

Research Article

Stigma Perspectives from Adults Experiencing Substance Use, Mental Health and Homelessness Issues

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Abstract

Background: Stigma in persons with Substance Use Disorder (SUD), Mental Health (MH) and homelessness issues plays a significant role in the number of individuals who seek treatment from a MH professional. Since stigma is often viewed by another's perceptions towards others with mental illness versus by individuals living with mental illness, our study sought to understand how adults experiencing SUD, MH issues and homelessness feel about self-stigma and stigma perspectives towards others facing similar situations.

Methods: Thirty-nine adults (27 males, 12 females; ages 18-62) with SUD, MH, and homelessness issues who were enrolled in a faith-based residential treatment center in Southern Alberta, Canada were asked to complete a two-part 20-item stigma survey on self and public stigma perspectives.

Results: Approximately 50% of respondents would tell a friend if they were having a MH difficulty, and if they thought someone in their life was having a MH difficulty. Women much more likely to tell someone that they were having MH problems than were men. Eighty-two percent would accept someone with MH issues as a friend, and 92% of respondents indicated that they did not think a family or friend seeking help for MH to be a sign of weakness nor if another person sought inpatient treatment for MH issues. However, 28% replied they would view them differently for having sought inpatient treatment. Forty-one percent would tell a professional if they were having suicidal thoughts, yet 23% would tell no one. Of that 23% over half would relapse and return to treatment for SUD within a year. Specific to SUD, 59% of participants would share with a professional that they were having an issue, and 92% were more willing to accept another individual in recovery. Fifty-four percent felt people could

fully recover and lead normal lives, yet the public should be better protected from people with MH difficulties.

Conclusion: Results from this current project suggest that persons in treatment for SUD, experiencing MH and homelessness had a positive internalized and societal stigma perspective, thus more willing to seek treatment. There appeared to be some indication of a connection between those who would tell no one they were having suicidal thoughts to predicating of relapse and return to treatment. Future research using stigma surveys to help predict and prevent relapse or indicate the likelihood of individuals to seek help for SUD and mental health problems is warranted.

Keywords: Anxiety; Depression; Homelessness; Mental health; Post-Traumatic stress disorder; Relapse; Stigma; Substance use

Introduction

Individuals who face stigma for Mental Health (MH) issues, including Substance Use Disorder (SUD) and homelessness, are less likely to seek treatment, experience hopelessness, be unemployed and encounter increased isolation [1]. In general, stigma is defined as disapproval from others, a mark of shame, and is considered a form of discrimination [1]. More specifically, Goffman's seminal definition of stigma, described as an "attribute that is deeply discrediting," causes individuals to feel reduced from a "whole and usual person to a tainted, discounted one" [2; p. 3]. As stated by Link & Phelan [3; p. 367] stigma can be categorized into 6 systematic components- namely (1) identifying and classifying differences, (2) employing harmful stereotypes to those labeled as different, (3) categorizing "us" vs. "them", (4) emotional reactions amongst both the labeled and the unlabeled, (5) discrimination and loss of status dealt to the "labeled" group, and (6) social, political, economic, social and political power that facilitates these processes to thrive.

Stigma may be perceived by oneself or shown from others. Self-stigma or internalized stigma occurs when an individual adopts pessimistic beliefs about their mental state resulting in tolerance of unfair treatment from others, unhealthy coping strategies, and concealment and withdrawal [4]. Research suggests that a key factor in the variability in outcomes associated with stigma for persons with mental illness is internalized stigma. As such, internalized stigma has been suggested as a possible mediator between "societal" stigma and psychological outcomes [5]. In addition, the internalization of stigma is key in the development of negative attitudes towards MH treatment and warrants more research on aspects of stigma in both the individual and community-based efforts to reduce stigma [6,7].

Mental illness and stigma

Mental illness stigma is a fundamental barrier to improving MH worldwide, but little is known about how to durably reduce it. In fact, the World Health Organization's (WHO) world health report describes stigma as one of the remaining greatest obstacles to the treatment of mental illness [5]. Growing evidence shows that the stigma associated with mental illness both disadvantages the stigmatized and is a major source of stress and social disadvantages with serious consequences

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on population health [8]. Current research on the stigmatization of mental illness recognizes that the stigmatization of individuals involves not only the public stereotyping of these individuals, which leads to prejudice, discrimination and unequal outcomes, but also the internalization of these stereotypes by the individuals who are being stigmatized [6]. In a recent study on refugees with PTSD, Nickerson et al., [9] found a reduction in barriers to seeking treatment after a stigma reduction program offering social contact with similar peers. Thus, increased understanding of stigma from persons with mental illness as a treatable medical condition may influence stigmatizing beliefs [10].

Specific to Canada, it has been identified that one in five Canadians ages 18 and older are screening positive for MH issues such as depression, Post-Traumatic Stress Disorder (PTSD) and anxiety [11]. Stigma regarding these MH challenges has been well documented as a major factor preventing individuals from seeking support [12]. In fact, stigma prevents upwards of 40% of individuals living with depression and anxiety from seeking medical help [13]. Anxiety and mood disorders are among the most common types of mental disorders in Canada [14]. An estimated 2.5 million Canadian adults who are 18 years and older will have a depressive disorder at one point in their lives [15]. Both anxiety and mood disorders have been proven to have major impacts on those who live with these illnesses [14]. With the economic burden of mental illness in Canada estimated at \$51 billion per year for health care costs, lost productivity, and reductions in health-related quality of life [13], there is a need for increased awareness and a better understanding of stigma experienced within these populations.

Substance use disorder and stigma

Addiction is a brain disease that leads to decreased ability to make rationale healthy choices when someone has SUD [16]. SUD can be described via the 4C's approach: Craving, loss of control of amount or frequency of use, compulsion to use, and continued substance use despite consequences [12]. Particular to Canada, people with a mental illness are twice as likely to have a SUD compared to the general population [12]. At least 20% of people with a mental illness have a co-occurring SUD [13]. Moreover, it is estimated that approximately 21% of the Canadian population (about 6 million people) will meet the criteria for addiction in their lifetime; with alcohol as the most common substance for which people met the criteria for addiction (Alcohol Use Disorder, AUD) at 18% [17]. Over the course of the lifetime, rates of SUDs are higher than the rates for mood disorders [17]; with females having higher rates of mood disorders than males, and males having higher rates of SUD [13].

Emerging evidence shows that the experience of stigma can also lead to maladaptive coping behaviors-including drinking-that increase risk for adverse health outcomes [8]. SUD is consistently associated with high rates of public stigma and institutional discrimination that may discourage individuals with substance abuse problems from getting health care. In addition, these individuals fear poor treatment by health care providers or trouble with the authorities [18]. Drug and alcohol use disorder are the number one and four most stigmatized conditions according to an international survey by WHO [19].

Homelessness and stigma

Homelessness in Canada is strongly associated with SUD and MH issues. Homelessness can be described as an individual without stable, safe, permanent, housing [14,20]. Further, homelessness is

considered chronic when individuals are continuously homeless for one year or more or have had at least four episodes of homelessness in the past three years. It has been identified that an estimated 35% of all individuals- and 75% of women experiencing homelessness have been diagnosed with a mental illness, and of those, 20-25% also suffer with concurrent disorders including SUD [21]. Thus, these individuals are more susceptible to the stigma attached to having these co-occurring issues and is a major concern afflicting homelessness [1]. According to the 2018 study on homelessness in southern Alberta, the largest group of individuals facing chronic homelessness were characterized as Indigenous adult males with co-occurring SUD and MH issues [22] with 2292 individuals accessed emergency housing [11].

Stigma in persons with MH, SUD and homelessness plays a significant role in the number of individuals who seek out the help of a MH professional [18]. Since stigma is often viewed by another's perceptions towards others with mental illness versus by individuals living with mental illness [7], our study sought to understand how individuals experiencing SUD, MH issues and homelessness, feel about self-stigma and stigma perspectives towards others facing similar situations. However, there are still challenges to studying the stigma concept. For example, many researchers who do not belong to stigmatized groups study stigma from theoretical or public perspectives do not take into account aspects of stigmatization, such as whether or not they will be accepted or rejected by others especially in a specific social situation [23].

Some of the current research, much like this study, is taking a look from the perspective of a researcher within a stigmatized group, conducting a study about self-stigmatization from a similar group that has been marked or tagged by the public and MH sector as stigmatized. This may be important to help mitigate the consequences of self-stigmatization of persons with mental illness, where one internalizes the negative stereotype and finds it difficult to relate to others and may lead to a reluctance in seeking help [9,23]. As individuals with SUD are underrepresented and often not included in research studies [24], the purpose of our study was to gather data in an effort to understand public and self-stigma perspectives from a small convenience sample of Canadian adults receiving treatment for SUD, with MH and homelessness issues conducted by researchers within those demographic groups.

Methods

A descriptive study was used to examine the attitudes of adults living in southern Alberta, Canada with SUD and MH issues experiencing homelessness towards MH problems. This data was collected as part of another study that was approved (# 2020-09) by the Human Participant Research Committee at a university in southern Alberta.

Participants

Participants were 39 Canadian adults with SUD and MH issues receiving treatment at a residential Christian Ministry serving persons experiencing homeless in southern Alberta. There were 12 females and 27 males, ranging in age from 18 to 62 (majority were 26-35 years old). Participants self-identified as Caucasian (n = 27), Indigenous (n = 8) and Indigenous/Caucasian (n = 4). Thirty-six of the participants self-reported AUD, SUD or AUD/SUD. Of the total number, (n=39) three participants did not meet this criterion, citing sexual addiction (n=1) and no reported addiction (n=2, staff). Twenty-three individuals revealed having symptoms of both anxiety and depression, with eight

others stating just anxiety and four more only depression. Twenty persons had PTSD, in which one was complex. Other diagnosis included four persons with attention deficit hyperactivity disorder, five persons with bipolar, three with borderline personality disorder, two with schizophrenia, two with fetal alcohol syndrome, one with high functioning autism, one with pervasive developmental disorder, one female with severe self-harm issues, and one female with an eating disorder. Detailed demographics are reported in table 1.

Characteristics and Category	n	%
Age Group		
18-25	5	13
26-35	17	44
36-45	9	23
46+	8	20
Gender		
Male	27	69
Female	12	31
Ethnicity		
Caucasian	27	69
Indigenous	8	21
Indigenous & Caucasian	4	10
Addiction		
Drugs/Alcohol	16	41
Drugs (Cocaine, Meth, Hash, Marijuana)	14	36
Alcohol	6	15
Sexual	1	3
Not Reported	2	5
Mental Health		
Anxiety/Depression	23	59
Post-Traumatic Stress Disorder	20	51
Anxiety	8	21
Bipolar	5	13
Depression	4	10
Attention Deficit Hyperactivity Disorder	4	10
Borderline Personality Disorder	3	8
Schizophrenia	2	5
Fetal Alcohol Syndrome	2	5
Autism Spectrum Disorder (Asperger's)	1	3
Pervasive Developmental Disorder	1	3
Attention Deficit Disorder	1	3
Self-Harm	1	3
Eating Disorder	1	3

Table 1: Demographic characteristics of participants (N = 39).

Measurement instrument

Participants were asked to complete the Stigma Survey Scale (SSS) which was derived and modified from the St. Patrick's MH Services 2020 Annual Survey Findings on Attitudes towards MH [25]. The SSS consisted of questions about the issues of MH and people who may experience a MH problem. The 20-item survey took about 7 minutes to complete and was comprised of two parts: 1) Perceptions towards personal MH/SUD-6 questions, and 2) MH/SUD attitudes towards others-14 questions. For part one, participants were

instructed to mark as many of the five categories that related to who they would personally tell if they had MH difficulties. The five categories included: friend, family member, partner, professional, or no one. For example, who would you tell if you felt like you had an issue with substance abuse? Part two asked participants would they or do they accept someone else with MH problems in various situations. Participants were instructed to choose one response for each question from three categories: yes, no, or maybe. For example, would you accept someone with mental difficulties as a close friend?

Data analysis

Descriptive frequency and percentage statistics were used to report the discrete data from the separate categories that the convenience sample of 39 adult Canadian participants marked on the SSS. Some relational data was also analyzed for males and females as well as from the suicidal response category.

Results

Frequency and percentage statistics for the highest response rate per category for each of the 20 items on the SSS are reported in table 2. From the 6-item responses in part one, participants self-perception towards MH/SUD stigma revealed that 49% would tell a friend if they were having a MH difficulty, and 54% would tell a friend if they thought someone in their life was having a MH difficulty. Approximately 51% were more likely to tell a professional if they were taking medication or had previously been an inpatient.

Question	Highest Category	Frequency	Percentage
Part 1			
1. Who would you tell if you were experiencing a mental health difficulty?	Friend	19	49
2. Who would you tell if you thought a person in your life was having a mental health difficulty?	Friend	21	54
3. Who would you tell if felt like you had an issue with substance abuse?	Professional	23	59
4. Who would you tell if you take medication for mental health issues?	Professional	20	51
5. Who would you tell if you had previously been an inpatient for mental health difficulty?	Professional	20	51
6. Who would you tell if you were having suicidal thoughts?	Professional	16	41
Part 2			
7. you accept someone with mental health difficulty as a close friend?	YES	32	82
8. Would you treat someone with a mental health difficulty the same as anyone else?	YES	30	77
9. Do you believe that being treated for a mental health difficulty is a sign of personal failure?	NO	31	79
10. Do you believe that patients in mental health services often fully recover and lead normal lives?	YES	21	54
11. Would you willingly accept someone who has received outpatient mental health treatment?	YES	35	90
12. Would you raise it with your partner if you were worried that your partner was having mental health difficulties?	YES	34	87

13. Would you be okay explaining to your boss that you needed time off work due to a mental health difficulty?	YES	24	62
14. Would you accept someone who has received inpatient mental health treatment?	YES	36	92
15. Do you view people who have spent time as an inpatient differently?	NO	28	76
16. Do you believe that the public should be better protected from people with mental health difficulties?	NO	21	54
17. Do you consider it a sign of weakness if you sought help for a mental health difficulty?	NO	31	79
18. Do you consider it a sign of weakness if a friend/family member or colleague sought help for a mental health difficulty?	NO	36	92
19. Would you willingly accept someone recovering from a substance abuse problem?	YES	36	92
20. Would you feel comfortable living next door to someone with mental health or substance use problems?	YES	28	72

Table 2: Stigma scale survey descriptive frequency results (N = 39).

*Part 1 reflects some respondents providing multiple answers to the same questions.

Further, while 41% would tell a professional if they were having suicidal thoughts, 23% would tell no one. This 23% included 2 females and 7 males all with SUD. Five of the seven had PTSD along with a diagnosis of anxiety/depression. The other two with PTSD had either anxiety or depression. Three males from this same group of individuals replied that they would tell no one if they were having MH or SUD issues on 4/6 items in part one. Two of these individuals relapsed within 4 weeks (one having overdosed on drugs). However, both returned to treatment. Another four males from this group also relapsed after completing treatment yet returned to the same recovery program one year later.

Part two contained 14-items on MH attitudes towards others. Positive responses were most frequently reported (54-92%) about perception of others having MH issues. Highlights from part two revealed that 92% of respondents indicated that they did not think a family or friend seeking help for MH to be a sign of weakness nor if another person sought inpatient treatment for MH issues. Yet, 28% replied they would view them differently for having sought inpatient treatment. Eighty-two percent of respondents would accept someone with MH issues as a friend and 89% indicated they would speak with their partner if there were concerns pertaining to their partners MH. Interestingly, 54% felt people could fully recover and lead normal lives. However, 46% also felt that they believe the public should be better protected from people with MH difficulties.

In general, for part one and two the results regarding gender specific characteristics and responses were analyzed. Women were much more likely to tell someone (professional) that they were having MH/SUD challenges than were men (would more likely tell a friend). Females were generally older than the men and were more likely to have anxiety (92%) whereas 67% of men had anxiety. Males were more likely to be in the recovery program but were much less likely than women to tell someone if they were having suicidal thoughts. Men were slightly more likely to accept someone who was an outpatient as friend than were women. Part one and two of the SSS each had one specific question regarding SUD (#3, #19). Overall, those responses

indicated that 59% of participants would share with a professional that they were having an issue with SUD, and 92% answered yes that they were more willing to accept another individual recovering from SUD. When specifically analysing how males and females responded to question #3 “Who would you tell if felt like you had an issue with substance abuse?” Results showed that men were most likely to tell a family member while women would be more likely to tell a professional. In general, both men and women were least likely to tell a friend or partner. For question #19 “Would you willingly accept someone recovering from a substance abuse problem?” Results showed that 100% of women with co-occurring SUD and AUD were willing to accept someone recovering from a SUD and 85% of men with co-occurring SUD and AUD were willing to accept someone recovering from a SUD.

Discussion

This study explored internalized and societal stigma and how it was perceived by adults in treatment for SUD, who also experience MH and homelessness issues. Since stigma is strongly correlated with an individual’s unwillingness to seek treatment for MH issues, it is important to explore stigma from the perspective of those actually willing to get help [1,3,5,9,12,18]. Our discussion highlights findings connected to willingness to seek help, impact of SUD co-occurrence disorders on relapse, connection to suicidal thoughts and the role of gender and stigma.

Overall, our results revealed that these adults receiving treatment for SUD with co-existing MH issues were more likely to seek professional help. These outcomes are congruent with the study on adults in Ireland, using the original SSS that showed a higher number of people would be more likely to tell a professional and a friend that they were having MH difficulties [25]. Moreover, the Ireland study found similar results to ours in the response to it not being a weakness to have MH problems and or be hospitalized for treatment, whether that be related to oneself or others [25,26]. Our respondents also strongly agreed that it was not a weakness for friends or family to seek MH treatment, yet some responded they would view them differently. Also, around half of our participants replied that while they felt that individuals with MH issues could fully recover, the public should be better protected from them. Perhaps these results can be explained by the views from individuals within a stigmatized cohort reporting that public attitudes towards treatment were not in line with how treatment was truly perceived by these stigmatized cohort [7].

There also have been notable changes over the past several years from Canadian stigma surveys that may shed a light on the complexity of interpreting some of the underlying factors related to stigma perspectives. For example, a survey conducted in 2008 revealed that Canadians were more likely to share with a family member that they had cancer, than a mental illness [27]. Additionally, more than half of those respondents revealed they would not maintain a friendship with someone who received a MH diagnosis, nor would they engage in a committed relationship with someone with mental illness [27]. Nearly half of respondents indicated that they believe a mental illness diagnosis is used as an excuse for bad behaviors and admitted being fearful of individuals with mental illness [27]. In 2015, a survey reported that nearly 60% of Canadians agreed that there was a decrease in stigma surrounding mental illness in comparison to the five years previous and felt that societal attitudes have become more positive surrounding mental illness [28]. Finally, a majority of those same

respondents agree that they have gained increased awareness of MH [28]. Despite these encouraging findings, a survey conducted in 2016 uncovered that nearly half of respondents admitted to experiencing anxiety and depression symptoms, yet did not access medical assistance, thus, indicating that stigma is still a barrier [29]. Perhaps some of these stigma results can be explained by the strong co-occurrence of anxiety, depression and PTSD that existed for our respondents with SUD and can shed some light on stigma as a barrier to treatment.

Our self-reported results and diagnosis show a relationship between one's ability to regulate emotions and relapse. Over half of our participants had both anxiety, depression and PTSD. Researchers have discovered that individuals experiencing challenges with emotional management were linked with an increased chance of relapse [27]. Of our 39 participants six relapsed within the first year indicating that they may have been experiencing challenges managing their emotions and staying clean. Further, Rasmussen et al., [10] concluded that there was a higher risk of stigmatizing personal beliefs towards persons who had been treated for MH issues and subsequently relapsed. Results from this current project may suggest that conducting stigma surveys that contain internalized and societal components like the SSS may have some connection to prediction of relapse depending on an individual's response to some of the prompts.

Both anxiety and mood disorders have been proven to have major impacts on those who live with these illnesses [14]. While living with a mental illness itself is not necessarily life-threatening, sadly upwards of 90% of individuals who take their lives have a diagnosable mental disorder, most often SUD and depressive disorder [30]. Twenty-three percent of our participants would not tell anyone they were having suicidal thoughts. This group of nine individuals also had mood disorders including anxiety, depression and PTSD. Six of these same individuals would go on to relapse in the first year but would all return to treatment. That being said, there appears to be some connection between not telling anyone about suicidal thoughts, along with having a diagnosis of SUD, and PTSD, anxiety/ and or depression in predicting relapse and return to treatment. Researchers Carpiniello and Pinna [31] indicated that stigma is a risk factor for suicide and encouraged support for those suffering from perceived or internalized stigma. With regard to PTSD and stigma, Nickerson et al., [9] found a reduction in barriers to seeking treatment after a stigma reduction program offering social contact with similar peers. The program strategies implemented in that study have been linked to an increase in seeking help, along with the reduction of stigma attitudes associated with help seeking [9]. Thus, encouraging social contact with others with PTSD proved to be beneficial in the reduction of removing barriers typically anticipated with seeking help for MH [9].

Our study found some differences in how males and females viewed stigma. Our female respondents who were more likely to be dealing with anxiety than men, were also more willing to tell someone they were struggling with MH or SUD issues. While men and women both preferred to tell a professional, men were less likely to tell their partner they were having problems and more likely to tell a friend. Men were more likely to seek treatment but less likely than women to tell someone they were having suicidal thoughts. Our findings are similar to other research that shows that men are more likely than women to experience addiction, whereas women are more likely to experience anxiety and mood disorders [12]. In general, individuals who are within a stigmatized cohort believe that public stigma is greater than perceived stigma, and that women are impacted by this to a higher degree than men [7].

Limitations

Despite the encouraging findings of this study there are limitations. This was a small convenience sample from a faith-based residential substance use treatment center specific to persons experiencing homelessness, SUD and MH issues thus results have limited generalizability. In addition, the data analysis conducted to this point only included frequency and percentage factors, indicating a need for further exploration of differences on other variables to find more correlational implications is needed. Our survey was led by a peer professional with SUD and anxiety and could have impacted the findings. Because of these limitations, it is unclear whether our findings of a possible connection between self-stigma and relapse or suicidal thoughts could be extrapolated to a broader population facing similar issues.

Implications

Understanding stigma and how to positively influence both internalized and societal impact on individuals facing the complexity of addiction and co-occurring MH issues is important for MH professionals to address how to remove barriers to seeking help and perhaps preventing relapse. Research supports the notion that recovery from SUD can be positively influenced by managing stigma and stigma attitudes [5]. Further, high levels of social supports from peer individuals also in recovery or having similar MH issues leading programs on stigma reduction have been shown to positively impact stigma and improve quality of life and recovery program outcomes [5,9]. This suggests that utilizing like peers and high social supports could be a beneficial addition to recovery programs.

Speaking further to the theme of stigma, most researchers are less likely to involve individuals who use substances to participate in research, due to the perception that these groups of people are more likely to provide poor data, be uncompliant and lack the capacity to consent [24]. Many researchers who do not belong to stigmatized groups study stigma from the theoretical or public perspectives and do not take into account aspects of stigmatization such as whether or not they will be accepted or rejected by others especially in a specific social situation [23]. Thus, our findings along with Nickerson et al., [9] provide support for continued need to research stigma reduction programs via social contact delivered by trained individuals within a similar stigmatized group with those living with mental illness and addiction. However, these types of interventions may be challenging to facilitate as individuals within stigmatized populations are known to avoid seeking out support for their mental illness and avoid sharing about their symptoms and personal experiences [9]. Thus, increasing understanding of stigma from persons with mental illness as a treatable medical condition may influence stigmatizing beliefs [10]. Overall, talking more about stigma and bringing public attention to it may in fact reduce stigma and stigma attitudes amongst members of society. In fact, bringing attention to stigma may reduce future stigma attitudes and encourage individuals to seek MH treatment [18].

Conclusion

Our stigma findings add to the literature on internalized and societal stigma from the perspective of adults in treatment for SUD with co-occurring MH and homelessness issues. This data revealed that persons dealing with SUD and MH issues who are experiencing homelessness are likely to tell a friend or professional that are having difficulties and accept others in their lives who have sought help.

This is promising, as other studies show a reluctance for persons with MH issues to seek professional help [11,18]. Future research on the benefits of using measurement scales containing both internalized and societal stigma constructs to help predict and prevent relapse or indicate the likelihood of seeking help for individuals with mental illness, substance use, and homelessness issues is warranted.

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