatric hospital, The Waterford Hospital. It is located near the downtown area of the city in the St. John's South-Mount Pearl district, very close to the large and lovely Bowring Park. There has long been a great deal of stigma associated with the Waterford (as it is locally called). The very name is locally synonymous with "crazy" and conjures up images of fear and shame (Crawford, 2010). The Waterford hospital has a long history in NL that is detailed in the book *Out of mind, Out of sight* by Patricia O'Brien (1988). Her book covers the history of how

psychiatric institutional therapy, and in particular the Waterford psychiatric hospital, evolved between the time period of 1800 to 1972. O'Brien explains how, in 1837, a British physician named Henry Stabb moved to NL to set up his practice as a physician. His family was one of the early merchant families of NL that conducted business in the province. Stabb became involved with mental health care, reportedly when he discovered how poorly the mentally ill were being treated. Mentally ill patients were being kept in very poor conditions in the St. John's public hospital; seeing this reality, Stabb aimed to influence government. He supported a provisional asylum in a farmhouse in the western outskirts of the town. Once the facility was established in 1846, Stabb made great efforts to treat patients and improve care for the mentally ill. However, the asylum was still not suitable in size and was inadequately staffed for the number of patients requiring treatment. Many years later, in 1854, Stabb was again successful in getting funding to build the Hospital for Mental Diseases or the Lunatic Asylum (the present day Waterford), to which patients from the 1846 asylum were moved.

Today, the Waterford is associated with much negativity and has been criticized for having poor mental health services. The structure of the building, including new sections added in the 1940s, is very old and long overdue for renovation. In 2006, the NL branch of the Canadian Mental Health Association (CMHA) openly criticized the hospital in an article in the province's leading newspaper, *The Telegram* (Mullowney, 2006). Based on a tour of the facilities conducted in 2006, the hospital was described as overcrowded (6 persons to a room) and not up to the standards of care expected for a mental health care facility. Even though the hospital had made efforts in the previous years to increase space, and has since turned offices

into private patient rooms, still massive problems were identified in the 2006 examination of the premises. There were rooms in which geriatric patients were placed with persons with brain injury, for example (Mullowney, 2006). Changes towards deinstitutionalization are further described in section 4.1.

Given the amount of attention and the reported inadequacy of the Waterford Hospital, it pleased many to learn that there would be a new hospital built for psychiatric care, with a focus on being more modern and aiming to reduce stigma (Robinson, 2014). The province's largest health region (Eastern Health) initiated a planning process that included consulting individuals with lived experiences of mental illness and family members of persons living with mental illness. During April 2014, Eastern Health held a series of Waterford Hospital Replacement Planning Sessions which gathered together stakeholders to examine various aspects of the plan for redevelopment. Eastern Health also invited input on outpatient clinic services, as well as on the severe and persistent mental illness health services (CHANNAL, personal communication, May 7, 2014). The proposal for the replacement of the Waterford Hospital was both a sign of, and contributor to, the cultural shift toward mental illness being taken more seriously in NL⁵.

⁵ In 2015, plans to work on the Waterford were put on hold due to provincial budget constraints. Despite the urgent need for massive renovations or replacement, no plans are in progress at the time of this writing (CBC, 2016).

3.2 Societal Impact of Stigma of Mental Illness

What is not seen are all the truck drivers, secretaries, teachers, lawyers, physicians, and government officials who have been successfully treated, who work, compete, and succeed.

-Jamison, 2006

It is estimated that about 20% of Canadians will experience some form of mental illness in their lifetime (Health Canada, 2016). Despite the fact that a large number of Canadians are living with mental illness, the stigma associated with a mental illness can be just as difficult to deal with as the illness itself. In 2008, Ipsos-Reid surveyed 3026 adults for the Canadian Medical Association to determine public opinion of the health care system. The results showed that 46% believe that a diagnosis of mental illness is merely an “excuse for poor behavior and personal failings”; 10% think that people with mental illness could “just snap out of it if they wanted”; 42% would no longer socialize with a friend diagnosed with mental illness; 55% would not marry someone who suffered from mental illness; 25% are afraid of being around someone who suffers from serious mental illness; and 50% would not tell friends or coworkers that a family member was suffering from mental illness. By contrast, 72% would discuss cancer, and 68% diabetes. 50% think alcoholism and drug addiction are not mental illnesses. Also important for understanding stigma, the survey revealed that 11% think depression is not a mental illness and 50% think that depression is not a serious condition (Ipsos-Reid, 2008). These survey results show that stigma is still very much present and integrated within our society and impacts how people understand and associate with people living with a mental illness.

There is an accumulation of messaging within social discourse which ends up becoming how people with mental illness are perceived. For instance, society has habitually viewed people with a mental illness as violent and unpredictable (Foucault, 1961; Goffman, 1963; Lauber, 2008). This is despite the fact that research consistently shows that people with mental illness are much more likely to be the victims of violence rather than the perpetrators. It has been estimated that 25% of people with mental illness will encounter violence inflicted towards them every year (Baun, 2009).

Cook and Wang (2010) conducted a cross-sectional telephone survey in Alberta, Canada, between February and June, 2006. They found some demographic differences between individuals who hold stigmatizing beliefs about depression compared to those who do not, after surveying 3047 people. For example, they found that more men than women held stigmatizing views about depression, and that those with a higher level of education held less stigmatizing views about depression. A survey on the stigma of mental illness conducted at the Canadian Psychiatric Association's (CPA) annual conference in 2008, revealed that of 394 respondents, 79% had witnessed discrimination towards a patient and 65% towards a mental health care provider (Abbey et al., 2011). Additionally, 53% of respondents stated that they had experienced discrimination towards the psychiatric profession (Abbey et al., 2011). This survey suggests that stigma associated with mental illness extends beyond the individual to those who are associated with it, such as mental health care workers. Abbey argues that the psychiatric profession itself has been subjected to stigma; there is an undervaluing of the work done within this area and as a result the profession is also under resourced and there is a lack of research

funding in this area (Abbey et al., 2011). Abbey argues that there can often be an attitude that psychiatric illnesses are less “real” and so are not as important as, for example, cardiology or oncology conditions. This in turn can impact the number of professionals recruited, and impact the overall level of service and support available to the mentally ill. It was found that 86% of respondents reported that we should work towards bettering inequalities in the health care system (Abbey, 2011). Results showed that 89% of respondents also stated that there was a need to decrease stigma and discrimination in the emergency department (89%). A further source of stigma can be within medical education, which survey respondents indicated is a time when stigma is cultivated against those with mental illness and their families (Abbey, 2011). Health professionals are part of society as well and can also hold stigmatizing views about mental illness that can create social distance from mental health consumers (Lauber, 2008).

Stigma can impact people with mental illness in many ways, it can cause them to have trouble accessing housing and can impact ability to find meaningful employment (Baun, 2009). Due to the fear of stigma people, might feel the need to hide that they have a mental illness; there is evidence that employers would be hesitant to hire people with mental illness (Link and Phelan, 2006). Therefore, there is a risk that one’s career or certain work privileges could be jeopardized if one’s mental health were ever questioned.

As previously noted, Goffman discussed how individuals living with mental illness may succumb to the power of stigma and might avoid socializing so that they can avoid feeling discredited by their peers (Goffman, 1963). Stigma can be so overwhelming for people with a mental illness, that they might go to lengths to conceal this fact. For example, a survey of

people with schizophrenia indicated that 72% of more than 700 individuals surveyed stated they have felt the need to conceal their diagnosis (Thornicroft, 2009). The feeling of safety in hiding the status of one's mental health is one possible outcome when social messaging about mental illness is internalized and accepted as truth by individuals living with a mental illness. Stigmatizing messages can accumulate in such a way as to prevent people from pursuing opportunities (Link, 2006). Stigma can also be an obstacle to seeking treatment and has been cited as the main reason for the under-diagnosis and under-treatment of mental illness in the United States (Satcher, 2000).

As discussed in this section, stigma of mental illness is engrained within our society, and it impacts the beliefs and actions of those living with a mental illness. The stigma also impacts how people view and treat those with a mental illness. The overall accumulation of stigmatizing messages can create a barrier to seeking treatment for symptoms of a mental illness. There is a fear of the label, as well as the repercussions of the stigma that this label brings with it, which adds to the barrier of seeking help.

3.3 Media portrayal

One major contributor to stigma is the influence of the media's portrayal of mental illness. Media messaging, through newspapers, radio, television, film, or social media such as Facebook and Twitter, can shape the public perception of mental illness. These messages often perpetuate the negative connotations associated with a label of mental illness.

Images of the mentally ill often show negative portrayals of persons who are childlike, homeless, criminals, unpredictable or violent (Edney, 2004; Schneider, 2011). These images

seem to shape a reality that these persons are functioning at a lower level than the rest of society and that they are therefore not worthy to be treated with respect. Negative messaging about mental illness through the media can trigger discrimination, impede recovery and add other obstacles for the mentally ill (Edney, 2004). Some research has found that negative media portrayals of mental illness can be so strong that they can override a person's own experiences or perceptions of those with mental illness (Baun, 2009).

Negative media portrayals of mental illness can exacerbate the feeling of isolation and make people with mental illness want to withdraw from social settings (Baun, 2009). In addition, there is evidence that negative messaging through the media can lead those with a mental illness feel more depressed and add to their anxiety (Edney, 2004). The UK organization MIND surveyed 515 mental health consumers about the impact of media-generated stigma. These researchers found that 25% of respondents stated that they have changed their plans to apply for particular jobs due to the negative media coverage about mental illness that impacted their confidence (as cited in Baun, 2009).

There has been some recognition of the impact of negative media portrayals of mental illness on those living with mental illness. For example, The Canadian Psychiatric Association (CPA) has called for guidelines for appropriate methods of reporting mental health related news (Abbey et al., 2011). The Canadian Website Mindset was formed to aid journalists with mental health reporting (Mindset, 2014). This website was a collaboration with the Canadian Broadcast Corporation (CBC) and was partially funded by the Mental Health Commission of Canada. Mindset has put together a guide for journalists which can be easily downloaded for

reference. This guide includes an overview of stigma, tips for interviewing around issues of mental health, and appropriate methods of reporting on mental health related events such as suicide. This guide also has a checklist that includes avoiding stereotypes in reporting, a reminder that violence with mental illness is a rare occurrence, and the directive to seek professional advice if required when reporting on mental illness (Mindset, 2014). It also includes a reminder to be aware of negative tones associated with the choice of words used to describe incidents involving persons with a mental illness.

3.4 Approaches to Combating Stigma

The stigma towards mental illness is long standing and embedded within society. To try to impact a change in these views will require a sustained reframing of what mental illness is. The following is a discussion of some of the research about what strategies are effective to decrease the stigma and social distancing associated with mental illness.

Public awareness campaigns can alter the perception of mental illness. Studies have shown that one of the most effective approaches to decreasing the stigma of mental illness is to recruit those who have a lived experience with a mental illness. When people with a mental illness interact openly with the public and discuss their own stories, this has been found to make the largest impact on stigma (Sartorius et al., 2010; Rusch et al., 2008; Reinke et al., 2004; Abbey et al., 2011). For example, an evaluation of two methods for public education about mental illness compared the impact of listening to a psychology lecture with presentations of personal stories by people with mental illness (Rusch et al., 2008). The presentations were followed by a post-intervention survey that measured the “social distance” towards mental

illness. Results of the surveys found that there was a more significant decrease in stigma with the group that had been exposed to the personal stories from a person with lived experience, than those seen in the group that had received the psychology lecture that was devoid of lived experience.

Research has also examined how best to combat the self-stigma of mental illness. Combating internalized self-stigma and the impact it has on self-esteem can also be a way to fight stigma on a large scale. A survey of 600 mental health consumers was conducted before and after anti-stigma campaigns in the United Kingdom. They found that there was a notable improvement in how a person with mental illness perceived how the public viewed mental illness after viewing the campaign messages (Schneider et al., 2011). However, there was no reported change in the degree of stigma felt on a day to day basis in the mental health consumer's social interactions.

A study conducted with 355 mental health consumers in Germany examined the strategies the respondents used to cope with and protect their self-esteem against stigma (Llic et al., 2012). The study found that effective strategies included such things as: having positive in-group stereotyping, community involvement and humour. Less successful or even harmful approaches included secrecy, selective disclosure and overcompensating (Llic et al., 2012).

3.5 Mad Pride: Positively Reframing Mental illness

Living with mental illness can be reframed through efforts to challenge the negative associations with mental illness. Such efforts can be seen in the social movement known as

“Mad Pride”, where people with a mental illness are reframing what it means to be labelled mentally ill (Everett, 2006). There is an effort to remove the shame of mental illness but work towards an emphasis on the unique perspectives that come from difference and a celebration of these qualities. Sometimes the symptoms that the medical model is trying to control could also be managed in other ways or accepted for what they are, however different.

For example, one aim of Mad Pride is to point out the ways in which people with a mental illness diagnosis can flourish to contribute to society. One such focus is on the distinctive ways that emotion and information may be processed in those with mental illness (Jost, 2009). Dr. Kay Redfield Jamison, a professor of psychiatry at Johns Hopkins University, has bipolar illness and has written many books openly describing her experience. A recent book by Jamison outlines the idea of exuberance and how people throughout history, such as Franklin D. Roosevelt and Winston Churchill, have had “large” personalities and a level of excitement (or exuberance) that was quite different from other people (2004). Jamison argues that these and other important thinkers and world leaders had to be outside the norm, deviant from society, to develop their unique views and intuitions.

Chapter 3 provided an overview of some of the relevant literature on mental illness and stigma, to provide a context for the analysis of stigma in policy that will be discussed in Chapter 5. The next section, Chapter 4, will turn to a more specific discussion of the historical context of changing mental health policies in Canada and NL.

Chapter 4: Stigma and Resistance in Canada and NL

This chapter adds more to the context and historical changes to mental health care and treatment policy in Canada and NL. There is an overview of the paradigm shift towards deinstitutionalization that started in the 1960s in Canada. This chapter also gives a short history of the provincial NL Mental Health and Addictions Program, as well as some of the recent policy changes within the Mental Health and Addictions Program in NL. Finally, there is some discussion about the current and recent strategies that NL has in place to reduce stigma around mental illness.

4.1 Changes in Mental Health Care in Canada and NL

During the 1960's there was a paradigm shift in Canadian psychiatry that occurred in three phases. During Phase 1, in the 1960s, there was a move towards deinstitutionalization driven by the idea of "medical integration" (Wasylenki, 2001). This recommendation was put forth by a group of prominent psychiatrists in partnership with the Canadian Mental Health Association and detailed in the 1963 report "More for the Mind" (Wasylenki, 2001, p. 96). In general, the plan was to move some psychiatric care from psychiatric hospitals to the general hospital's psychiatric wards (Wasylenki, 2001, p. 96). It followed that from 1960 to 1975, there was a decrease in 35,000 beds from Canada's provincial psychiatric hospitals. This was subsequently replaced with 5,000 beds within the general hospitals (Wasylenki, 2001, p. 96). The suggestion was that those with mental illness would only need to occupy the beds during episodes of mental illness; they could then go back out into the community. However, this placed a lot of

pressure on provincial general hospitals. One concern raised by researchers, was that people may not be getting the treatment they need, and, as a result, more mentally ill people might become homeless (McQuiston et. al, 2003).

During the second phase, from the 1970s to 1980s, there was a shift towards community care whereby supports were funded for communities (p. 97). Wasylenki argues that the move towards community care for mental illness has resulted in a decrease in accountability as there is a lack of an adequate system of monitoring and responsibility in place with the necessary organization (p. 97). From 1965 to 1981 there was an overall 70.6% decrease in the bed capacity of psychiatric hospitals across Canada (Sealy & Whitehead, 2004). This varied from a high of an 84.3% decrease in Quebec, to a lower 34.5% decrease in Prince Edward Island. In Newfoundland and Labrador there was a 57.4% decrease in bed capacity, from 1965 to 1981 (Sealy & Whitehead, 2004). Following this, there was a push towards mental health reform in the 1980s that called for a more inclusive account of the multifaceted issues and aspects of mental illness, including such things as comorbid substance abuse, and the need for more integrated support from the community.

The third phase, in the 1990s, focused on evidence based approaches and best practices (Wasylenki, p. 100). During this time, assertive community treatment (ACT) plans or community treatment orders (CTOs), were developed for those with severe and persistent mental illness. These were more intensive models aimed at better case management within the community (Wasylenki, p.100).

From the 1960s to 2000s, there has been a big shift in how mental illness has been treated by the medical community. In the 1960s, there was more of a focus on the treatment of the mentally ill within the hospital, where people would receive treatment on a more long-term basis. The move towards less in-hospital treatment, with a focus on community treatment, seems intuitively to be a good approach; however, the stigma of mental illness needs to change as well in order for the community-based treatment to be effective. The reduction or elimination of stigma towards mentally ill persons within the community is necessary to create a safe environment for the mentally ill to reintegrate back into society.

4.2 History of the NL Mental Health and Addictions Program

The Health Care Corporation of St. John's was formed, in 1995, through the merger of the 7 predecessor health care organizations. The merger provided for the consolidation of acute, chronic and mental health care hospital services in St. John's under one board and management. This involved the construction of the new children's hospital, the Janeway Hospital. A decade later, in 2005, the province's six health boards were combined to form four integrated regional health authorities (RHAs). Prior to 2005, there were separate mental health services for each hospital. After the health boards were combined into four RHAs, the mental health and addictions services came together as one program within each RHA. With the re-alignment, some policies were re-branded and there was some re-organization of services. Overall, from 1995, there was a move towards building a continuum of services between hospital and community. Along with that move to provide a continuum of care, there emerged new programs designed to enhance the continuum of care, including the START clinic at St.

Clare's (where patients, 18 years or older, who have urgent mental health needs can be seen by a mental health practitioner sooner than if they were on the provincial wait list), the short-stay unit at the Waterford (which enabled an immediate response to emergency cases for those who might have previously been detained in lock-up), the Bridges program for adolescents (targeted towards youth who are struggling with mental health issues and are given short-term access to psychotherapy, family therapy and other skill-building support), as well as increased community based services.

4.3 Changes in Mental health and Addictions in NL

Prior to 2006, the province of NL had the oldest mental health legislation concerning involuntary treatment in Canada (Luther, 2003). As previously discussed, in the year 2000, two men, Norman Reid and Darryl Power, lost their lives tragically in police interventions (Luther, 2003, p. iii). As a result, there was an inquiry conducted by Judge Donald Luther to assess the need for provincial mental health legislation reform. In this report it is stated that "Both men were caught in a downward spiral toward disaster, which the societal safeguards, such as they were, could not or would not prevent" (Luther, 2003, p. ii). From the report, there were recommendations for reform of the provincial Mental Health Act of 1971 (Luther, 2003, p. 158). Judge Luther also recommended the use of community treatment orders (CTOs) (Luther, 2003, p. 160). The resulting Mental Health Care and Treatment Act (2006) did include CTOs and had some considerable changes from the previous act, including new admission criteria, a range of individual rights and protections, and more developed roles for nurses and peace officers (law enforcement officer).

4.4 NL Strategies to Reduce Stigma

During May 2014, the provincial Department of Health and Community Services launched a campaign to help raise awareness and to reduce the stigma that exists around mental illness and addiction (Government of Newfoundland and Labrador, 2015). There was also a provincial website launched: <http://www.understandnow.ca/>, which contains information about stigma, statistics on mental illness, and resources for those looking for help. The website features the stories of local people who live with mental illness and also live fully productive lives, a strategy that has been shown to reduce stigma (Abbey et al., 2011; Sartorius et al., 2010 and Rusch et al., 2008).

Since 2014, there has been an increase in the efforts to combat stigma around mental illness, and to draw attention to the need for more mental health services in NL. There was a town hall meeting in June 2014 about the mental health services in the province, with over 300 people in attendance. The panel of presenters included local actor and comedian Andy Jones along with Mark Gruchy, a criminal defence attorney and former president of the Canadian Mental Health Association (CBC, 2014). Following this meeting, the Community Coalition for Mental Health, or CC4MH, was formed (Brake, 2014). This coalition is part of the Provincial Advisory Council on Mental Health and Addictions, and so it has been engaged more recently with provincial efforts to combat stigma and develop the provision of services.

The CC4MH Launch took place October 15, 2014 at a St. John's high school auditorium and drew much media coverage (Brake, 2014). There were speeches by persons with lived experience of mental illness, who shared their personal perspectives on what they believed was

needed to improve the care of the mentally ill. Various needs were identified, including alternative services and supports along the lines of those already in existence, such as the Hearing Voices Network (an organization that supports those who have auditory hallucinations [Hearing Voices Network, 2016]) and the Soteria houses (drug-free and minimum medication therapeutic environments, for people who are experiencing mental health distress or are in crisis [Soteria Network, 2011]). As well, there were requests for an after-hours mental health support, for example for a provincial 24-hour peer-run phone support program.

As part of the provincial momentum toward enhanced support for the community of people affected by mental illness, increasing numbers of people with a public profile have begun to speak openly about their experiences with mental illness, which ultimately will pave the way for more people to be comfortable discussing their illness. One noteworthy example is the Juno award-winning singer/songwriter Amelia Curran, who put together a music video to increase social awareness of mental illness. This video included artists and other mental health activists from St. John's holding up signs filled with facts and statistics about mental health and mental health care in the province, as well as across Canada (Curran, 2014). Also, Curran herself has come forward publicly about her own struggle with anxiety and depression.

This chapter helped to give a brief overview of some of the significant changes in policies and the care of those with mental illness that have occurred within Canada, and NL. There has been much effort locally, and a coalition was formed within the province to focus on the needs of the mentally ill.

This chapter concluded the background and literature review necessary for contextualizing the analysis of stigma in mental health care and treatment policy. The following chapter is the main focus of this thesis, the policy analysis.

Chapter 5: Policy Analysis

This chapter focuses on the example of stigma in mental health care and treatment policy in one Canadian mental health and addictions program. It examines six policies from the mental health care facilities of the Eastern Health regional health authority of Newfoundland and Labrador. Using the method of critical discourse analysis, these policies were analysed for hidden sources of stigma. This type of analysis is useful for uncovering hidden power dynamics by bringing to light the network of ideas embedded in society, and their origin. There were three major themes that came from this analysis that illustrate the hidden aspects of stigma within these policies: *paternalism*, *deviance*, and *social exclusion*.

This chapter begins with a discussion of the role and importance of therapeutic alliance, a feature of clinical care that is key to understanding the scope and impact of stigma in mental health care and treatment policy. It then provides an overview of the three themes, introduces the six policies (Table 1) that were analyzed, and provides the analysis. Each policy is also located in the Appendix E. The chapter concludes with a discussion of how the three themes are relevant to understanding how stigma of mental illness may be purveyed and perpetuated.

Table 1: Mental Health Policy and Hidden Stigma

Name of Policy	Elements of Hidden Stigma
Smoke-Free Environment Policy ADM-135	Paternalism; Deviance
Identification Badges OPS-SC – 040	Deviance; Social Exclusion
Use of Unauthorized Substances 275P –ESS – 060	Paternalism; Deviance; Social Exclusion
Searching of Inpatients Belongings 275H-CPC-170	Paternalism; Deviance; Social Exclusion
Duty to Warn-Report 275P-LE-010	Deviance; Social Exclusion
Janeway Hospital: Visiting Guidelines Dec 2011 275H-JWPS-260	Deviance; Social Exclusion

5.1 Therapeutic Alliance and Themes of Stigma

Therapeutic alliance is a term used to describe the relationship that will ideally form between health care workers and patients. A focus on therapeutic alliance has been part of the approach to psychiatric treatment since Freud began his research on psychotherapy (Horvath et al., 2011). Bordin defined therapeutic alliance as consisting of three parts: 1) agreement on goals, which are the desired outcomes of the therapeutic process, 2) agreement on tasks, which are the steps that will be undertaken to achieve the goals, and 3) bond between client and therapist (Bordin, 1979). The therapeutic alliance is built over a period of time, and grows from the tasks and goals that patients and providers work on together. It can include rapport, trust, communicative success and agreement.

Given the established impact of stigma within society, and the level of associated shame, it can be difficult to build a relationship with a patient who has many reasons to not trust a health care worker (Black et al., 2013). There are many subtle aspects of body language that can send the wrong impression to an already vulnerable client. Of course, there are more obvious behaviours like not smiling, resisting eye contact, choice of words or keeping a “safe” distance from a patient, which can all hinder the formation of a therapeutic alliance. To build a strong therapeutic alliance there should be a focus on working with a patient from a place of “trust, respect, genuineness, and empathy” (Bozarth, 1997).

For many patients, the bond formed from the therapeutic alliance can be a significant contributor to healing, as it allows for open communication and also for trust to form (Horvath

et al., 2011). There is research that suggests a strong bond formed with a therapeutic alliance can aid in emotional transference and therefore help the patient heal (Horvath et al., 2011). It has been found that patients who have been able to form a good therapeutic relationship with their caregivers are able to have greater improvement in their overall healing process (Horvath et al., 2011). Therefore, a focus should be placed on developing a strong therapeutic alliance in hospital and as an outpatient.

As mentioned, there are three central themes that emerged in the policy analysis that were particularly salient for understanding how stigma gets perpetuated: paternalism, deviance and social exclusion. These themes are representative of the implicit assumptions that contribute to the stigmatization of the mentally ill. What follows is an overview of the three concepts, which will help frame my analysis of stigma within the mental health care policies.

5.1.1 Theme 1: Paternalism

That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others.

-John Stuart Mill, 1859

Beauchamp and Childress define paternalism as “the intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions

are overridden” (2001, p. 176). A critical examination of the existence of paternalism in mental health policy first requires an introduction to basic ethics principles used to guide ethical decisions within health care. Two authors well known in the field of biomedical ethics are Tom Beauchamp and James Childress; they have developed an ethics framework, which is widely used to support medical research and practice (Beauchamp and Childress, 2001). Their framework includes four principles: autonomy, beneficence, non-maleficence and justice. These principles can help guide physicians’ decision making on a day-to-day basis. The following is a brief description of each principle. For this discussion and analysis around mental health, autonomy and its partner concept paternalism will be discussed in greater detail than the other principles. There is also a brief discussion of justice, which is an attempt to balance the principles of autonomy, beneficence, and non-maleficence within given scenarios.

The word autonomy historically stems from Greek society, and means self-rule (Beauchamp and Childress, 2001). Having autonomy involves the ability of a person to have self-determination, self-governance, liberty, privacy and individual choice. Having liberty means that one is free from controlling influences, and also has agency, meaning they have the capacity to make a choice. The concepts of competency, capacity, and consent are also important to keep in mind when considering the loss of a person’s autonomy.

Because a person’s autonomy is impacted by their capacity there are means to try to measure and assess the cognitive capacity of an individual. Accessing capacity can sometimes be complicated, as it is an empirical test based on normative behavior, or in other words, what

might be considered normal behaviour or ability for a particular society. However, it is necessary to have a way to determine the decision-making capacity of the individual, to best help them. For instance, there are times when a person with a mental illness may require involuntary admission to a psychiatric hospital, if they meet certain criteria. According to the NL Mental Health Care and Treatment Act (2006), a certificate of involuntary admission is assessed on two separate occasions and signatures from two physicians are also needed. The criteria also needed for involuntary admission is as follows,

“(i) has a mental disorder, and (ii) as a result of the mental disorder
 (A) is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she is not admitted to and detained in a psychiatric unit as an involuntary patient,
 (B) is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision, and
 (C) is in need of treatment or care and supervision that can be provided only in a psychiatric unit and is not suitable for admission as a voluntary patient”

A person’s autonomy can be overridden when an individual qualifies for involuntary admission, under this definition. In this case, in order to treat a person for a mental illness, it might be necessary that the individual is involuntarily admitted into hospital.

Of particular interest to mental health and patient centered care is the concept of relational autonomy. Relational autonomy is a concept that brings consideration to the variety of forces in an environment which impact how a person makes a decision, for example the political atmosphere, economic climate, a person’s gender, or ethnicity. Susan Sherwin has written much in this area, including discussion on the means by which oppression can also act

to remove a person's autonomy (McLeod & Sherwin, 2000). Applying the concept of relational autonomy to considerations of stigma in relation to mental illness can be very useful, as it helps provide a deeper and more meaningful understanding of the kind of supportive or oppressive forces that influence a person's autonomy (McLeod & Sherwin, 2000). This concept can also be used to understand Goffman's point, discussed above, that a voluntary admission can also be another method for coercion by friends or family. It is this approach to critical thinking that is necessary when analysing mental health care policies. Understanding the concept of relational autonomy can also help to understand the difficulty that mentally ill patients may have around trust, and how lack of trust may threaten the therapeutic alliance.

The concept of beneficence involves making decisions that provide benefits, while balancing the benefits against the risks and costs to the person in a fair manner. This principle may guide people in positions of power to act in altruistic ways to benefit others (Beauchamp & Childress, 2001). Acts of beneficence can be complicated by competing needs, and so achieving balance can be difficult. In a hospital setting, this can explain the need to have policies which require health care workers to be aware of the potential for harm, and to act in ways to prevent such harm. Staff may act on this motivation to prevent harm through the education of persons around better health care choices, for example. They could work to inform patients about medication options that can prevent physical and mental deterioration. Staff may also need to use their own judgement about each individual case, and their knowledge of each patient's personal information, as well as their knowledge of the individual's episodes of care.

Non-maleficence is a principle based on the avoidance of causing harm to a person. Beneficence may require taking actions towards achieving beneficial outcomes, whereas non-maleficence requires intentionally refraining from actions that would cause harm (Beauchamp & Childress, 2001). Trying to achieve justice for the persons involved requires balancing some possible competing benefits and costs, to arrive at a fair outcome for the persons involved.

These ethical principles as described are important to any discussion of paternalism within the mental health care system. In terms of the degree of intervention within paternalism there are two main types: weak and strong paternalism. In a weak paternalistic action, there is an intervention that acts on the grounds of beneficence or non-maleficence to intervene to help a person to achieve what they would have chosen for themselves. Strong paternalistic actions intervene in and override a person's choice with the idea that they are making the wrong choice, even if it was an informed and autonomous decision (Beauchamp & Childress, 2001).

There are also anti-paternalistic stances which are opposed to strong paternalistic actions because they are deemed to restrict free choice and hinder individual rights (Beauchamp & Childress, 2001), such as the harm reduction principles behind the needle exchange program. There is also libertarian paternalism, which has been termed the "nudge" by Thaler and Sunstein (2008). This light form of paternalism, would focus more on increasing the development of policies that would maintain personal liberty and freedom of choice, while trying to influence the choices of others. Some examples of "nudging" can be seen in the

health promotion ideals that try to encourage people in society to eat healthier, exercise, or refrain from risk related behaviour such as smoking, while not removing their choice to do so (Thaler & Sunstein, 2008).

The above was a brief overview of paternalism and its associated ethical concepts of autonomy, beneficence, non-maleficence and justice. Now, I turn to an overview of the second of the three themes, deviance.

5.1.2 Theme 2: Deviance

New opinions are always suspected, and usually opposed, without any other reason but because they are not already common.

- John Locke, 1689

Deviance can be classified under two different types: informal and formal deviance (Innes, 2003). Formal deviance occurs when a person breaks a law, for example, through actions such as robbery or assault (Innes, 2003). Informal deviant acts are those which go against societal norms, for example burping loudly or having an inappropriate level of physical closeness given the type of relationship (Innes, 2003). There can be consequences for both types of deviance. Acts of formal deviance may result in the individual being fined or even imprisoned. However, informal deviance can have social repercussions, which can be subtle. Deviance itself can also benefit social change within society. There are instances where discrimination towards groups of persons once thought deviant (such as members of the LGBTQ [lesbian, gay, bisexual, transgender or queer] community) has been overcome through acts of social change. Deviance from normal social structures and routines can bring about new and creative perspectives

(Spreitzer and Sonenshein, 2004). Such social changes require an initial acceptance of the deviance by individuals or groups in order for increasing numbers of individuals within society to be able to think outside of the norm and work toward change. Persons living with mental illness are often associated with being deviant (Jamison, 2006; Jost, 2009). This association is particularly negative and stigmatizing for the mentally ill, because it is also associated with criminal or “bad” behaviours.

If a person is unable, for some reason or another, to live up to what society expects as normal behaviour, they will be labeled as deviant (Innes, 2003). For example, during the 17th century women were wrongfully persecuted for being witches if they displayed signs of “evil,” and at various times and places historically women who differed from the norm were deemed to be suffering from “hysteria” (Quintanilla, 2010). A more recent example is that of homosexuality, which was once considered a mental disorder. The psychiatric diagnosis did not cease to be part of the DSM until 1974 (Mayes and Horwitz, 2005). Throughout history, deviance has not been treated well by society and fears of difference still exist today.

In terms of social structure, deviancy is not accepted and does not flow well with the functions of society. Foucault has argued that therefore, structures have been set in place to try and contain and control deviance (Foucault, 1961). There is a need to reform deviants, so that they can fit well and not add to disorder within society. Through a method of reform within institutions (education, health care, or professional) there are ways to create a well ordered society.

The underlying religious belief that mental illness is a punishment for immoral activity has not entirely disappeared; this idea remains deeply rooted in attitudes toward those living with mental illness today. Having a higher socio-economic status can place one in a position of power. This can act as a sort of social transformation for previously socially unacceptable deviant behaviour to make it sometimes seem more eccentric rather than deviant and therefore socially acceptable (Innes, 2003). Historically, poverty or the impact of living in a marginalized population has also been associated with deviancy (Downes and Rock, 2007). Deviance is associated with sin and immorality (Douglas, 1966). In order to have a basis for what is good or evil, there has to have been some initial basis for moral judgements (Senekel, 1999). At the base of the morality judgements associated with deviancy, is the influence of the Judeo-Christian belief system.

There has been a tradition of stigmatization of mental illness from moral positions that place the blame of mental illness on the sufferer themselves (Foucault, 1961). Wesselmann and Graziano, researchers in social psychology, sought to uncover the current stigmatizing views that different Christian denominations hold. They surveyed Roman Catholic, Protestant and non-denominational students at a Midwest university in the United States (Wesselmann & Graziano, 2010). They found that there was a tendency within these Christian identified groups to see those with a mental illness to have done something sinful or immoral, which led to their current state of mental illness and suffering (Wesselmann & Graziano, 2010). Although not always on the forefront of discussion, there is a history of looking at mental illness as a sort of intervention from God. Foucault described how leprosy was once seen as a symbol of the

action of God to show the power of God to society (Foucault, 1961). Wesselmann and Graziano summarize three ways in which mental illness was explained or treated by the Christian⁶ belief system: 1) possible demonic possession to explain erratic behaviour; 2) a sinful lifestyle leading to divine punishment; and 3) having enough faith and prayer while leading a good moral life can cure a person of mental illness (Wesselmann & Graziano, 2010). Foucault argued that, historically in European society, there was a cluster of inter-related concepts such as sin and slothfulness tied to ideas about mental illness (1961). To a great extent, these notions around mental illness are still present within society today (Jost, 2009; Rose et al., 2007; Wesselmann & Graziano, 2010).

This introduction provided a short overview of deviance and its historical treatment in society. Deviance is often associated with sin and immorality; mental illness is in itself a socially labeled deviant state. The close social association between mental illness and ideas of immorality normalize these notions. This normalization enables stigma to exist, which in turn allows for social exclusion.

5.1.3 Theme 3: Social Exclusion

Scapegoat—Any material object, animal, bird or person on whom the bad luck, diseases, misfortunes and sins of an individual or group are symbolically placed, and which is then turned loose, driven off with stones, cast into a river or the sea, etc., in the belief that it takes away with it all the evils placed upon it.

-Maria Leach 1950 as cited in Douglas, 1995, p. 3

⁶ While other religions may also have ideas about mental illness, I mention Christianity specifically here as it is the dominant religion on the island of Newfoundland and Labrador.

To describe the social impact of stigma, it is important to examine social norms of behaviour toward those with a mental illness. Three relevant areas of discussion are: social distancing, social exclusion and scapegoating. Social distance is a concept that describes how comfortable a person is with associating with a particular type of person or group of people. For example, low social distance would be when a person has many things in common with another person, such as similar experiences, and has a sense of belonging to the same group. Having a high social distance from another person occurs when someone is a stranger or outsider from another culture and is treated as such, with an associated level of fear (Smith & Cashwell, 2011 and Baumann, 2007).

Social distancing occurs as a need to avoid the aberration to the normal social flow and order, which is altered by the “other” group of persons (Baumann, 2007). The social process of dealing with outsiders or strangers, is one where they cannot be easily “ordered” socially, in the mind of others (Baumann, 2007). There is an unknown expectation of what characteristics these “other” people possess, and therefore a level of indifference is the response. Similarly, there is a lack of understanding in the interpretation of what is on the other side of the “unknown”, and without enough curiosity and exposure, there can be a continuous state of uneasiness or fear of him or her (Baumann, 2007).

Social exclusion is, in some ways, a stronger or more visible form of social distancing. It describes the power relations in action that extend stigma to the exclusion of marginalized groups from society (Everett, 2009). Foucault has described the process of the “great confinement” where the mad, sick and other outsiders, were confined all over central Europe

from 1650 to 1800 (Foucault, 1961). The process Foucault describes is one of controlling through segregation; excluding controls access to the benefits and the social capital of being included with the rest of the social group, and is a means to exert power by ordering and socially controlling the disordered.

Being left out of a group or a process will ultimately leave a person unable to access the same benefits as others who belong to the group. The benefits of inclusion can vary in form; for example, benefits of inclusion are social networking, connections and other forms of information sharing. Therefore, the acts of not fitting in, or not meeting social expectations around belonging, can disconnect individuals more from the resources they need, which can lead to additional marginalization, and this can then lead to further disempowerment (Everett, 2009).

The term scapegoat⁷ is also useful to describe how persons with mental illness are excluded from society. Foucault discussed the way in which the emergence of shame and exclusion of the mentally ill followed the disappearance of leprosy within society (Foucault, 1961). There was a need to fill the social space within society that had been occupied by the “lepers”, to create a new group that would occupy the space of the “lower ranks” with the lowest forms of power, in order to maintain power relations and social control within society.

⁷ The word scapegoat was first thought to have derived from the Hebrew term “Azazel” which has many meanings: the “rebel angel”; or “counterpart of the devil” who has been cast out of heaven; or “Azal”, to remove completely (Douglas, 1995). The ancient Hebrew beliefs contain a ritual whereby communities would cast the sins of the people upon a goat, which would then be cast out of the community on the “Day of Atonement” taking the evil with it; the goat was said to have “suffered to escape”. The word scapegoat is related to the word “scapegrace”, which has been said to be linked to escaping the grace of God (Douglas, 1995).

As such, there was a need for the poor, sick and marginalized to be labeled “mad” or less than the rest of society (Foucault, 1961). The pressure of the power imbalance is relieved by having this group play the role of the scapegoat, which served as a social symbol for atonement for the sins of society, thus providing social relief for the guilt that individuals may feel. There have been instances where mental illness has been used as a scapegoat for a larger social problem. This can be seen in the media or in general discussion to explain why someone may have committed a particular act or crime. Foucault also discussed the way in which madness was an excuse to avoid dealing with the real social issues present in society, such as poverty, sexual oppression and violence.

Mentally ill people are often used as scapegoats to explain violence in society. The National Rifle Association (NRA) in the United States has indicated the need for those with mental illness to be placed in a database to prohibit them from accessing guns with the aim to prevent mass shootings (Knoll, 2013). This is an effort to label, control, or place blame or to try and contain the problem within society. This attitude is similar to social evolutionary arguments that try to justify the need to separate the weak and the vulnerable from the stronger and more able-minded in order to make for stronger offspring (Baumann, 2007). These arguments are also the basis for eugenics and other social exclusionary practices, and are an attempt to make it socially acceptable to continue to exclude and remove power from the excluded.

The way in which a person may experience exclusion can be very subtle. However, anyone who has ever been excluded or treated as an outsider can understand the impact of

such subtle social cues associated with being treated as “other”. Excluded persons can sometimes identify with being part of an excluded group and so internalize the normalization of these negative stereotypes; that is, the identity of the individual is formed out of others’ images of the individual as an outsider (Everett, 2009). Therefore, the exclusionary processes come from and perpetuate the power of stigma, acting from within and around a person to continue the social exclusion, which has been on a large scale a repeated tradition throughout history.

These internalized notions can be quite strong disempowering forces on people with mental illness. Common day-to-day words such as “mad,” “psycho,” schizo” or just “crazy” are more frequently becoming slang terms to explain ordinary actions (Rose et al., 2007). The increase in slang and general social exclusion of mental illness increases its likelihood to be treated as a scapegoat, perpetuating society’s unjust treatment of the marginalized. Of course, the internalization of social exclusion can also eventually have the reverse effect, whereby the oppressed take up the symbols or language used by the mainstream against them as a means of empowerment through resistance, as argued by Jamison (2006) and more specifically by Jost (2009) around the reclamation of the term “mad” by those labelled mentally ill.

5.2 Policy Analysis

Above, I described the concepts of paternalism, deviance and social exclusion that I use to argue how stigma exists in relation to mental illness. In this section, I further analyse how stigmatizing ideas are embedded within society and exert power covertly, focusing on the six policies chosen for further analysis. Using the theoretical frameworks of Michel Foucault, Erving Goffman and Pierre Bourdieu, I critically examine how the hidden power of stigmatizing

ideas of mental illness have become embedded within the social structures of our society, as evidenced in discourse such as hospital policy.

Given the subtle ways in which everyday ideas of mental illness may perpetuate stigma, even for policy makers working within mental health, an awareness and understanding of one's own personal knowledge of mental illness and potential prejudices is essential when designing policy for mental illness, as it is for policy design pertaining to any other marginalized and/or stigmatized group. This hidden aspect of stigma makes it so persuasive, because it influences society both inside and outside of institutions in a synergistic, flowing, process along long established lines of relational power.

5.3 Policy Development

A mental health policy and plan is essential to coordinate all services and activities related to mental health. Without adequate policies and plans, mental disorders are likely to be treated in an inefficient and fragmented manner.

-WHO, 2004

Good policy requires that the policy designer has good knowledge of the specific area, as well as adequate time and resources to write effective policy (Howlett, 2011). Policy, ideally, should not just be a reaction to circumstances or events, but anticipate the needs of those to whom it is applicable. Policy development should be an ongoing progression with the possibility for open discussion; however, in the day-to-day, policy changes often occur on an as-needed basis, due to events that trigger a need for change (Howlett, 2011).

In order for a policy maker to be able to design useful and applicable policy, it is necessary to have a good understanding of the policy "space" or environment within which one is

working. This may include the history of the policy area in focus as well as the influential forces, such as political environment, which have been in play for quite some time within the community. In addition to having a full and comprehensive understanding of the subject area, the policy makers (often a committee) need to be able to make autonomous decisions about policies (Howlett, 2011). This may be a problematic task, given that policy makers often work within government or governmental agencies, where bias or influential power relations exist, and making fully autonomous policy choices can be trying.

Furthermore, designing policy for the mental health care hospital environment can be a very difficult task to accomplish. The area of mental health is rather ambiguous at times, and lacking in solid data to support policy decisions, as the population of hospitalized mentally ill is not large. However, there is a wide range of persons that are impacted by mental illness, and as such, policy can often become narrow in its scope, as it attempts to meet the practical and functional needs of the hospital environment. While sometimes it is important to take into account the worst-case scenario, in order to gauge risk and prepare for it, a narrow scope within policy development can also leave room for stigmatizing assumptions to become embedded within policy.

5.4 Policy Development at Eastern Health

The section gives a brief overview of Eastern Health's policy structure. There is also a short summary of the process of policy development that occurs within Eastern Health. In addition, there is some discussion of the guidelines set in place for structuring "good policy".

There are four levels of policy, each level covering a different scope, at Eastern Health:

The Level I policies are global, meaning that they apply across all Eastern Health to all employees and staff; Level II policies are system policies, which means that they are more specific to a program, but they can also apply across multiple programs in some circumstances, which would be noted in the policy; Level III policies are specific to a program, department, or discipline; and Level IV policies are specific to a particular division or unit these policies impact only the unit for which they were developed.

Eastern Health has a Policy Development Framework which describes the process of developing a policy for Eastern Health. There are five stages of policy development: 1. Policy Initiation, 2. Policy Development, 3. Policy Approval, 4. Policy Implementation, and 5. Policy Review and Revision. The framework itself gives a more in-depth overview of the process, from how the idea of a new policy is managed to the approval of the policy by the Eastern Health Policy Advisory Committee (EHPAC). A new policy may also be scrutinized through internal committees and stakeholders. This may also include a review by ethics, human resources, privacy, risk management, and legal representatives. If there are any changes deemed necessary, then the policy is revised and goes through the policy development, approval and implementation process again. Any further revisions are sent to the Policy Office to be placed with the original policy.

Within the Policy Writing Handbook for Eastern Health there is an outline of what a “good policy” should contain (Eastern Health, 2010). A good policy should: be user-friendly; describe why policy is needed, including what are the intentions, when it comes into effect, and who is

affected; be based on fact and not opinion; be future-oriented and proactive; be a general guide to aid the organization in decision-making; and be able to be created, adapted or changed over time. There is also some direction given around tone and the potential impact of any negative phrasing in a policy. For example:

“Positive words/statements are more effective than negative words/statements (e.g. none, never, not, can’t, won’t, don’t, unable, unwilling...). They are perfectly valid words, but should be used sparingly because of their very strong impact.” (p. 5)

The handbook includes a discussion of sensitivity for diversity, such as around using gender-specific terms. For example, while writing a policy one may want to take into account how the impact may vary in regards to age, sexual orientation, stigmatized or marginalized groups, and cultural or ethnic background. This is in keeping with standards for policy making; it is important to write health policy that comes from an inclusive frame instead of one that may inadvertently send out exclusionary messages (Everett, 2009). However, within the Eastern Health policy writing handbook there is no specific mention of how to be sensitive to mental illness, or any mention of any other vulnerable groups either (Eastern Health, 2010).

5.5 Smoke-Free Environment Policy ADM-135

The Smoke-Free Environment Policy is a Level I Global policy, which impacts all of Eastern Health facilities, patients and staff. The policy was implemented uniformly across all programs, with the intention of providing the same health promotion stance to all patients, regardless of the presence of mental illness, as a means of ensuring that stigmatization would not occur. There is a contentious debate around the ability of those with a mental illness to quit smoking

(Lawn & Campion, 2014; Ziedonis et al., 2003). One key aspect is that those with mental illness have a unique obstacle with stigma and the need to self-medicate, which may be different than the rest of the population. Additionally, other aspects associated with mental illness can make it more difficult for them to quit smoking. Those with a mental illness are more likely to have low socioeconomic status, homelessness, and generally live in situations with a higher level of stress (Weir, 2013). Though, there is strong evidence to show that a combination of nicotine replacement therapy (NRT) along with counselling to aid with the process of smoking withdrawal can be very successful to help people, with or without a mental illness, to quit (Lawn & Campion, 2013). It should also be noted that nicotine replacement therapy (NRT), is available to patients at Eastern Health (Fern Brunger, ethicist for Eastern Health, personal communication, December 12, 2014).

Eastern Health states in its Smoke-Free Environment policy that it “prohibits the use of all tobacco products on properties owned and leased by Eastern Health”. This is a global policy, so it impacts all of Eastern Health facilities, patients and staff. The policy also contains some exemptions around its implementation:

“Exceptional case exemptions should be rare and exemptions are considered on a case-by-case basis. In the palliative, mental health and long-term care settings exceptional case exemptions are considered within pre-set parameters supported by clinical assessment and recommendations.”

There was a scoping survey of Canadian best practices, along with focus group-style ethics consultations held within the Mental Health and Addictions Program, to determine if patients being treated for mental illness should qualify for an exemption to this policy (Fern Brunger,

ethicist to this process, personal communication, December 12, 2014). It was decided that there would be no allowance for “Exceptional Case Exemptions”, therefore smoking was banned everywhere on the premises of the Waterford hospital and its grounds, with no allowances made on the basis of the mental health of patients. Patients would still be able to get passes, when qualified for them, to smoke outside the grounds.

The choice to implement this policy uniformly across all programmes was made with the intention of providing the same health promotion stance to all patients, regardless of the presence of mental illness, as a means of ensuring that stigmatization would not occur (Key informant #1). It was decided, through research and discussion, that it was more stigmatizing to treat mentally ill patients different than other patients.

There is extensive and strong evidence based research that demonstrates the harmful effects of smoking and of inhaling second-hand smoke (WHO, 2015). Based on this research, the World Health Organization has set safety guidelines around allowable exposure below levels of 10 µg/m³ of second-hand smoke (WHO, 2005). These health concerns have prompted bans on smoking inside and outside hospital grounds in many countries (Lawn & Campion, 2013), and is an effort to avoid the risk of harms of second-hand smoke to both staff and to other non-smoking patients (Zellers et al., 2007). A recent cross-sectional study by Ballbe and colleagues (2013) looked at the second-hand smoke exposure in 64 mental health inpatient units in Catalonia, Spain. They found that only those with both total indoor and outdoor smoking bans had PM_{2.5} (particle) levels below the safe standards recommended by WHO.

Psychiatric units with more permissive smoking policies still had exposure from environmental tobacco smoke that has been shown to have harmful health effects (Ballbe, et al., 2013).

The province of Newfoundland and Labrador has a high rate of smoking. In 2012, the Canadian Tobacco Use Monitoring Survey (CTUMS) reported that there was an estimated 19.7% of the population who were current smokers, which was significantly higher than the national rate of 16.1% (Statistics Canada, 2012). It is widely accepted that there is a higher prevalence of smoking among people with a mental illness, which has been supported by research on populations in the United States (Lasser et al., 2010). Most who try to quit smoking will experience nicotine withdrawal, which includes mental and behavioural symptoms such as: anxiety, depression, drowsiness or trouble sleeping, restlessness, frustration, headaches, weight gain, and/or problems concentrating (U.S. National Library of Medicine, 2015).

The level of difficulty with quitting smoking within the mentally ill population has been heavily debated. Symptoms of nicotine withdrawal can also worsen the symptoms of the mental illness (Lasser et al., 2010). There are other arguments which try to explain the increased difficulty for those with mental illness to try and quit smoking. For example, those with a mental illness are more likely to have low socioeconomic status, homelessness, and generally live in situations with a higher level of stress (Weir, 2013). In addition, poverty is associated with mental illness (Shrivastava et al., 2012). A lack of financial resource can make quitting smoking difficult, as there is a high cost associated with some nicotine replacement therapy or cessation medications, which can be higher than the cost of cigarettes for some people. There is also some research that supports the view there is a biological predisposition

for addiction in persons with a mental illness, which may make it more difficult for them to quit smoking (Ziedonis et al., 2003). In addition, some research suggests there is an increased dependence on nicotine for those with schizophrenia as the nicotine helps to overcome the cognitive impairment associated with the illness and/or the medication (National Institute of Drug Abuse, 2010). However, it should be noted that pointing out biological differences between people with or without a mental illness also adds to stigma (Shrivastava et al., 2012). In terms of the question of whether patients are less likely to quit while hospitalized for a psychiatric crisis, there are research studies that have shown patients with mental illness are not less capable of quitting smoking, but they would need the proper support to do so, such as nicotine replacement and/or counselling (Morris et al., 2011 and Campion et al., 2008).

Nicotine addiction in itself can be very difficult to overcome, without managing a mental illness. There is research that has looked at the experiences of psychiatric hospitals going smoke-free. As mentioned, strong evidence exists to show that a combination of nicotine replacement therapy (NRT), along with counselling to aid with the process of smoking withdrawal, in a hospital environment, can be very successful to help people, with or without a mental illness, to quit (Lawn & Campion, 2013). The use of these methods has also resulted in a decrease in patients with mental illness that continue to smoke post-discharge (Lawn & Campion, 2013).

There is a strong concern for the long-term health of those with mental illness, as there is growing evidence that this population is having overall generally negative health outcomes (Lawn, 2012). For example, there has been evidence to suggest that those with a mental illness

are more likely to be at risk for chronic health conditions like those that result from metabolic syndrome (a collection of symptoms that include obesity), such as diabetes or heart disease (Galletly et al., 2012). In addition, conditions such as cardiac and respiratory disease are found in a higher prevalence among the population of those with mental illness. The increased health promotion for self-care and preventative health measures hopefully will lead to a decrease in the rates of smoking and perhaps also decrease chronic conditions in this population. However, as previously noted, there is a strong association of mental illness with poverty and isolation, and as such, this association complicates efforts to promote self-care behaviour. Therefore, quitting smoking may not be realistic given the circumstances surrounding individuals' lives.

The ban on smoking on hospital grounds can also be beneficial for both patients and staff. There has been research to suggest that there is a culture around smoking within the hospital environment, which can cause a host of social difficulties for staff and other patients (Lawn & Campion, 2013). For some hospital environments, cigarettes are treated like a commodity that can be withheld or doled out by staff for favours; this can add to the tensions between staff and patients, and also interfere with other behaviour modification treatments (Lawn & Campion, 2013). People also tend to use smoking as a socializing act; it has been suggested that some patients may start smoking while in hospital so that they can socialize with others (Lawn & Campion, 2013).

If the Smoke-Free Environment Policy were not implemented, there could be a perception that the exception was needed because patients with mental illness are fundamentally different from or weaker than other patients within Eastern Health. The points raised above

help to explain why the implementation of the smoke-free policy within the hospital environment and grounds was deemed to be necessary. Despite arguments those with a mental illness would have more difficulty quitting smoking, the implementation of the policy in full was seen to be the more justified action.

Paternalism

When considering the meaning and scope of paternalism in the context of mental illness and the smoke-free policy, the concept of relational autonomy is useful. Research has strongly demonstrated that people who receive help earlier on in an episode of mental illness, for example in the early stages of depression, have better outcomes (Halfin, 2007). However, there are also obstacles to health care access, such as stigma, that prevent people from seeking treatment, specifically within a hospital environment. The concern is that a requirement for smoking cessation will be an additional barrier to seeking treatment.

The act of smoking for those with mental illness can be a way, for some, to self-medicate and cope with stress and anxiety through difficult times or during episodes of chronic mental illness (Campion et al., 2008). Regardless of whether a person is voluntarily or involuntarily admitted, they will have to quit smoking in order to receive treatment while in hospital. Some have argued that people who have a mental illness and smoke will find the need to quit smoking in order to receive treatment for their mental illness to be a deterrent to seeking treatment (Parle et al., 2004).

There are aspects of paternalism inherent in the “choice” to stop smoking that is being made for patients. While that in itself does not seem to be entirely negative, given the health

benefits of quitting smoking, it is the messaging associated with that paternalism, the socio-cultural normative assumptions about the nature of people with mental illness, which is problematic. People with mental illnesses are deemed to be weak and child-like and in need of protection, a stance in mental health care that has been such a long-standing tradition in western society (Foucault, 1961). While the smoke-free policy is global, and therefore theoretically is equally paternalistic to all patient populations, it is uniquely problematic in the context of mental health and addictions where a high degree of paternalism already exists, and where passes to go off-site are required. The policy further normalizes paternalism (rather than autonomy) as the 'default' in caring for patients with mental illness. Paternalism to this extent (outside of pediatric care) is unique to psychiatry; a person will lose certain rights and have decreased autonomy when they enter into the psychiatric ward to a far greater extent than they will in other adult units.

Patients within psychiatric wards of the hospital are subject to more surveillance than other areas of the hospital. Psychiatric patients are frequently checked and monitored in a manner that pushes the boundaries of personal autonomy and privacy, more so than with patients in other areas of the hospital. In this way, there are normalized lines of power made evident to the patient, through paternalistic interventions that exist in varying levels within the hospital. There is an added layer of scrutiny and judgement placed upon mentally ill patients which can become more apparent in patient-staff relations in the hospital setting (for example, the paternalism inherent in the non-smoking policy may have a cumulative effect when combined with the policy of searching belongings for dangerous substances). These instances

of surveillance can occur easily due to the power dynamics between patient and staff. Choices made by patients who are mentally ill are looked on with more scrutiny from the gaze of the psychiatric medical practice. Policies add to this assertion, by making it acceptable or even mandatory to examine mentally ill patients' actions with more scrutiny. There is further justification in the need for paternalism, as the more one looks, the more one finds; the policies, therefore inadvertently reinforce the need for increased surveillance.

Whether the mentally ill patient should be able to smoke when compared to other patients is not as much the issue as the concern that they are denied the autonomy to make that choice to be able to do so. They may not be able to leave the hospital grounds to smoke, as there are controls around the movement of mentally ill patients outside of the hospital and so more limitations are placed on them having the access to a smoking area off hospital premises (a challenge that is, of course, shared with mobility impaired patients throughout the hospital system). Patients need to be given passes to leave in order to smoke, and in the early stages of admission may not be able to have a pass at all.

The hospitalization process itself brings with it another layer of loss of control within the confines of a hospital, that further works to enforce reform on the individual's identity, behaviour and choices, as part of the normalizing judgement and forces that create a "good citizen" (Foucault, 1973). The patient within the hospital system has to respect controls, in order to receive treatment, and then is sent out into the community to manage the internalized notions inscribed on them from within the hospital (Goffman, 1963).

Paternalism works to enforce the behaviour necessary for cohesion and order within the hospital, as well as outside the hospital and within society. For example, the fact that landlords often do not want to rent to smokers is one motivation for reforming the mentally ill person to fit better in the community (Key Informant #5). If the mentally ill person does not fall in order, and it is difficult for them to find a place in society, then there are ramifications for them and they will continue to be outsiders. This will make accessing the same resources, such as housing, more difficult than it is for others who do reform to meet expectations. In a sense, there still exists the tradition of rehabilitation of the mentally ill, to follow the desired behaviours in service of a well ordered society (Foucault, 1961).

The non-smoking policy, while addressing the concerns around harm to oneself and others from smoking, is also projecting the stigmatizing ideas of a need to re-order the disordered person, which harms identity. The policy acts as an extension of the stigmatizing societal belief that the mentally ill are in ways child-like and need to be shown how to be in order to reintegrate within society. This is the normalized notion, that setting them in order with what society wants and expects is the best solution.

Deviance

The act of smoking is increasingly being considered a deviant type of behaviour across Canada and elsewhere, and rates of smoking are declining in Canada (Statistics Canada, 2012). There is some research to indicate that across the world even though the prevalence of smoking has decreased, the actual number of people who smoke has increased, due to population growth (Ng et al., 2014). The act of smoking cigarettes was at one point considered

a socially acceptable activity that people used to relax or remain alert in their jobs. Health promotion activities have sought to reduce smoking by encouraging the ideas that smoking is antisocial and undesirable, attempting to stigmatize the smoker (Bayer and Stuber, 2006). This approach began in the 1970s. A notable quote in the New York Times from a psychiatrist at that time demonstrates the turn in social control of tobacco: “What we need is a national campaign that results in the stigmatization rather than the glorification of the smoker” (in Bayer and Stuber, 2006). Smoking cigarettes in the presence of children is beginning to be framed as child abuse and neglect (Bayer and Stuber, 2006). In addition, smoking itself has been compared to a slow form of suicide (Bayer and Stuber, 2006). Smoking has become a moral choice instead of being the risky health behaviour; the reframing of it gives social license for populations to stigmatize others. Smoking is becoming almost a criminal action with a punishment for that crime to be judgement by peers and harsh labels that attack their moral character.

Within society, which is organized along unwritten moral codes of conduct, stepping outside the lines has repercussions. In public health campaigns and in society in general, there is a de-emphasis on why people smoke; rather, the focus is narrowed to the idea promoted by public health that smoking is wrong and that we as a society cannot condone this behaviour (Bayer and Stuber, 2006). The idea being perpetuated is that we have a moral expectation as good citizens to uphold the majority agreed upon truths about what is seen to be good and what is seen to be bad. The choice to smoke, for example, is then criticized in the social setting by peers who have also internalized the overall message of what it means to be a “good

citizen". The origin of how these ideas were formed and the means by which they make their way to the population becomes lost in the process of health policy development (Bayer and Stuber, 2006).

The progression over time of reframing the image of a smoker also becomes problematic for mental illness, as there is a high prevalence of smoking among the mentally ill (Lasser et al., 2010). Increasingly, as discussed, smoking is becoming viewed as a socially deviant choice; and it is socially acceptable to criticize, or socially police, those who still choose to smoke. The mentally ill are often already marginalized and have already been labeled as having behaviour that does not meet the societal expectations for order. The stigma attached to the act of smoking gives power and agency to others to act out judgement and further label the mentally ill person as deviant. This adds to the already prevalent idea that people who are mentally ill do not know what is good for them and are incapable of understanding that smoking is "bad".

There is a systematic approach to labeling the behaviours of mentally ill persons as pathological, and so there is a further extension within the hospital setting, throughout training within the health care field, that much of what a mentally ill person says or does is part of their illness. This continues with the projected need to be ordered along the lines of what they should be doing to make their behaviour and their bodies better fit with what is expected. If individuals with mental illnesses have better ordered bodies, and follow in line with what society expects of them, then they will be able to fit into the order of the system again. By doing this, they will not miss out on the benefits of society that comes to those who fit in.

Hospitals both perpetuate and recreate ways to manage deviancy by reforming patients to conform to societal expectations in order that patients may receive the benefits of inclusion upon reform. This can impact a person's identity, as they are internalizing these messages as part of moral career, or how they see themselves in relation to the rest of society (Goffman, 1963). As Goffman explained, this can further isolate persons, thus causing a further deviation from societal expectations and result in other ways to be disqualified within the system (Goffman, 1963). Being labeled as deviant can bring with it the perception of a removal of personal power; one's agency can be limited and constrained by the medical gaze on to the mentally ill person (Foucault, 1973).

This gaze is reinforced through the extension of power of the stigma that flows through the individuals who carry out these policies in the hospital environment. The patient is already dealing with the label of being deviant for having a mental illness, and is being further labelled as making deviant choices around their health. It is a disempowering aspect to label someone as deviant and to add those expectations to their identity. It is also an extension of the perceptions of society overall, that work through the policies, which act to control and manipulate this behaviour (Bourdieu, 1977). People can fulfil the expectations and limitations placed on them by society, not just a self-fulfilling prophecy, but these expectations or limitations can also become the person's reality, because of the apparent lack of choice in the context of their lives.

Summary, Smoke-Free Environment Policy

Eastern Health's smoke free environment policy is applied evenly throughout all programmes, which does serve to avoid furthering the perception that patients with mental illness are somehow different from and weaker than other patients. However, by applying it uniformly and ensuring that all areas of mental health and addictions are smoke-free, the policy risks furthering paternalism and the perception that mentally ill patients are weak or childlike, because taking away their choice to smoke is done in the context where so many other rights and privileges are removed for the sake of the patient's health. A patient already routinely loses certain rights and has decreased autonomy when they are admitted to a psychiatric ward. The non-smoking policy furthers this. Additionally, there is a message being stated about what is considered to be a deviant choice. Choices deemed to be deviant are policed in the hospital environment, a policing process that extends to the community setting in terms of defining what it means to be a "good citizen".

5.6 Identification Badges OPS-SC – 040

This is a Level I Global policy, which means that it has application across all of Eastern Health. It governs the content and specifications around Eastern Health's staff identification badge. An interesting aspect of this policy is that staff can remove their last names from the badge, if they are concerned about their safety. The policy states specifically,

"In areas where staff safety issues may be of concern regarding the information visible on ID badges, such as the use of last names, the Director may contact the manager responsible for Audio Visual Services to discuss concerns and request modifications to the badges for staff in their area."

This aspect of the policy originated within the psychiatric unit. It applies to staff that work in areas that may have psychiatric patients, such as emergency and psychiatric units. This policy may have evolved from past experiences that warranted such a policy. The key informant explained that the concern is that if patients were able to know the staff member's full name, perhaps they would be able to track the person down and harass or hurt them at their own residence (Key Informant #3). Omitting surnames is a trend often seen on social media sites such as Facebook, as well as in public professions such as Social Work and Nursing, where staff may not want to display their full names in order to protect their privacy (Starr, 2014).

This policy is a way of controlling the information given to patients about staff. It is a method of displaying power, by removing the right to know who is taking care of the mentally ill patient. This practice of withholding the full identity of staff conveys to both patients and staff that there is less of a focus on the accountability of the actions of staff, and more of a focus on treating patients as potential threats. The policy adds another layer of social distance between staff and patients.

Deviance

Patients have a right to know who is caring for them. This is in keeping with Eastern Health's Statement of Rights and Responsibilities, described in the *Client's Rights and Responsibilities Brochure*, which states that patients have a right to "know the names and roles of those involved in your care" (Eastern Health, 2013). The right to know the names and roles of those providing care is part of the trust within the therapeutic bond in health care, and adds

to the trust that patients place in the health care system. The use of identification badges also enables patients to hold staff accountable for their actions.

Allowing an exception for staff to remove their last names on their identification badge sends a stigmatizing message, because, as the key informant indicated, there is an exception being made for staff members who are placed in areas that may have psychiatric patients, such as emergency and psychiatric units (Key Informant #3). The exception appears to be directly associated with the types of patients often seen in these areas (i.e., mentally ill) (Key Informant #3). The practice of removing one's last name sends a strong message to both staff and patients about the expectations and perceptions of persons with mental illness.

This action of concealing one's identity appears to be motivated by fear. The key informant explained that the origin of the policy was staff fear that if patients knew the staff member's full name, the patient, after discharge, might harm the staff member outside of the health care institution (Key Informant #3). Having a fear of patients becomes normalized through this policy. In addition, the policy projects the stigmatizing notions that deviant or criminal actions are likely, and that staff should expect such behaviors from patients. Although subtle and indirect, the expectations placed on behaviour can be cumulative, with the other notions of the mentally ill, to further shape the social construction of the mentally ill as being violent. As discussed earlier, those with a mental illness are believed to be threatening and dangerous (Brickell et al., 2009 & Kanerva et al., 2013) and so there is a perceived need to be proactive about the potential for violence.

Bourdieu had also described how ideas can be internalized within the body as habitus, and can have a subtle impact, which can be magnified in a group of people carrying the same internalized notions (1977). It is this subtle process by which ideas are normalized and seen to be true by both staff and patients, that gives them more power to influence and further stigmatize those with a mental illness.

Social Exclusion

This policy originated in the psychiatric area of the hospital (Key Informant #3). This projects the perception of a need for social distance between health care staff and patients. This added message of exclusion from the right to this information is internalized by staff and patients. The lack of transparency is a threat to the accountability within the health care system at Eastern Health. It adds to the perception that there is need to have safe distance from the mentally ill and further exerts the power relations imposed by the notions of stigma.

As noted, the act of hiding staff identification is an extension of the stigmatizing need for social distance from those with a mental illness. The action of distancing health care workers from patients sets up a dynamic for power relations within the hospital environment. The distance creates more room for objectification of patients to be treated as the “other” and the outsider.

Staff members are public employees of Eastern Health, and so their identities should be available to the public. If, for instance, a staff member acts in a manner of disrespect, or abuses their power by in some way harming a patient, then having their identity hidden impacts

accountability. Patients need to be able to trust staff and feel safe in their environment while they are within the hospital and are vulnerable.

The implication that hiding staff identity is normal for staff working with the mentally ill is internalized by both staff and patients and further propagates the stigmatizing power relationship within the hospital whereby the rights of the mentally ill are less important than the rights of other patients⁸. Further, it perpetuates the idea that mentally ill patients are to be feared because of the expectation of deviance, in particular violence. The discourse within this policy portrays a hidden message that frames the mentally ill as potentially dangerous and not deserving of accountability within the health care environment. People presenting with mental illnesses in a hospital environment, where some of their rights are being removed, are being subjected to policies which inadvertently categorize and order the exact stigmatizing aspects that they need to be able to overcome within the community (in particular, the association with deviance and violence). The normalization of the removal of staff identifiers in situations where staff are working with mentally ill patients adds to the control and power that stigma can have. There is a strong and powerful message portrayed, that mentally ill patients are different from other patients, in that they do not have the right to know the full identity of the person who is taking care of them.

⁸ Having staff names identified on charts or rosters does not offset the harms caused by the lack of last name on an identification badge. Firstly, patients do not access charts or staff rosters, and in some cases would not have the knowledge to do so. More importantly, it is the symbolic gesture of a staff not wanting the patient to know their full name that is harmful, in its implication that patients are dangerous and should not have access to a full name as they would in other areas of health care.

Summary, Identification Badges

This policy communicates a powerful message that patients with mental illnesses are somehow less worthy than other patients and do not deserve the same right for transparency within the care environment. This policy acts, as the others do, as an extension of the power that stigma has, through the policy, within the hospital. It adds to the construction of the identity of a mentally ill person in a way that is stigmatizing. An added result of this reinforced identity is that it also reinforces the internalized surveillance (self-stigma) that works to control the behaviour of the individual in order that they stay within the order placed upon them (Foucault, 1975). This represents an extension of the impact of social exclusion which causes silencing of the excluded, and engrains in them the belief that they are less important within the hospital and, by extension the community.

5.7 Use of Unauthorized Substances 275P–ESS–060 & Searching of Inpatients’ Belongings 275H-CPC-170

The “Searching of Inpatients’ Belongings” and “Use of Unauthorized Substances” policies allow for staff to search patients for unauthorized substances and/or potentially harmful objects. The “Searching of Inpatients’ Belongings” policy states, as part of assessment:

“2. Patients who are considered at risk (i.e. to self harm/harm others) and who have potentially harmful items (items) on their persons will be:

- asked to give the items to a support person, if accompanied
- asked to give the items to nursing staff who will place the items in a safe and secure area

3. For personal belongings other than a purse/wallet, nursing staff will request that patients allow these belongings (i.e. suitcases, knapsacks,

boxes; bags; other) to be placed in a safe and secure area until the admission psychiatric assessment is completed.”

These policies are Level III policies, which means that they apply to all frontline clinical nursing staff working in the Psychiatric Emergency Department, Health Science Centre, the Short Stay/ Psychiatric Assessment Units of the Waterford, and all inpatient units of the Mental Health and Addictions Program, except the Forensic Service at the Waterford site. Importantly, these policies were only developed for the psychiatric units.

These policies have been deemed necessary to protect staff and patients from the possibility of harm while in hospital. The goal of these policies is to consider the overall safety of the unit, for patients and staff. A search of all patients and their belongings is conducted upon admission and when patients return from approved outings. The search is intended to be thorough and would include checking the clothing pockets and seams/linings, the patient’s room, containers, and other potential areas to hide objects. In addition, people suspected of being “at risk” to self-harm or to harm others would be checked more frequently to see if they are carrying “harmful items”. Any confiscated Items would be kept in a safe place for return to the patient upon discharge.

A recent review of the literature about patient safety supports the need to block access of patients to sharp objects, and the need for safety checks (Kanerva et al., 2013). Research suggests that there is a need for staff to be aware of any potential threats of acts of aggression within the environment as a precaution for patient and staff safety (Kanerva et al., 2013). Some of the top priority areas that mental health care providers are concerned with, in terms of

patient safety, are medication safety, slips and falls, suicide, aggression and violence among patients or staff (Brickell et al., 2009). There are also emerging issues around substance-use related harms (Brickell et al., 2009). Given these real and present concerns, there is a need to assess the risks in the hospital environment and to protect patients and staff from the possibilities of harm.

There is a need to avoid adverse events with patients, so many policies, such as this one, are intentionally “over inclusive” to reduce chances of harmful objects entering the hospital environment. Even if an individual patient is not at risk to misuse an object, there is a perceived risk that another patient, who could be dangerous, could intrude into another person’s space and take objects. Having widespread, overly inclusive policies in place can help assure the safety of staff and patients, while also putting staff and patients at ease knowing that these checks are in place.

Paternalism

While the need for such policies is clear, the policies may also contribute to stigmatizing paternalistic beliefs about mental illness and grant staff the ability to exert dominance over patients. As already mentioned, there is a strong embedded belief within society that those with a mental illness are threatening and dangerous (Brickell et al., 2009 & Kanerva et al., 2013) and so there is a perceived need to be proactive about potential violence. Because of the association of mental illness with addictions, there is a strongly associated assumption that mentally ill patients are more likely than other patients to have unauthorized substances on

their person (Key informant #1). However, only about 1 in 5 people with a mental illness also have a substance addiction (The Centre for Addiction and Mental Health, 2012). There is also the assumption that when a person is mentally ill, they are more likely to intrude into another person's space (Key informant #1). While this may be true for patients suffering from certain conditions, staff may inadvertently perpetuate the assumption that patients with mental illnesses suffer from a "weakness of the will" and require restrictions on their actions. Mentally ill patients, unlike other patients, are being treated as having the potential to be dangerous even though, as previously discussed, research does not support the notion that a mental illness alone is a predictor of violence.

The policy allows for this exertion of power; there is literally no place which can be private for the patient within the hospital environment. The breaking down of these boundaries of privacy and lowering the standards of patient rights creates an increased vulnerability for the patient. There is a constant state of surveillance being imposed. The act of searching a person, exerting dominance over the control of the patient's body, has become normal and a valid part of the treatment environment. It is a symbolic form of power displayed outwardly, through the action of surveillance, which maintains stigmatizing ideas about mental illness in a perpetual cycle.

Taking away a person's power through the acts of an institution can have long lasting implications after the person is discharged from the institution into the community. The impact could be disempowering, through internalization self-stigmatizing ideas such as the projection the notions of "weakness of will" or ideas of patients being child-like.

Deviance

The act of checking patients' clothing has been occurring since the beginning of housing the mentally ill, as far back as the 1800s (Granville, 1877). The nature of searching someone and their belongings creates a feeling of fear and mistrust between patients and staff, as well as furthering the stigmatizing notions that the mentally ill are criminal and deviant. There is a perceived idea being projected to staff and patients that mentally ill patients need to be checked because they are likely to be "offenders"; either they are more likely to carry risky objects or to use these objects against themselves or others. The message inadvertently being perpetuated is that the mentally ill will deviate, cannot be trusted and are likely to offend.

The act of searching a person and their belongings can further add to self-stigma, because it could also make a person feel as though they are a criminal and in some way deserve this treatment. The overt message is almost a symbol of punishment and control through being subjected to the search, which becomes internalized. There is a message being projected about expectations of deviancy, and the overriding of the rights of individuals within a hospital environment.

Summary, Use of Unauthorized Substances and Searching of Inpatients' Belongings

There is a tension between the need to prevent harms to patients and staff, and the need to avoid perpetuating stereotypes about violence. The act of searching projects assumptions about the competency, dangerousness and morality of patients within the hospital walls. These internalized ideas help to foster the culture of stigma around mental illness and negatively impact the identity of those with mental illness inside and outside the hospital. While

protecting against the potential actions of some aggressive patients, towards themselves or others, we also need to protect the dignity and privacy of the non-violent, non-aggressive patients. However, this “one-size-fits-all” policy is treating all patients the same way based on a small number of people with the potential to be dangerous. If people are treated as deviant, they can internalize this messaging; the impact of self-stigma can be crippling, and the shame of being associated with deviancy within society can have great implications for one’s self-worth and value within society (Kavanagh, 2010; Kenny, 2001).

5.8 Duty to Warn-Report 275P-LE-010

This is a Level III policy that impacts the mental health and addictions program. The rationale for the Duty to Warn policy is described in the policy as: “Physicians and other professional clinical staff have a legal obligation to inform law enforcement agencies, the medical examiner and other designated staff/persons when the interests of public safety override their clients right to confidentiality”. Research supports the use of such policies, which are deemed ethically necessary in order to protect the public from serious risk of harm (Ferris et al., 1998).

The origin of the Duty to Warn within Canada was influenced by a number of legal decisions that were made around situations involving mentally ill patients in the United States. One of the most important cases that led to the Duty to Warn was the 1969 case of “Tarasoff v. Regents of the University of California” in the United States, whereby Prosenjit Poddar killed Tatiana Tarasoff, after having confided his intention to do so to a psychologist who worked at

the University of California (Gostin, 2002). The outcomes of this case triggered ethical debates within the medical community (Henderson, 2015). This case resulted in a widespread movement towards an awareness of the need to breach confidentiality under a Duty to Warn (Chaimowitz et., al, 2002). There was a perceived need to protect the safety of the public and, in certain circumstances, the need to break patient confidentiality in order to do so. If a patient discusses imminent intent to harm an identifiable person, then confidentiality must be breached, and there is a duty to warn those who may come into danger.

The situations in which Duty to Warn would be necessary can be complicated. For instance, an expert panel in Ontario deliberated on the question of when a physician should inform, and they determined that if a physician believes there is more than a 50% chance that the threat will be carried out, then they have a duty to warn (Ferris et al., 1998). If there is a less than 50% perceived chance this is necessary, then there is no duty to warn. A drawback of the Duty to Warn policy often sighted in the literature is the impact on trust, which is also very important to the patient and doctor relationship (Henderson, 2015).

Deviance

There is a Duty to Warn policy within the psychiatric unit, in addition to the one that always applies across the board to health care workers. The policy was made a Level III policy for the mental health care professionals, in addition to the general ethical Duty to Warn that already applies to any staff in any area of health (as discussed above) . This suggests that there is a perception that there is an increased threat of deviance from a patient with a mental illness. The normalization of a scrutinizing or surveillance atmosphere around and within the

hospital environment is an extension of the medical gaze on mental illness. The potential for threat creates an atmosphere of being “on guard”, which also threatens the therapeutic bond because it impacts the feeling of trust.

As previously discussed, a label can have a major impact and can permeate the way that a person views others as well as him or herself. In general, this policy adds to the notion that there is something potentially deviant about this group of patients, and there needs to be an added awareness or alertness to the potential of harm. For example, having a reputation for harmful behaviors such as damaging a home can make finding housing very difficult. The public stigma of having a mental illness diagnosis alone can make it difficult to find adequate housing (Everett, 2006). For instance, one study that looked at landlords’ opinions about renting to those with serious mental illness found that there was hesitation among landlords to rent to those with a serious mental illness because of previous bad experiences that had left them feeling more cautious (Bengtsson-Tops and Hansson, 2014). There is an expectation that these people will repeat their past behaviours which makes the need for rehabilitation for the greater good of a patient seem necessary, though it is still coming from the standpoint of exerting power over the body and behaviour through means of policy. The impact of these forces on the patient is that they must reform their behaviour so that they can meet the standards necessary in the community for housing, and move away from the deviant label.

As noted, the duty to warn is not necessarily unique to psychiatric facilities, so the fact that it has been included within the list of policies for the mental health and addictions program is adding more to the notion that such a policy is needed for this group more-so than for others.

The exertion of this force, although not visible, is quite powerful because it is reinforcing the idea that the mentally ill need more attention and focus, as they are more of a risk. Thus, this policy further reinforces the association of mental illness with deviant or criminal acts. This notion adds an expectation of dangerous behaviour to the medical gaze, which also limits the level of confidentiality that staff can uphold. It also adds another layer of control and surveillance within the hospital space, which is internalized by both patients and staff.

Social Exclusion

This policy is adding to the perception that those with mental illness are potentially dangerous and so adds to the social distance between patients and staff. The policy gives further allowance to objectifying the patients through this stigmatizing label and treating them more as potential threats and less like equals. Staff may feel more compelled to look for the signs of dangerousness in the psychiatric population than they would in the “normal patient” population. For instance, probing into the private lives of patients in the unit may not even be warranted, but staff may feel because it is a mentally ill patient they have more of a duty to check and ask personal questions.

As previously discussed, this policy also projects the fear of the mentally ill and perpetuates the idea that they are likely to commit a crime, and so there is a perceived need for extra surveillance. These notions are internalized and work within the patient and the staff to reinforce the power relations within the environment. This policy is another example of how the power of stigmatized ideas can extend from policy and influence the actions of staff and patients. These ideas can also shape the perception that the mentally ill patient has a high

potential of being a threat to others, which adds to the social exclusion and distance between staff and patients. These notions, as others, also become embedded within the community.

Summary, Duty to Warn

As noted, much as this policy was designed to be specific to mental illness, however there is also an ethical Duty to Warn that applies to all patients within Eastern Health. Any person could be capable of committing an act that would require warning others. The idea being portrayed here is that those with mental illness are more likely to do such a thing. As a special policy was developed for the psychiatric unit, it reinforces the perception that the mentally ill are more likely to be criminal or deviant. This notion gives power to staff to survey the mentally ill population and place their behaviours and history under more scrutiny. It is another example of a policy that is adding to the internalized messaging and the normalization of treating the mentally ill as deviant persons, and adds to the social exclusion of them.

5.9 Janeway Hospital: Unit Guidelines Dec 2011 275H-JWPS-260

This is a Level IV policy that applies to all physicians and staff of the Janeway Hospital's psychiatric unit. It governs the actions of staff within the Janeway Hospital's psychiatric unit. Within the policy it reads: "*Discharged clients are encouraged not to visit co-patients for three (3) months after discharge*". The addition of this line was done in an effort to reduce the risk of the development of "negative friendships" (Key informant #2). In particular, this section of the policy was put in place due to a concern that children and adolescent patients were at risk of forming harmful friendships while in the hospital; that is that the friendships could influence

them towards negative behaviours. In the past, at this hospital, there was a situation that occurred where patients had practiced self-harm (cutting behaviour) together (Key informant #2).

Caring for children and adolescents within a psychiatric setting poses a unique situation as they are more vulnerable than adults to having others influence their choices and behaviour (Sondheimer, 2010). In particular, there are concerns about autonomy and the ability for youth to make choices around their health care or, in this case, who they form friendships with (Sondheimer, 2010). There are many physiological changes occurring during childhood and adolescence and it is also the time when an individual is forming their identity (Sondheimer, 2010). It is important to incorporate this contextual information when making decisions for and treating mentally ill children and adolescents.

During childhood and adolescence, the desire to fit in with one's peers is of high importance. Youth is also a time when an episode of mental illness is often first encountered (Canadian Mental Health Association, 2014). Having strong friendships can be a source of support during hard times, such as those felt with mental illness; however, they are also times in which some negative views can be reinforced by peers who share such views (Brinthaup & Lipka, 2002). The need to protect patients from the further reinforcement of negative influence is a strong motivation to enforce policies around relationship forming behaviours, after hospitalization. The acknowledgement of their maturity level and also their increased dependence and vulnerability warrants more room to override the child and adolescent patient's autonomy when making choices around their health care.

Deviance

As discussed above, the section of the policy that addresses the guidelines around visiting patients was developed out of a fear that some friendships could potentially lead to harm to one or both patients (Key informant #2). There is an assumption within this policy that interactions with visitors who are potentially friends of the children or adolescent patients will somehow lead to deviant acts. This messaging is read by staff, patients and parents, who can internalize that there is something “wrong” with patients having visitors. They can then further perpetuate the idea that the friendships formed within the hospital have the potential to be dangerous to patients and a source of deviant behaviour, and are a risk better avoided.

The hospital staff enacting this policy work to control friendships and so act as an extension of the policy. The policy gives power to staff to categorize and modify human connections and interaction within the hospital walls. This policy gives allowance to staff to regulate and frequently survey patients’ friendships, and also influences the parents to do the same. The normalization of these ideas within the hospital walls, which gives power to the notion of a need to control, monitor or manipulate patients’ relationships, extends to the community context as well. Thus, the policy and medical gaze exert further control over behaviour even after the patient has left the hospital.

The policy frames the relationships between patients as a source of deviant acts, while in fact there are many other sources for deviant behaviours. The perpetuation of these ideas as being truth can be internalized, and as such continue as a form of social control outside of the hospital. Parents and also discharged patients may continue to be watchful for negative

relationships and become anxious for the potential risk they hold. This is another example of a policy that amplifies the medical gaze, through the increase in surveillance and control of the potential for deviancy within the community of people living with mental illness.

Social Exclusion

Social support during a mental health crisis is a very useful thing. It is well known that there are benefits of social and peer support for mental illness recovery (O'Hagan et al., 2010). With this policy, there is an imposed social distance that necessarily results by discouraging friendships formed in hospital to continue after discharge. The policy was formed as a result of an event whereby two young patients reportedly begun "cutting" together (Key Informant #2). In a way, this policy is also discouraging the positive social support among children and youth, based on a fear of a repeat of events such as this. In this way there is a normalization of the idea that there is a need to monitor relationships.

The focus on the friendships formed between patients is a distraction from understanding why patients are engaging in self-harming activities. This further isolates patients and objectifies the bonds that may form between the patient and other child and adolescent patients. For instance, there has been research into the friendships of "shy and withdrawn" children (Rubin et al, 2006). Researchers found that these children depend a great deal on friendships, as even poor quality friendships help children to cope in the social atmosphere of a school environment (Rubin et al, 2006). It was noted that despite the maladaptive behaviours that friendships can encourage, the perception of needing to keep the friendship "at all costs"

wins over the threat of loneliness. The threat of feeling socially rejected and excluded by peers when alone is a strong motivation to maintain friendships.

This policy has the potential to shape patients' ideas that there is something wrong with them, or other patients like them, as there is a strong messaging that the friendship with them is "unhealthy". This perception perpetuates the notion of weakness and vulnerability within the mentally ill population as well, exerting a need to reform patients by instructing them about what a "good" friendship looks like. There is the perception that patients are not able to decide who is a good friend, so this encourages distance between child or adolescent patients.

Summary, Janeway Hospital: Unit Guidelines

This policy has a section that is meant to protect child and adolescent mentally ill patients from potentially harmful relationships. However, in the process of doing this, there is an assertion of the idea that any relationship with another mentally ill patient, whether within or outside the hospital, is deviant and needs to be monitored. The difficulty with this message is that it also sends mixed messages around friendships. On one side, relationships formed outside the hospital are seen to be good sources of peer support, and are normalized as such. However, within the hospital there is a notion that either patient in the friendship dyad has the potential to be the perpetrator or the victim of harm in the relationship, and so beyond the hospital there is a need to limit further interaction with other patients.

There is an additional potential of harm to the therapeutic relationship as a result of the policy. The ideas portrayed in this policy could be damaging to trust and respect, which are

already difficult to cultivate in the mental health care environment. Being perceived as a threat or as deviant creates more obstacles, in addition to social distance, when trying to form a therapeutic bond based on trust. This is particularly important to consider in terms of the impact on younger patients, who are laying the foundations of trust with the mental health care system.

The policy's aim is to protect those who are particularly vulnerable to being influenced. However, by surveying and regulating relationships within the hospital, and perpetuating stigmatizing ideas in the process, the policy has the potential to negatively impact the identity of a young person by constructing them as having a lack of agency to make their own "correct" decisions about friendships.

Chapter 5 gave an in-depth analysis of six mental health care policies to reveal how stigma exists in covert ways within health care discourse. Three key themes that demonstrate how stigmatizing ideas about the mentally ill are perpetuated through policy were examined: *paternalism* in health care; the conflation of mental illness with *deviance*; and health care practices that perpetuate the *social exclusion* of those with mental illness. I demonstrated that these three ways in which stigma is perpetuated permeate the development and application of the six policies examined. This institutional discourse comes from, and in turn reinforces, negative ideas about the mentally ill in the community in general. By providing a guide to treatment, it gives power to these unwritten nuanced assumptions about mental illness. In the next and final chapter I provide an overall conclusion, including recommendations for policy

development that can work toward improving the awareness and reduction of stigma around mental illness.

Chapter 6: Conclusion and Recommendations

A real subjection is born mechanically from a fictitious relation [...] He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribed in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection.

- Michel Foucault in Dreyfus and Rabinow, 1983

This thesis sought to answer the following questions: (1) to what extent do mental health care policies inadvertently convey and perpetuate ideas about mental illness that may be inaccurate and stigmatizing?, and (2) what are the provincial and national initiatives in place to reduce stigma? Through the process of critical discourse analysis, hidden aspects of stigma were identified. In addition, I have summarized some local and national initiatives to reduce the stigma associated with mental illness.

How the mentally ill are treated in the mental health system is most certainly impacted by societal normative assumptions and practices. A particular history of understanding and treating the mentally ill in ways that reflect and perpetuate paternalism, the association of mental illness with deviance, and social exclusion remains embedded in policies that are in place in the mental health care and treatment programme examined in this example. Given that the Eastern Health policies are aligned with standards across Canada and more broadly, there is every reason to assume that this is the case elsewhere as well. These notions have been accepted as a valid way of thinking, which can influence the people who work within the hospital system and reinforce attitudes toward the mentally ill throughout the community.

In addition, the mentally ill can internalize these messages and perpetuate the roles that are being placed upon them (as either the child-like victim or the deviant criminal) because of the lack of alternative (“normal”) roles and social space in the community. As discussed in section 5.1.3 (Social Exclusion), the lack of a place for the mentally ill within society, outside of the harmful stereotypes, creates more of an obstacle for people to overcome these negative associations.

This analysis of hospital policy has shown that there remains some stigma in the health care system. The influence of stigmatizing ideas can be a form of power when people make choices and take action based on these ideas. Similar to what Bourdieu outlines in his discussion of “habitus” (1977, p. 72), subtle chains of interactions that perpetuate stigmatizing ideas can become widespread large networks which work in tandem to keep these stigmatizing beliefs embedded in our culture. However, there is room for change in the act of uncovering the existence of these ideas, within ourselves and within policy. Critical discourse analysis, such as this project, can add to the resistance to stigma; it draws attention to the otherwise hidden sources of stigma in our society. It contributes to “heterodoxy” (Bourdieu 1977, p. 159) contesting the unspoken assumptions about mental illness. In the same spirit of resistance to normative assumptions, community based efforts to reduce stigma are emerging in Newfoundland, as elsewhere, and are promising for bringing about changes in cultural beliefs. Movements such as the local Community Coalition for Mental Health, Canadian Mental Health Association (CMHA), NL branch; Consumers Health Awareness Network Newfoundland and Labrador (CHANNAL) are important for resisting previously held assumptions about the

mentally ill. Nationwide, celebrities are also speaking out about their own experience bringing attention and some credibility to living with mental illness while raising awareness in noteworthy campaigns, such as Bell Canada's campaign, "Let's Talk".

6.1 Recommendations

This critical discourse analysis has revealed some of the hidden stigmatizing assumptions that are embedded in hospital policy. These messages can be counter-acted and the stigma resisted by attempting to reframe the space and roles given to those with mental illness. This can happen in several ways, including empowerment of patients against the hidden messages, increased education about these internalized ideas, explicitly attending to stigma in policy development, and emphasising the role and importance of the therapeutic alliance. The following is a more detailed description of these recommendations.

First, patients need to be aware that they can become empowered and not internalize the hidden stigmatizing messages of paternalism, assumed deviance and social exclusion that are present in their environment. Empowerment towards an achievement of stability and control is part of a strong recovery process (Fisher, 2005). The overarching problem with the mental health care policies I analysed, is that they are too narrow, in a sense that they focus on a small subsection of the patient population. Therefore, these stigmatizing ideas that are being perpetuated are impacting a larger group, unnecessarily.

As discussed, the role of a "spoiled identity" is core to understanding the difficulty that the mentally ill are facing. The result of self-stigma can cause a deep acceptance of negative perceptions and a hopelessness, which can further marginalize or remove power from the

individual. Negative messages, both explicit and subtle in society, create, and also in effect spoil, the construction of a strong identity among those with mental illness.

The World Health Organization has developed a guide to help evaluate mental health policy (2007). A major goal of mental health care policy is to help, or empower, those with mental illness back into the community as integrated persons (WHO, 2007). One way that empowerment can happen is by changing the treatment environment.

In providing treatment, health care workers are able to influence recovery by encouraging empowering beliefs in individuals with mental illness. To better balance patient and staff safety with the stigmatizing effects of policy, the health care system could work to broaden the options for treatment, in particular for community-based treatment. For example, alternative treatment places (such as Soteria houses as mentioned earlier) exist in Europe elsewhere and provide a more open and less controlled environment. If the space in which treatment occurs is sufficiently reoriented, then this may decrease stigma by reducing social exclusion and thus limit the perpetuation of negative stereotyping. This will avoid the scenario whereby stigma is perpetuated by hospital policies developed to protect against the potential harms caused by a small minority and end up stigmatizing the entire group.

Second, there is a need for increased education of staff and patients on the stigma of mental illness, as noted by the Mental Health Commission of Canada (2013). In the health care environment of the example presented in this thesis research, staff orientation includes a discussion of one academic journal article on stigma; however, this is most likely not sufficient for mitigating against the effects of stigma inadvertently perpetuated in the hospital

environment. The education needs to be more in-depth, for example including a discussion of paternalism, deviance, and social exclusion. Also, involving people with lived experience of mental illness may help to facilitate social inclusion and reduction in stigma. However, caution should also be taken when involving those with lived experience, as the process can involve reliving traumatic life events. That being said, full disclosure about the potential risks of participating, without being paternalistic, should be enough preparation for a person to have an ability to make this choice for themselves.

Third, the process by which policies are developed could more effectively incorporate attention to stigma. None of the mental health care policies I examined made reference to the concept of stigma. In addition, the current protocol for policy development within Eastern Health does not include a discussion of stigmatizing language around mental illness. The World Health Organization guidelines emphasise that policy should lessen the impact of stigma within the areas that the policy governs (WHO, 2007). I believe that policy will be strengthened by involving community representatives with a lived experience with mental illness, who could help to research and develop mental health care policies. They would be able to provide much needed insight into the subtle ways that paternalism, social exclusion and ideas of deviance are perpetuated in policy.

Fourth, the relationship between stigma and the therapeutic alliance deserves careful scrutiny. The therapeutic alliance cannot be fully developed if the environment does not foster it. Strengthening communication between staff and patients is important, because unclear or mixed messages impact the formation of a good therapeutic bond. Policies aimed at protecting

staff and patients also portray many elements of stigma that create an unpleasant environment for patients. For example, an over-emphasis on paternalism can create a large disconnect between patients, staff and the goals of treatment. Stigmatizing messages can make patients feel unwelcomed and uncomfortable, and therefore eager to leave. This can lead to the “revolving door” effect of patients returning for treatment.

6.2 Limitations

The major limitation of this study is that mental health patients and mental health care workers (such as nurses or doctors) were not interviewed about the impact of these policies on their lives. Such an analysis of the embodied experience of stigma through health care policy would be a complex project, given the deeply rooted and hidden nature of stigma. Doing such a project would have required more in-depth qualitative research than this Master’s thesis project was able to complete at this time.

6.3 Further research

Further research is needed to scrutinize the existence and perpetuation of stigma in mental health care policy and treatment. Qualitative research engaging mental health consumers and health care workers would provide much-needed information on how policy impacts the overall hospital environment, perpetuates community-based assumptions about mental illness, and influences recovery. Further research could also look into the particular aspects of stigma, such as paternalism, deviance and social exclusion, from the perspectives of those who have lived experience of mental illness.

6.4 Final Words

This thesis has given me a deeper understanding of the stigma of mental illness, as well as the societal construction of what it means to have a mental illness. Critical discourse analysis was ideal for this research project as it enabled me to uncover evidence of stigma hidden within Eastern Health's mental health care policies. As was described in the literature review, the mentally ill have historically been marginalized. The three themes that emerged from the analysis paternalism, deviance and social exclusion are evidence of the stigma being perpetuated through health care policy discourse. I am hopeful that with further awareness and education we can work towards reducing stigma within policy and the health care environment, as well as within the overall community.

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Appendix A: Email for Interview

Email invitation to participate in interview

Version 1 (for those who provided policies)

Hello [name],

Thank you again for providing me with policies to review for my Master's thesis on "An Inquiry into Stigma within Mental Health care Policy". I have a number of questions about the policies and their development and use. Would you be available and willing to meet with me, at your convenience, to be interviewed for your perspective on the policies? Your insights will be useful to me as I conduct my policy analysis. Specifically, I am interested in: why and how the policy was developed, and how it is used. If you are interested in speaking to me about this, would you be free to meet with me for approximately 1 to 1 ½ hours sometime in the next few weeks? I can be contacted by email, or be telephone at: #697-3296. A copy of the consent form is attached for your perusal. If you agree to be interviewed, a copy of this consent must be signed in advance of the interview. Thanks for considering my invitation,

Sonya Bowen

Version 2 (for those who had not provided policies)

Hello [name],

I was referred to you by [name]. I am a Master's student in the Faculty of Medicine (Community Health & Humanities) at Memorial, working on a thesis on "An Inquiry into Stigma within Mental Health care Policy". I am conducted an analysis of various policies used within the Mental Health & Addictions program of Eastern Health. I have a number of questions about the policies and their development and use, and [name] suggested that you would be an ideal person to provide me with some of this contextual information. Would you be available and willing to meet with me, at your convenience, to be interviewed for your perspective on the policies? Your insights will be useful to me as I conduct my policy analysis. Specifically, I am interested in: why and how the policy was developed, and how it is used. If you are interested in speaking to me about this, would you be free to meet with me for approximately 1 to 1 ½ hours sometime in the next few weeks? I can be contacted by email, or be telephone at: #697-3296. A copy of the consent form is attached for your perusal. If you agree to be interviewed, a copy of this consent must be signed in advance of the interview. Thanks for considering my invitation,

Sonya Bowen

Appendix B: Interview Guide

Interview Questions

Key informant interviews with managers engaged in policy development in mental health

[Note to REB reviewers: The interviews will be open-ended and fairly unstructured. The questions listed below are meant to guide the interview; they are not meant to be read out as written here]

1. What is your professional position and role in relation to the policies you have provided me for analysis?
 - a. How long have you been in that position?
2. Describe your work with policy development.
 - a. What is entailed in creating a policy?
 - b. Who is involved in policy development?
 - c. How long does it take to develop a policy?
 - d. Do you refer to policies of other institutions? Do you adapt policies of other institutions?
 - e. What kinds of dilemmas and challenges are faced when developing a policy? (Economic resources, lack of space, human resources).
3. Using some of these examples of policies that you use [show the paper copies of policies provided to me], can you tell me about how and why each of these was developed?
 - a. History to the policy
 - b. Background work that went into it
 - c. What types of staff and managers were involved in creating it
 - d. Time from concept to implementation
 - e. Dilemmas and challenges
4. As you know, I am examining these policies to look for the potential for stigmatizing assumptions to be recreated or purveyed by the end users (nurses, for example). What are your thoughts on what I might observe?
5. Is there anyone else that you think I should speak to about the policies?
6. Final comments?

Appendix C: Information Sheet

Information Sheet

12.023

TITLE: An Inquiry into Stigma within Mental Healthcare Policy

INVESTIGATOR(S): Sonya Bowen, Principle Investigator

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This information sheet form explains the study.

1. **Introduction/Background:** This is a research project that seeks to answer questions about stigma and mental illness in Newfoundland and Labrador. Health policies should address stigma. They should also aim to decrease the impact stigma has. There has been a lot of attention to the medical side of mental illness and much has been written on stigma; but there has been very little thinking and writing about managing stigma from a health policy view. This research addresses that gap.
2. **Purpose of study:** This study seeks to understand whether mental health care policies may unintentionally promote stigma.
3. **Description of the study procedures:** Interviews will be done with program managers from the mental health programs of Eastern Health, including the Waterford and the Janeway. The goal is for me to better understand the policies. You will be asked about how these policies were developed, and how they are used. Interviews will be audio recorded and typed up.
4. **Length of time:** Each interview will last 1 to 1 ½ hours.
5. **What about my privacy and confidentiality?** Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study. Information collected for this study will kept for five years. If you decide to withdraw from the study, the information collected up to that time will be destroyed. Information collected and used by the research team will be stored on a password protected computer. Sonya Bowen is the person responsible for keeping it secure.
6. **Questions or problems:** If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is: Sonya Bowen (709) 237-2411. Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through: Ethics Office Health Research Ethics Authority 709-777-6974 or by email at info@hrea.ca

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Version date: January 27, 2012

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Appendix D: Consent Form

12.029
November 2011

Consent to Take Part in Research

TITLE: An Inquiry into Stigma within Mental Healthcare Policy

INVESTIGATOR(S): Sonya Bowen, Principle Investigator

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. Introduction/Background:

This is a research project that seeks to answer questions about stigma and mental illness in Newfoundland and Labrador. Health policies should address stigma. They should also aim to decrease the impact stigma has. There has been a lot of attention to the medical side of mental illness and much has been written on stigma; but there has been very little thinking and writing about managing stigma from a health policy view. This research addresses that gap.

2. Purpose of study:

This study seeks to understand whether mental health care policies may unintentionally promote stigma.

3. Description of the study procedures:

Interviews will be done with program managers from the mental health programs of Eastern Health, including the Waterford and the Janeway. The goal is for me to better understand the policies. You will be asked about how these policies were developed, and how they are used. Interviews will be audio recorded and typed up.

4. Length of time:

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Subject's Initials: _____

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Each interview will last 1 to 1 ½ hours.

5. Possible risks and discomforts:

This is a low-risk project. The only discomfort to you will be the time it takes to complete the interview.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made.

When you sign this consent form you give us permission to

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Use of your study information

The research team will collect and use only the information they need for this research study.

This information will include your

- *information from study interviews*

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

12.023
November 2011

Information collected for this study will kept for five years.

If you decide to withdraw from the study, the information collected up to that time will be destroyed.

Information collected and used by the research team will be stored on a password protected computer. Sonya Bowen is the person responsible for keeping it secure.

9. Questions or problems:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is:

Sonya Bowen (709) 237-2411

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office
Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

After signing this consent you will be given a copy.

12.029
November 2011

Signature Page

Study title: An Inquiry into Stigma within Mental Healthcare Policy

Name of principal investigator: Sonya Bowen

To be filled out and signed by the participant:

	Please check as appropriate:
I have read the consent	Yes () No ()
I have had the opportunity to ask questions/to discuss this study.	Yes () No ()
I have received satisfactory answers to all of my questions.	Yes () No ()
I have received enough information about the study.	Yes () No ()
I have spoken to <u>Sonya Bowen</u> and he/she has answered my questions	Yes () No ()
I understand that I am free to withdraw from the study	Yes () No ()
• at any time	
• without having to give a reason	
I understand that it is my choice to be in the study and that I may not benefit.	Yes () No ()
I understand how my privacy is protected and my records kept confidential	Yes () No ()
<i>I agree to be audio taped</i>	Yes () No ()
I agree to take part in this study.	Yes () No ()

Signature of participant Name printed Year Month Day

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator Name printed Year Month Day

Telephone number: _____

Appendix E: Policies

Note: Due to the length of the policies, just the first page has been included. Also, it should be noted there have been reviews of some policies since beginning this thesis, but no changes have been made.



SMOKE-FREE ENVIRONMENT POLICY
ADM – 135
PAGE 1/3

SMOKE-FREE ENVIRONMENT POLICY	Administration ADM – 135
Issuing Authority (sign & date)	Don Keats, President and Chief Executive Officer Signed by Don Keats Dated August 11, 2014
Office of Administrative Responsibility	Human Resources Program and Policy Development
Author	Natalie Moody, Regional Director Health Promotion and Regina Coady, Director, Occupational Health, Safety and Rehabilitation
Level	One (I)
Original Approval Date	September 21, 2009
Effective Date	Upon signature
Scheduled Review Date	August 2016; August 2017
Actual Review Date	November 2, 2012; August 11, 2014
Revision Date(s)	August 11, 2014

Overview

Over the past 25 years comprehensive tobacco control initiatives such as legislation, taxation, policy enforcement, education/awareness, and support for people to quit smoking have resulted in a reduction in tobacco use in Canada.¹ Despite significant progress smoking remains the leading cause of preventable illness, disability and premature death in Canada.² Reducing the tremendous toll caused by tobacco use is a shared responsibility.

As a leader in the health sector, Eastern Health is committed to building a healthy workplace for its employees and promoting and supporting health among the people and communities of the eastern region.

In accordance with our vision of *Healthy People, Healthy Communities*, mission and values Eastern Health promotes and supports an environment free from tobacco and second-hand smoke for its employees, physicians, clients, patients, residents, visitors, students, volunteers, outside user groups and all other agents of Eastern Health.

POLICY

It is the policy of Eastern Health to provide a tobacco and smoke-free workplace and environment. Eastern Health prohibits the use of all tobacco products and

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IDENTIFICATION BADGES	Operations OPS-SC – 040
Issuing Authority (sign & date)	Marilyn Thompson, Vice President Signed by Marilyn Thompson Dated August 5, 2013
Office of Administrative Responsibility	Human Resources
Author	Susan Pereira, HR Strategist
Level	One (I)
Original Approval Date	August 22, 2007
Effective Date	August 24, 2007
Scheduled Review Date	Aug 2008; June 2016
Actual Review Date	August 5, 2013
Revision Date(s)	

POLICY

Eastern Health employees and agents must wear an approved Identification (ID) badge while working within Eastern Health facilities and while visiting clients, residents and patients in their homes.

Scope

This policy applies to all Eastern Health employees and agents.

Purpose

This policy is intended to:

- Identify those who are authorized to work by Eastern Health to members of the public, to clients, patients and residents.
- Identify the Identification badge as a key part of information and physical security within Eastern Health facilities.
- Identify how and where staff, physicians, volunteers, pastoral care workers and students are issued ID badges.

Procedure

General

- A sample Identification badge is attached. Content Includes:
 - Photograph

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USE OF UNAUTHORIZED SUBSTANCES	Emergency Plan, Safety and Security 275P-EPS – 060
Issuing Authority (sign & date)	Kim Baldwin, Regional Director (Acting), Mental Health and Addictions Program (MH&A) Program Signed by Kim Baldwin Dated June 27, 2011
Office of Administrative Responsibility	Regional Director, MH&A Program
Author	Isobel Keefe, Assistant Director, MH&A Program
Level	Three (III)
Original Approval Date	June 27, 2011
Effective Date	Upon signature
Scheduled Review Date	June 2014
Actual Review Date	
Revised Date(s)	

Overview

All employees of Eastern Health have a duty to maintain a safe and therapeutic environment.

POLICY

All patients are informed upon admission and/or transfer to the MH&A program of the MH&A policy regarding unauthorized substances and the MH&A Search policy.

This policy will be reviewed as part of patient orientation to MH&A program inpatient units.

Incidents of substance abuse will be addressed on an individualized basis.

Scope

This policy applies to MH&A nursing staff working on inpatient units and/or the Psychiatric Assessment /Short Stay Assessment units.



SEARCHING OF INPATIENTS BELONGINGS	Client /Patient Care
	275H – CPC – 170
Issuing Authority (sign & date)	Kim Baldwin, Regional Director (Acting), Mental Health and Addictions (MH&A) Program Signed by Kim Baldwin Dated June 13, 2011
Office of Administrative Responsibility	Regional Director, MH&A Program
Author	Isobel Keefe – Assistant Director and Project Lead Program Managers Committee, MH&A Program Ruby Constantine, Quality and Patient Safety Leader, MH&A Program
Level	III (Three)
Original Approval Date	June 13, 2011
Effective Date	Upon signature
Scheduled Review Date	June 2014
Actual Review Date	
Revised Date(s)	

OVERVIEW

The MH&A Program is responsible to provide a safe, therapeutic environment. Eastern Health (EH) staff are obliged to take reasonable care for the safety of patients, employees, agents and visitors.

POLICY

At the point of entry for psychiatric assessment /admission, and throughout the inpatient stay, patients may present with risks of self harm/harm to others. Frontline clinical nursing staff will routinely screen for, search and secure from patients, and record all potentially harmful items. All searches will be conducted in a least restrictive/least intrusive manner and will follow a strict code of conduct. Patients' dignity and right to privacy will be considered and protected at all times.



DUTY TO WARN /REPORT	Legal /Ethics 275P – LE – 010
Issuing Authority (sign & date)	Kim Baldwin, Regional Director (Acting), Mental Health and Addictions (MH&A) Program Signed by Kim Baldwin Dated June 27, 2011
Office of Administrative Responsibility	Regional Director, MH&A Program
Author	Isobel Keefe, Assistant Director and Chair Policy and Procedure Committee, MH&A Program
Level	Three (III)
Original Approval Date	June 27, 2011
Effective Date	Upon signature
Scheduled Review Date	June 2014
Actual Review Date	
Revised Date(s)	

Overview

Eastern Health (EH) recognizes that physicians and clinicians are responsible for the welfare of the clients they serve, as well as society at large.

Within the MH&A Program, disclosure of information without the clients consent can at times be necessary to prevent harm to others or to protect clients from self-harm. In these circumstances, disclosure is undertaken with reasonable care and with the client's knowledge unless it is believed that informing clients would impede the due process of the law or violate the duty to warn others.

Most professions have Codes of Ethics which explicitly state clinician obligations with respect to Duty to Warn/Report legislation.

POLICY

Physicians and other professional clinical staff have a legal obligation to inform law enforcement agencies, the medical examiner and other designated staff/persons when the interests of public safety override their clients right to confidentiality.

J4D INPATIENT UNIT GUIDELINES	Janeway Psychiatry Services 275H – JWPS – 260
Issuing Authority (sign & date) DRAFT	Kim Baldwin, Regional Director (A), Mental Health and Addictions Program
Office of Administrative Responsibility	Regional Director, Mental Health and Addictions Program
Author	Jeannette Piper, Program Manager, Child /Adolescent Psychiatry, Mental Health and Addictions Program
Level	Four (IV)
Original Approval Date	
Effective Date	On Signing
Scheduled Review Date	
Actual Review Date	
Revised Date(s)	

POLICY

The Janeway Psychiatry inpatient unit, J4D, uses a standard set of guidelines to govern client behaviors while they are inpatients on the unit.

Scope

This policy applies to all employees and clinical staff working on the Janeway Psychiatry inpatient unit, J4D.

Purpose

J4D Inpatient Unit Guidelines provide a common set of rules to ensure a safe and respectful therapeutic environment.