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Introduction

One of the strongest deterrents to seeking mental healthcare is the stigma associated with mental illness in our society. Johnstone (2001, p. 201) stated, “People suffering from mental illness and other mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society.” Stigma is a pernicious form of discrimination that has broad effects on the lives of those seeking treatment, their families, and caregivers. One in four of us will personally experience mental illness in our lifetime. We are all likely to deal with mental illness at some point in our life journey, whether with a family member, a loved one, a friend or professional colleague, neighbor, or with ourselves. The effects of stigma

on an individual, their families and their friends can be overwhelming (Wahl 1999; Wahl and Harman 1989). As individuals living with mental illness experience the full brunt of the disease, their loved ones experience the ramifications of the disease, right along with them. Denial, anger, fear and sadness are just a few of the emotions experienced by individuals with mental illness—the experience is much like being on an emotional roller coaster. The difficulties associated with living with mental illness are magnified by one’s experience with rejection and discrimination, which are consequences of stigma.

Deegan (1993) and Reidy (1993) provided their personal experience with stigma and how it impacts self-esteem, empowerment, hope, and sense of recovery. Accompanying the roller coaster of emotions, people who have intimately experienced mental illness encounter various challenges that complicate their lives caused by the stigma that surrounds mental illness, such as lack of social support, housing, employment, that negatively impact their mental health treatment (Borinstein 1992; Corrigan 2004; Link and Phelan 2001; Link et al. 1997; Overton and Medina 2008). Furthermore, mental illness knows no boundaries and, like any other illness, does not discriminate based on race or ethnicity. The stigma of mental illness affects all ethnic groups and cultures and it is necessary to understand that culture has a direct impact on the stigma attached to mental illness. In fact, in certain cultures individuals are less likely to seek

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mental health treatment based on their cultural beliefs surrounding mental illness, such as Latinos, Asians, and African Americans (Anglin et al. 2006). Discrimination, prejudice, and stigma also have a negative impact that may lead to mental health issues in minority populations. Kidd et al. (2011) described the powerful impact of prejudice and social stress, and its impact on the mental health of lesbian, gay, and bisexual populations. Likewise, Williams and Williams-Morris (2000) identified how racism affects the mental health of African Americans.

The Surgeon General (2015) reported that more than 43 million adults in our country struggled with mental illness in the past year. Half meet the criteria for a diagnosable mental health condition at some point in their lives; one quarter by the age of 14, and more than 20 million adults have an alcohol or drug abuse problem. Yet, in spite of how common mental illness and addiction are in our families and in our communities, prejudice and barriers to accessing care still keep too many people from getting the treatment they need. Earlier, Kessler et al. (2005) reported that researchers have noted there is a worldwide epidemic of individuals with psychiatric problems not seeking treatment.

One of the main barriers to seeking and accessing care is the stigma that occurs when one reports or is identified as having a mental illness. While most people who experience a mental illness do not have to enter an inpatient hospital setting, those who do, experience the most potent form of stigma. The individual, their families, and friends all are affected by the experience. The person can be traumatized by the sudden lack of independence, will likely remember many aspects of the experience and may need to identify it on a variety of applications for licensure, health care, housing, and/or employment. While the American with Disabilities Act (ADA) has prevented many of these overt forms of discrimination, stigma plays a subtler role and creates discriminatory practice that are not under the control of ADA regulations. This is one of the reasons that the Surgeon General identified stigma as one of the most pressing issues affecting public health. There is nothing

shameful about having mental illness and there is nothing weak about reaching out for help; however, no other medical condition experiences the degree of stigma that mental health experiences.

Stigma has the harmful consequence of diminishing motivation to enroll and participate in many forms of treatment. Aakre et al. (2015, p. 125) identified that “when the individual receives a mental health diagnosis and/or identifies as a person with a mental health condition, these stereotypes become personally relevant. This puts the person at risk for ‘self-concurrence’, or believing that the stigmatizing attitudes are true of him or herself. This is self-stigma.” Self-stigma is a major deterrent to seeking behavioral health care and is based on the negative attitude that many individuals have regarding the likelihood of improvement or the “I am so damaged that I can’t be helped.” In a survey conducted by the American Psychological Association (Miller et al. 2006), 76 % of potential consumers had low confidence in the expected outcomes of services. The self-stigmatizing attitude has been nurtured by portrayals of mental health services by the media, in the workplace, school settings and by the very professionals who provide care. The attitude that “therapist’s know best” have made many consumers feel helpless and that improvement, if it is to occur at all, is long drawn-out arcane process based only on the skills of the therapist (Corrigan et al. 2009). Self-stigma results in negative judgments we levy against ourselves based on devalued group identities (Scheyett 2005). This attitude is in conflict with what research has indicated to be the most important predictor of successful outcome: engagement and participation in treatment (Orlinsky et al. 1994).

Myers described two forms of stigma. According to Myers, enacted stigma is exterior and refers to discrimination against people with a psychiatric illness because of their perceived unacceptability or inferiority. Felt stigma is interior and refers to both the fear of enacted stigma and a feeling of shame associated with having a mental illness. Myers described enacted stigma as systemic, including the lack of parity in health insurance coverage, employment discrimination,

housing discrimination, and denial of insurance coverage for preexisting conditions. Felt stigma is how the shame and guilt that the person experiences can impact the person's willingness to seek or remain in treatment, or to reveal issues to their treatment professionals.

The cognitive and emotional reactions to stigma resemble the effects that have been duplicated in behavioral research studies on the phenomenon of learned helplessness (Seligman 1977). Learned helplessness is the person's inability to see any effective solution to an environmental stressor. It is caused by a series of experiences in which the person learns that nothing they do matters to change the stressful situation and the belief that your actions will be futile. Learned helplessness can be prevented if, before the experience with helplessness occurs, the person learns that his/her actions can make a difference. Unremitting learned helplessness can lead to hopelessness and depression.

A major problem in combating stigma is the lack of public awareness of the advances made in the field of psychiatry and behavioral health over the past several decades. Too often, perceptions are guided by the media which portrays psychiatric inpatient hospitals as "snake pits" or that all patients are undergoing intensive, five-day-a-week psychoanalysis or experience arcane treatments, such as lobotomies. Vast ignorance continues to exist in society with respect to the advances made in psychiatry and other mental health fields, which coupled with the pervasive stigma attached to having a mental illness prevent people from recognizing, seeking, and receiving the help they need (Fung et al. 2010). Further complicating matters is the myth that the American character should embody one of strength and self-reliance and being able to take care of ourselves. This false perception continues to take precedence over the concept that mental illness is a biological illness that is treatable and not self-induced (Fink and Tasman 1992).

The way that mental illness is portrayed in the media and the entertainment industry has significantly contributed to stigma. Stigma (like beauty) is in the eye of the beholder, and a body of evidence supports the concepts of stereotypes

of mental illness (Byrne 1997, 2000; Philo 1997; Townsend 1979). Goffman (1961, 1963) described the difference between a normal and a stigmatized person as a question of perspective, not reality. Public (or social) stigma is the awareness of stereotypes that the public and society holds about people who are living with mental illnesses. In movies, this often means portraying characters with mental illness as physically violent and unpredictable. A salient example is the 1978 movie, *Halloween*, in which the villain is a patient who escaped from a mental institution and terrorizes everyone he encounters. Public stigma also involves prejudice, or ascribing to stereotypes that foster negative emotional reactions, such as fear and avoidance. With the rapid evolution of media, it has become a powerful tool for most of us to learn, to understand, to seek advice, and obtain knowledge.

Research has shown that many people get their only information about mental illness from the mass media (Wahl et al. 2002). What they see and hear influences their thoughts and opinions. Mental Health America (1999; formerly the National Mental Health Association) reported that, according to a survey for the Screen Actors' Guild, characters in prime time television portrayed as having a mental illness are depicted as the most dangerous of all demographic groups: 60 % were shown to be involved in crime or violence. Most news accounts portray people with mental illness as dangerous. The vast majority of news stories on mental illness either focus on other negative characteristics related to people with the disorder (e.g., unpredictability and unsociability) or on medical treatments. Absent are positive stories that highlight recovery of many persons with even the most serious of mental illnesses (Wahl et al. 2002).

Inaccurate and stereotypical representations of mental illness also exist in other entertainment media, including music, novels, and cartoons (Wahl 1995). The media can perpetuate stigma, giving the public narrowly focused stories based on stereotypes; however, the media can also be a useful means to challenge and replace these stereotypes. Contrary to what is often portrayed in the media, people with psychiatric disabilities

are far more likely to be victims than perpetrators of violent crime (Appleby et al. 2001). In spite of this, Watson et al. (2004) reported that police and correctional officers often have attitudes that people with mental illness are dangerous. Researchers at North Carolina State University and Duke University found that people with severe mental illnesses—schizophrenia, bipolar disorder, or psychosis—are two and half times more likely to be attacked, raped, or mugged than the general population (Hiday 2006; Hiday et al. 1999, 2001, 2002; Phelan et al. 2000; Townsend 1979). Partially due to the media, many people associate individuals with mental illness with psychopathic or what is now known as sociopathic personality disorder. This condition represents only 1.2 % of individuals with mental illness. In fact, the vast majority of criminal acts are committed by individuals who display instrumental criminal acts, designed to obtain money or revenge (Mulvey 1994).

Over time, the media has slowly become conscious of these harmful portrayals. In 2013, the Associated Press added an entry on mental illness to its *Stylebook* to help journalists write about mental illness fairly and accurately. And, in recent years, Hinshaw (2005, 2006), Hinshaw and Cicchetti (2000), Hinshaw and Stier (2008) noted, screenwriters have made an effort to portray more humanized characterizations of individuals with mental illness. For example, Carrie Mathison on Showtime's *Homeland* who has bipolar disorder, Bradley Cooper's character in *Silver Linings Playbook* and John Nash, the Nobel Prize-winning economist, with schizophrenia in *A Beautiful Mind*. In each case, the portrayals are more realistic and hopeful, and show that individuals can attain valued lives.

What we do know today is that stigma is not a new problem. Stigmatization of people with mental illness has continued throughout history in the United States (Araujo and Borrell 2006) and can be traced as far back as ancient Greece. The word originated from markings or brandings placed on Greek slaves to clearly separate them from the common, free man. Goffman (1961, 1963), an early scholar, defined stigma "a mark of disgrace." This perception of individuals with

mental illness reduced their value as human beings and labeled them as being "less than" in society. In ancient civilizations, mental illness was thought to have been caused by supernatural forces serving, largely, as a punishment for sins. These afflicted individuals were allowed to live free as part of society, just as long as they were not dangerous.

Today, while progress has been made, from a societal as well as system perspective regarding the views, acceptance and treatment of people with mental illness, much work still remains to demystify perceptions, engage with and educate the general public and health care professionals, and build capacity for complete inclusion. Efforts to combat stigma are focused on reinstilling hope, supporting resiliency, and providing dignity to those who have been and continue to be deprived the right to fully participate in society (Corrigan and Watson 2002). These principles can be realized in inpatient settings when staffs have appropriate training and supervision.

The Dynamics of Stigmatization

Stigma and discrimination associated with mental illness is an epidemic that impacts peoples' lives in a chronic and severely debilitating manner. People who suffer from mental illness are challenged doubly. On the one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. Although research has gone far to understand the impact of diseases, it has only recently begun to explain stigma in mental illness (Brohan et al. 2010). Much work yet needs to be done to fully understand the breadth and scope of prejudice against people with mental illness. Fortunately or unfortunately, social psychologists and sociologists have been studying phenomena related to stigma for several decades and

what is known is that stigma is often internalized by individuals, and is even fostered by some health care professionals (Reavley et al. 2014; Stuber et al. 2014). This ethics-laden issue acts as a barrier to individuals who may seek or engage in treatment services.

The report *Respect Costs Nothing* is a survey that was conducted to identify how people with experience of mental illness have faced discrimination and the impact such discrimination has had on their lives (Mental Health Foundation, 2004). Respondents to this survey identified discrimination associated with mental illness in all aspects of their lives. The report highlights that fear of further discrimination often prevents people from participating in many activities. In addition, internalizing stereotypes about mental illness discourages people from pursuing dreams or goals. Lucksted and Drapalski (2015) described the pervasive effects of stigma, as “Much like breathing in polluted air, it is very hard to not take in at least pieces of societal prejudices like racism, sexism, classism, homophobia, and mental illness stigmatization” (p. 99).

The impact of stigma is twofold, public stigma, which is the reaction that the general population has to people with mental illness and self-stigma, the prejudice which people with mental illness turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination. Stigma about mental illness seems to be widely endorsed by the general public in the Western world. Studies suggest that the majority of citizens in the United States (Link 1987) and many Western European nations (Bhugra 1989) have stigmatizing attitudes about mental illness. Furthermore, stigmatizing views about mental illness are not limited to uninformed members of the general public; even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illness (Keane 1990, 1991).

Several themes describe misconceptions about mental illness and corresponding stigmatizing attitudes. Media presentations typically portray those with mental illness in three ways: people with mental illness are homicidal maniacs who

need to be feared; they have childlike perceptions of the world; or they are responsible for their illness because they have weak character (Gabbard and Gabbard 1992). Results of two independent factor analyses of survey responses of more than 2000 English and American citizen’s parallel the Gabbards’ observations (Brockington et al. 1993). The survey revealed that the public had the following perceptions of people with a mental illness: (a) fear and exclusion—persons with severe mental illness should be feared and, therefore, be kept out of most communities; (b) authoritarianism—persons with severe mental illness are irresponsible, so life decisions should be made by others; and (c) benevolence—persons with severe mental illness are childlike and need to be protected.

Although stigmatizing attitudes are not limited to mental illness, the public appears to disapprove of persons with psychiatric disabilities significantly more than persons with related physical illness (Corrigan et al. 2000). Severe mental illness has been likened to drug addiction, prostitution, and criminality (Albrecht et al. 1982). Unlike physical disabilities, persons with mental illness are perceived by the public to be in control of their disabilities and responsible for causing them (Corrigan et al. 2000). Furthermore, research respondents are less likely to pity persons with mental illness, instead reacting to psychiatric disability with anger and believing that help is not deserved (Socall and Holtgraves 1992). The behavioral impact (or discrimination) that results from public stigma have been examined in many studies and has shown that the public will withhold help to some minority groups because of corresponding stigma (Weiner et al. 1988). A more extreme form of this behavior is social avoidance, where the public strives to not interact with people with mental illness altogether and it takes four forms: withholding help, avoidance, coercive treatment, and segregated institutions.

People with psychiatric disabilities living in a society that widely endorses stigmatizing ideas, internalize these ideas and believe that they are less valued because of their psychiatric disorder. Self-esteem suffers, as does confidence in one’s

future (Allport 1979). Given this research, models of self-stigma need to account for the deleterious effects of prejudice on an individual's conception of him or herself. However, research suggests that, instead of being diminished by the stigma, many persons become righteously angry because of the prejudice that they have experienced (Chamberlin 1998). This kind of reaction empowers people to change their roles in the mental health system, becoming more active participants in their treatment plan and often pushing for improvements in the quality of services (Corrigan et al. 2000).

Low self-esteem versus righteous anger describes a fundamental paradox in self-stigma (Corrigan et al. 2000). Models that explain the experience of self-stigma need to account for some persons whose sense of self is harmed by social stigma versus others who are energized by, and forcefully react to the injustice (Corrigan 2004, 2011; Corrigan et al. 2000, 2002, 2009, 2013; Corrigan and Lundin 2001; Corrigan and Penn 1999; Corrigan and Rao 2012). In addition, there is yet a third group that needs to be considered in describing the impact of stigma on the self. The sense of self for many persons with mental illness is neither hurt, nor energized, by social stigma, instead showing a seeming indifference to it altogether.

Attitudes Toward Mental Illness and the Power of Stigma

An issue that people consider before consulting a mental health professional, or encouraging someone else to do so, is the stigma many people experience by reporting that they are in "therapy." When people engage in counseling or therapy from a psychiatrist or psychologist, they have to realize that they may have to answer challenging questions when they are posed on a job application or interview, applications for occupational or professional licensure, a driver's license,

applications for health or life insurance, and/or questions posed on school and college applications such as, "Have you ever had psychiatric or psychological therapy?" When a person applies for a job, or an occupational licensure or driver's license, or for an insurance policy, or admission to an educational program, or even better—wants to serve our country as a member of a jury or to enter the military, will often be required to answer questions about their health status. When people answer such questions, candidly and honestly, admitting to having received psychiatric or psychological help, the result all too often will be loss of important opportunities.

Answering "yes" to such questions often results in rejection for employment, licensure, admissions, acceptance, denial, and even services to one's country. Sometimes the person will be forced to ask their therapist to file a report when they apply for a license, become insured, or required by Child Protective Services to reunite a family. If, on the other hand, the person conceals their experience of psychiatric or psychological therapy by answering "no," thereafter they will have to worry, and for good reason, that they will be found out and the "cover-up" revealed (Corrigan et al. 2012).

Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun. Not surprisingly, Swarbrick and Roe (2011) identified the adverse impact that stigma has on the persons willingness to take psychotropic medications. Stigma yields two kinds of harm that may impede treatment participation: It diminishes self-esteem and robs people of social opportunities. Although the quality and effectiveness of mental health treatments and services has improved greatly over the past 50 years, many people who might benefit from these services choose not to obtain them, or do not fully adhere to the treatment regimens once they are begun (Fung et al. 2010). Stigma is one of several reasons why people make choices to avoid the

label of mental illness that results when people are associated with mental health care (Livingston and Boyd 2010).

Stigma and discrimination continue to be a reality in the lives of people suffering from mental illness and prove to be one of the greatest barriers to regaining a normal lifestyle and overall health. Negative attitudes about mental illness often underlie stigma, which in turn, can cause people affected to deny symptoms, delay treatment, be excluded from employment, housing or relationships, and interfere with recovery. Furthermore, these societal attitudes that view symptoms of psychopathology as threatening and uncomfortable are frequently the catalysts that foster stigma and discrimination toward people with mental health problems. Such reactions are common when people are brave enough to admit they have a mental health problem, and they can often lead to various forms of exclusion or discrimination, either within social circles, the workplace or in the military. Hoge et al. (2006) reported that the percentage of military personnel experiencing mental health concerns who utilize behavioral health services could be as low as 23 %. Gould et al. (2010), Kim et al. (2010), Ben-Zeev et al. (2012) and the Mental Health Advisory Team (2009) identified stigma as the most prominent reason that military personnel do not seek mental health care.

Where Did the Stigma of Mental Illness Begin?

Stigma is not a new problem and has a history that dates back to the age of what were called asylums. While these asylums no longer exist in their previous form, they represent society's efforts to deal with mental illness in what they thought was a humane approach by segregating people with mental illness from others. While long-term segregation is no longer the general approach, there continues to be a social separation between those with mental illness and others. The separation no longer needs a physical

location; it now consists of a mental attitude known as stigma.

Mental Illness and the Age of the Asylum: A Historical Perspective

The public mental health system is experiencing new challenges in a rapidly changing environment. Health care reform, economic restraint, complex civil commitment laws, and the need to ensure civil rights have placed pressures on the capacity and adequacy of state psychiatric inpatient hospitals. Today, most people with mental illness are served successfully in community settings; however, at times, those with the most serious mental illness need inpatient care provided in community outpatient or community inpatient psychiatric hospitals. While there is no broad consensus on what the role community inpatient psychiatric hospitals play in the continuum of care, the National Association of State Mental Health Program Directors (NASMHPD 2014) reported that psychiatric inpatient hospitals, including state psychiatric hospitals, play a vital role in the continuum of recovery services.

In order to fully understand the effects of stigma on individuals with mental illness, we need to examine the roles that psychiatric inpatient hospitals have played in the past and present. It is important to have an understanding of the history and the context of the mental health system in the United States, and to understand how and why state and community psychiatric inpatient hospitals function as they do in the present day. State psychiatric hospitals were originally established to reform how persons with mental illness received care. It was done with humanitarian motives. In colonial times, persons who were considered "demented" were placed in local jails or almshouse if no relative, loved one, or neighbor could care for them. With limited funding and oversight, these environments became riddled with abuse and neglect.

In the 1840s, and during the time period known as the *Age of Asylums* in the US, Dorthea

Dix, a schoolteacher from Cambridge, Massachusetts and an advocate for better treatment for people with mental illnesses, helped establish the construction of asylums. Dix led a movement to establish a national policy for caring for persons with mental illness and for federal lands to be set aside across the country dedicated to asylums as outlined in the 12–225,000 Acre Bill. The movement emphasized the need for humane care based on compassion and moral treatment, rather than ridding the person of demonic possession through corporal punishment. Care would be provided in asylums rather than housing people in jails, poorhouses, or having them live on the streets. Dix testified before the legislature in 1844 to the conditions individuals with mental illness suffered living in inhumane conditions, often without heat, water, bathrooms, and bound by chains. The stigma of being mentally ill was such an unfavorable quality that society did not feel it necessary to treat these individuals humanely.

Madness was seen as a domestic problem to be taken care of by families or parishes. If families could not care for their loved ones, they were sent to other family members for private seclusion. Further, due to the shame and stigma of having a family member with mental illness, many families hid their mentally ill relative in cellars and cages, or were abandoned altogether. During this time, society practiced social distancing by separating individuals from their families who bore the “mark of disgrace.” The effect on individuals with mental illness was deep, with an increase in the number of asylums. Care for individuals with mental illness transferred from families to asylums and further distanced people from the natural supports of their families.

Individuals living in asylums were taken care of by people who were often poorly trained and, in some cases, unsympathetic to mental illness. Further, asylums were not a place of treatment for individuals who were suffering from mental illness, but merely a place to house the mentally ill, keeping them isolated and out of mainstream society. The living conditions in asylums were deplorable, with no sanitation, no engagement with the outside world, and food was often

sparse. If individuals were given treatment for their afflictions, it followed the best practices of the times, which included bloodletting and ice cold baths. It was not until later that treatment options expanded to include shock therapy and lobotomies. Individuals and their families had neither voice nor choice in their treatment.

While the legislation Dorothea Dix advocated for passed the House and Senate in 1854, President Franklin Pierce vetoed the bill stating that the responsibility for care of persons with mental illness should be placed on the states, not the federal government. States were left to rely on state tax dollars to fund these facilities. Despite this veto, Dix’s advocacy led to the establishment of 32 psychiatric inpatient hospitals in 18 states. The implications of this veto and placement of this responsibility on states have had long lasting fiscal and philosophical effects that are still felt today.

The Deinstitutionalization Movement

Beginning in the 1950s, there was an effort throughout the United States to remove long-term patients from psychiatric facilities and place them in community-based treatment programs. The impetus of this *deinstitutionalization* movement came from a convergence of several social forces. First, with the successes in treating soldiers traumatized by their experiences in World War II, psychiatrists became optimistic about their ability to effectively treat mental disorders outside of hospital settings. Second, there was a growing feeling that the abusive conditions found in most state psychiatric hospitals, and the negative effects of long-term institutionalization, were at least as harmful as the chronic mental illness itself. Many came to believe that the civil rights of people with mental illness were being violated. Third, fiscal conservatives in the government were concerned with the enormous expense of caring for patients in large institutions. Finally, in 1954, the discovery of chlorpromazine (Thorazine), the first effective anti-psychotic medication, made it reasonably possible to manage the care of persons with chronic mental illness outside the hospital. All

together, these forces brought about a dramatic shift in admission and discharge practices at state and county psychiatric hospitals.

While this initiative could have had a positive impact on stigma in the community, the services that were needed to treat these individuals were not readily available, leading many to homelessness and jails (Butterfield 1998). The net effect was an increase in the community's perception that individuals with serious mental illness could not adapt to the community and needed to be isolated in segregated settings. While improvements have occurred in the availability of some services, there continues to be gaps that pose significant barriers to community integration.

According to Jencks (1994) the deinstitutionalization movement in the United States has been an utter disaster. Jencks (1994) reported that good care is expensive, whether it takes place in a hospital or in the community and deinstitutionalization saves big money only when it is followed by gross neglect. Furthermore, Jencks added the term deinstitutionalization, as it is applied in the United States, is a misnomer and a more accurate way to describe what took place would be *dehospitalization*. Long-term patients were discharged, while short-term inpatient care increased. Care for those suffering from chronic, serious mental illness did not change, but rather just the patterns of care. For many patients, they were merely reinstitutionalized and placed back in settings such as nursing homes and board-and-care facilities while others were relegated to temporary shelters and single-room occupancy (SROs) hotels (Jencks 1994). Perhaps the worst development of this time period would be the criminalization of mental illness and the front row seat the criminal justice system had taken on replacing the old state hospitals (Lamb and Weinberger 1998). Citing jail as possibly "our most enduring asylum," Briar (1983) noted that, "when traditional pathways of care are blocked, the local jail becomes the recycling station for some deinstitutionalized persons. Like the old asylums, the jail increasingly functions as the one place in town where troubled persons can be deposited by law enforcement and not be turned away."

In addition, since the 1980s, homelessness and criminalization amongst persons with serious mental illness has become increasingly prevalent and has been cited as a significant consequence of the gaps in policy shift from institutional to community-based care. Studies demonstrate that persons with serious mental illness are ten to twenty times more likely than the general population to be at risk for homelessness (Sharfstein 2000). For example, Steadman et al. (2009) found rates of current serious mental illness for recently booked jail inmates were 14.5 % for men and 31.0 % for women across the jails and study phases. These percentages further reinforce the substantial prevalence of inmates entering incarceration with serious mental illnesses (Sharfstein and Dickerson 2009).

The 1950s were also overshadowed by an ununiformed public perception of mental illness. Social scientists began to address questions concerning lay persons' understanding of mental illness and how they reacted to people who suffered from mental illness. The results were disheartening in that the studies revealed an uninformed public orientation toward mental illness and a social fabric that was inundated with negative stereotypes, fears, and rejection (Phelan et al. 2000). Indeed, based on interviews with over 3000 Americans, Star (1952, 1955, 1957) concluded that there was a strong tendency for people to equate mental illness with psychosis and to view other kinds of emotional, behavioral, or personality problems in nonmental health terms as "an emotional or character difference of a non-problematic sort" (Star 1952, p. 7).

Further, it was because mental illness was defined in such narrow and extreme terms that the public feared, rejected, and devalued people with mental illnesses (Crochetti et al. 1973; Gove 1982). Regardless of the source of these negative attitudes, their presence was well documented. Nunnally (1961, p. 46), for example, found that people were more likely to apply a broad range of negative adjectives such as "dangerous," "dirty," "worthless," "bad," "weak," and "ignorant" to a person labeled as "insane" or "neurotic" than to an "average" person. Similarly, Star (1952, 1955) found that many Americans, in using their own

words to describe their understanding of the term mental illness, included characteristics such as dangerousness and unpredictability. Cumming and Cumming (1955), in their study of two communities in Saskatchewan, found that most people preferred to avoid close personal contact with someone who had been mentally ill and that the researchers' efforts to change those attitudes were met with anxiety and hostility. Not surprisingly, Yarrow et al. (1955) found that fear of stigma was a serious concern for wives of psychiatric patients.

The public's negative orientation toward mental illness also extended to the professionals who treated it. Nunnally (1961) found that the public evaluated professionals who treat mental disorders significantly more negatively than those who treat physical disorders. Star (1957) found that the idea of consulting a psychiatrist enjoyed little public endorsement, with few people knowing anyone who had met with a psychiatrist or who they thought might be helped by a psychiatrist. As one respondent bluntly put it: "I don't think I'd have to go to anybody to tell me I was crazy to just hold my hand and talk to me for twenty dollars an hour. If they didn't have any more sense than to go to a psychiatrist they ought to be put in a nut house" (Star 1957, p. 3). Jennings et al. (2015) concluded, "When individuals perceive that others would view them negatively for seeking treatment, they may endorse similar stigmatizing beliefs toward themselves, and subsequently prefer handling problems on their own rather than seek treatment. Thus, heightened stigma may make individuals feel that they should handle problems themselves rather than seeking professional help."

These findings were discouraging to mental health professionals and researchers for several reasons. They implied that public education efforts regarding mental illness had produced little effect. They implied that persons identified as mentally ill might suffer extreme rejection and stigmatization. In addition, they implied that many people would fail to seek mental health treatment that might benefit them.

According to the groundbreaking first Surgeon General's Report on Mental Health (1999), in the 1950s, the public viewed mental illness as

a stigmatized condition and displayed an unscientific understanding of mental illness. Survey respondents typically were not able to identify individuals as mentally ill when presented with vignettes of individuals who would have been said to be mentally ill according to the professional standards of the day. The public was not particularly skilled at distinguishing mental illness from ordinary unhappiness and worry, and tended to see only extreme forms of behavior (i.e., psychosis) as mental illness. Mental illness carried great social stigma, especially linked with fear of unpredictable and violent behavior. With the advent of new pharmaceuticals that made it possible to moderate the extreme behavior of many who were institutionalized, it was thought that allowing patients to leave and be treated in the community would be more humane. Unfortunately without the necessary community resources, this hope was not realized.

The Community Mental Health Centers

The history of the consumer/survivor movement began in the 1960s, when President Kennedy signed the Community Mental Health Center Act and moved people with mental illness out of institutions and into community settings. The intention of the act was to deinstitutionalize people with mental illness and place them into community settings where they could receive local services. These community mental health centers developed as an important part of our mental health system and formed an important core of a growing community mental health movement. However, they were never adequately funded and so were never able to provide community-based mental health care for all those who had been deinstitutionalized. Deinstitutionalization reduced the population of state and county mental hospitals from a high of about 560,000 in 1955 to well below 100,000 by the 1990s. While deinstitutionalization eliminated over 90 % of former state psychiatric hospital beds, an adequate community-based mental health system has not been created, even today (Sigurdson 2000).

On July 30, 1965 Medicare, a federal single payer system for those over 65 and, after 1972 for those with a disability, was created. Its companion program Medicaid was also created to cover long-term care for the elderly and others, and care for mothers and children who met income guidelines. Unfortunately, to this day, Medicare discriminates against mental health coverage, charging 50 % co-pay for mental health care while charging 20 % co-pay for medical and surgical care. In addition, there was no Medicare coverage for pharmaceutical care outside the hospital setting for the first four decades of the program. As Medicaid moved to a managed care model, additional challenges emerged in serving this population. Limits on the number of psychiatric appointments and lengths of stay in hospital settings continue to exist.

The continued growth of a wide variety of pharmaceuticals led to an increased reliance on pharmaceutical care rather than hospital care for mental health as well as medical and surgical care. After the failed 1992 national health care reform effort, managed care became the standard way to organize care, including mental health care. This business model of mental health treatment helped further medicalize mental health care by disconnecting it from support services. The rise in reliance on pharmaceutical care, combined with managed care led to a decrease in other forms of therapy and support for those who were deinstitutionalized. In fact, it would not be an understatement to say that pharmaceutical companies took on a growing role in defining care options. In mental health, this led to the colloquialism, “off his meds,” to refer to someone who was exhibiting symptoms of psychiatric illness.

In speeches to medical societies in the 1940s and 1950s, Bill Wilson, the founder of Alcoholics Anonymous, noted the important role played by leading psychiatrists in the development of AA. Yet, there developed a split between the treatment of mental illness and the treatment of substance abuse and addiction. The varying stigma associated with these two sets of disorders, and the public’s and the health care community’s failure to understand their interrelationship, led to a situation where patients with co-occurring mental illness

and substance abuse or addiction were bounced back and forth between these systems because neither system was fully able to treat both disorders. This is now changing due to the new brain science that is clarifying the underlying disease processes at work and making possible the identification of effective dual-diagnosis treatments.

After the Vietnam War, military veterans fought for years to gain the recognition of the diagnosis of posttraumatic stress disorder, PTSD, as a diagnosable and treatable mental health disorder. Later it was recognized that PTSD could also affect other sufferers of trauma, sexual assault, and torture. During the conflicts in Iraq and Afghanistan, it was recognized that combat and operational stress are treatable disorders and that their immediate treatment can lower rates of PTSD in warriors who experience the stress of life in the combat zone. In addition, military health care providers are seeing the importance of traumatic brain injury (TBI) and this is leading to the recognition of the importance of treatment of this disorder throughout the health care system, and a reduction in the stigma that our wounded warriors felt when they returned home.

Consumer movements, like those that lead to the recognition of PTSD, have also grown up with a number of other mental health disorders. Consumer organizations, and organizations of family members of those with mental illness, have played an important role in recent years in raising awareness among policy maker and health care leaders in the need to treat mental illness. The consumer/survivor movement continues to advocate for many of these same consumer rights, such as (a) An individual’s rights to safe medication and other treatment, (b) Being given the facts needed to make informed choices about one’s own care, (c) The right to choose the care one receives, and (d) The right to be heard in the development of government policy and programs.

The Consumer–Survivor Movement

One set of initiatives that has addressed stigma has been the development of the consumer–survivor movement. Their efforts to inform the

public about the mental illness, their insistence on equal rights and their advocacy for appropriate services has had a positive impact on reducing stigma. These groups have called attention to erroneous media portrayals of mental illness, health insurance inequalities, inhumane practices, and inadequate community care.

The consumer/survivor movement started in the 1970s in response to decades of inadequate care in hospitals and the community. During this time, state hospitals across the country were being closed and people who were released began meeting in groups to share feelings of anger about the abusive treatment they experienced while they were there, and their need for independent living. Eventually these groups coalesced with the common desire for personal freedom and radical system change, and a liberation movement began (Zinman 2009). The groups that were part of this movement developed key principles. Members were against forced treatment, against inhumane treatment such as certain medications, lobotomy, and electroconvulsive therapy, against the medical model, and in favor of consumer involvement in every aspect of the mental health system. The groups' members, who described themselves as "psychiatric inmates," were primarily located on the east and west coasts.

The groups had militant names like Network against Psychiatric Assault, Insane Liberation Front, and Mental Patient Liberation Front. Group members developed a communication vehicle called "Madness Network News," and held the annual "Conference on Human Rights and Against Psychiatric Oppression" at campgrounds and college campuses.

Since the 1970s, there has been fierce debate over whether deinstitutionalization has been a direct cause of homelessness among persons with chronic mental illness who comprise only about one-quarter to one-third of the entire homeless population. Although the deinstitutionalization process began in the mid-1950, a disproportionate number of mentally ill persons only began to appear among the homeless population in the mid-1970. This lag of twenty years makes it impossible to claim that deinstitutionalization

was the sole cause of homelessness among persons with chronic mental illness. The prevalence of housing and employment discrimination made it impossible for many people discharged from hospitals to overcome poverty, one of the primary factors in homelessness.

Second, as originally planned, deinstitutionalization was to take place in conjunction with the establishment of community mental health programs that would take on the responsibility for the treatment of persons with chronic mental illness. President Kennedy signed the Community Mental Health Center Act in October 1963, which allocated federal funds to community clinics if they provided a full range of services, including outpatient, inpatient, and crisis services to persons with mental illness. However, these comprehensive community mental health centers were never adequately developed, and neither were the supportive services (e.g., housing and rehabilitation programs) that are necessary for maintaining individuals in the community. Thus, neglect in the community took the place of abuse in the asylum and stigma continued to grow as the community witnessed more individuals with serious mental illness living in the community without the services they needed.

The Self-help/Peer Support Movement

In the 1980s, the groups became more streamlined and its members began the process of reentering the world that they felt had previously betrayed them. The mental health system began funding self-help/peer-support programs and drop-in centers, such as On Our Own in Baltimore started in 1981, Berkeley Drop-In Center in 1985, Ruby Rogers Drop-In Center in Cambridge, Massachusetts in 1985, and Oakland Independence Support Center in 1986. The federal National Institute of Mental Health Community Support Program funded consumer/survivor-run programs. Statewide consumer-run organizations, such as the California Network of Mental Health Clients, began in 1983. Rights protection organizations were developed and there were gains in protective legislation.

More consumers/survivors began to sit on decision-making bodies.

Client-Run Systems Change

The 1990s saw the fruition of changes sought in the mental health system in the previous decade with consumers being employed in the mental health system and in self-help programs, including in management level jobs. Growth emerged in self-help/peer-support programs with system-level funding from federal sources, which resulted in the establishment of two consumer/survivor-run technical assistance centers supporting self-help programs (Allen et al. 2010). During this time the consumer/survivor involvement was noticeable at most levels of the mental health system, and client-run research began. The same principles as the earlier days were expressed in positive terms, such as self-determination and choice, rights protections, stigma and discrimination reduction, holistic services, self-help/peer-support programs, involvement in every aspect of the mental health system—“Nothing about us without us”—and the concept of recovery, which encompasses all of the above.

Important developments in mental health occurred during the 1980s and 1990s to include the growth and impact of self-advocacy service recipient movement (Sledge et al. 2011). This critical movement in social justice began with the establishment of self-help groups and further expanded and formalized in the 1990s toward organized advocacy, peer-services, and roles and services within the state and in federal initiatives (Steadman et al. 2009). The 1999 Surgeon General’s Report on Mental Health and the 2003 President’s New Freedom Commission Report on Mental Health sought service recipient input and found that, “nearly every consumer of mental health service expressed the need to fully participate in his or her plan for recovery. Service recipients and families told the Commission that having hope and the opportunity to regain control of their lives were vital” (Susser et al. 1997).

Another development during this period was the amendment of the American with Disabilities Act (1990). The United States Congress found that “(1) physical or mental disabilities in no way diminish a person’s right to fully participate in all aspects of society, yet many people with physical or mental disabilities have been precluded from doing so because of discrimination; others who have a record of a disability or are regarded as having a disability also have been subjected to discrimination; (2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem; (3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services; (4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination; (5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities; and (6) the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity” (Sect. 12010).

In most recent history, the Mental Health Parity and Addiction Equity Act of 2008 reflects

reduced discrimination against people with mental illness with the understanding that financial and treatment requirements for mental illness and substance use disorders can be no more restrictive than those of medical or surgical benefits. Further, the passage of the Affordable Care Act (ACA) of 2010 may help expand access to mental health services. However, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 does not include psychiatric hospitals and community mental health centers as eligible recipients for the Electronic Health Records (EHRs) stimulus payments that general hospitals can receive. Further, there was a growing understanding of the relationship between children's and adult mental health and the effects of early childhood trauma on the person's entire adult life.

The Decade for Recovery, Wellness and the Mental Health Services Act

In the 2000s, systems culture change has occurred at all levels of the mental health system as a result of consumer/survivor involvement. The *Mental Health Services Act* (MHSA) has consumer/survivor values embedded throughout, such as voluntary promotion of self-help/peer support programs, involvement of consumers/survivors at all levels of the mental health system, inclusion of consumers/survivors to train the mental health work force, and promotion of recovery as a goal. The Substance Abuse and Mental Health Services Administration's (SAMHSA 2012) *National Consensus Statement on Mental Health Recovery* reflects basic consumer/survivor principles. Generally speaking, consumer/survivor-run programs and peer support are essential components of most mental health programs (Zinman 2009).

Many people never get to hear or experience the message that people with mental illnesses can and do recover. Staff who work in inpatient psychiatric settings are particularly challenged to see individuals who they have served living successfully in the community. Mental illness is an illness, just like diabetes and any other chronic

diseases. People with mental illnesses can recover and go on to lead happy, healthy, productive lives. They contribute to society and make the world a better place. People can often benefit from medication, rehabilitation, therapy, self-help or a combination of these.

One of the most important factors in recovery is the understanding and acceptance of family and friends and the community. The experience of support from friends, family, and professionals combat stigma by creating hope. The evocation of hope can be the most important and central element of recovery by proactively addressing situations that can be changed in a positive manner. Related to this is an acceptance of situations that cannot reasonably be altered despite one's efforts. Measures of hope have been found to correlate with a broad range of positive outcomes. Summarizing this literature, Snyder concluded that "high hope persons have a greater number of goals, have more difficult goals, have greater happiness and less distress, have superior coping skills, recover better from physical injury, and report less burnout at work." In fact, inspiring hope is the practitioner's first duty to the client and major contribution to treatment.

Promising Developments in Mental Health

Many promising developments emerged during the twenty-first century and psychiatric treatment has become highly specific by diagnosis or age groups, enabling treatment to be more individualized with more emphasis on choice. Service recipients and family members have become more educated, informed, engaged, and involved in shared decision-making. Particularly since 1990, advances in brain science, brain scans, growing understanding of brain biochemistry, advances in psychological therapy, electrical brain stimulation, and the role of the genome in brain development and functioning are bringing important new understandings to health care providers, policy makers, and the public. The concept of recovery has become more infused philosophically into care, and peer-supported

services have increased, contributing to the recovery process for people with serious mental illness.

In addition, evidence-based practices have emerged and treatment and options continually improve. The U.S. Supreme Court's *Olmstead* decision and the American Disabilities Act have also been important developments that underscore people living and being treated in the community wherever possible and at a fraction of state psychiatric hospital care costs. The recognition that mental health is integral to overall well-being has begun to drive the integration of mental health, addiction, and primary health care with an increased focus on overall health and wellness for people with mental illness. Furthermore, harmful, inhumane practices such as seclusion and restraints are being reduced and facilities are being held accountable for those practices. Frank and Glied (2008) have attributed improvements in the care for mental illness to people with mental illness being able to receive disability income and housing supports, greater care options and choice, newer medications that are easier to tolerate and prescribed appropriately, and more people with serious mental illness being treated successfully by primary care physicians.

Capacity Building for Recovery

Changing the Culture and Building the Continuum of Recovery Supports

Stigma and discrimination manifest themselves in many ways, and these barriers will need to be eliminated or significantly reduced for individuals seeking behavioral health care and gaining access to comprehensive care. Stigma needs to be eliminated not only toward individuals with mental health or substance abuse service needs, but also across professional groups, such as between primary care providers and behavioral health providers.

Inpatient psychiatric hospitals are a vital part of the continuum of care and should operate as

recovery-oriented and integrated facilities with connections to a robust set of community support services. The conditions in psychiatric hospitals and the need for humane treatment, however, have been an underlying theme driving reform over history. Since the late 1990s, the NASMHPDs has focused on national efforts to reduce coercive environments and practices to change the culture of violence that has existed in many inpatient psychiatric hospitals. Through such changes, many inpatient psychiatric hospitals have significantly altered their culture and reduced the use of seclusion and restraints.

Changing the environment, climate, and culture of the inpatient psychiatric hospitals are paramount to providing effective care. The culture of the psychiatric hospitals should be recovery-oriented, trauma-informed, culturally and linguistically competent and appropriate, transparent, hopeful, respectful, holistic, peer infused and supported, and driven by meeting the needs of the people served in inpatient psychiatric hospitals while addressing and maintaining the utmost in safety for the people being served, staff, and the community. Such cultures can create environments where those individuals being served heal and staff thrives.

Regardless of the reason for being admitted to the hospital or a person's behavior in the hospital, all people being served in inpatient psychiatric hospitals should be considered to be in the process of recovery and the focus should be to engage the person in their care and empower them to participate in making decisions about their care, with the ultimate goal of helping each person manage his or her own illness. This approach is similar to treating people with other chronic health care conditions, such as diabetes, high blood pressure, or congestive heart failure.

Inpatient psychiatric hospitals and the services provided should be respectful, person-centered, and recovery-oriented. Recipients of services should be integral in the process of recovery and should be served in the most integrated and least restrictive environment possible. This paradigm shift in thought and practice is complicated, however, by the fact that states and other key

stakeholders have varying definitions of recovery. In response to the need for defining this important and fundamental concept, the SAMHSA (2012) developed a working definition of recovery that includes the following guiding principles:

Recovery emerges from hope. The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven. Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) toward those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In doing so, they are empowered and provided the resources to make informed decisions, initiate recovery, build their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways. Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds, including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment, use of medications, support from families and in schools, faith-based approaches, peer support, and other approaches. Recovery is nonlinear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. In some cases, creating a supportive environment can enable recovery pathways. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic. Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, oral healthcare, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be comprehensive, integrated, and coordinated.

Recovery is supported by peers and allies. Mutual support and mutual aid groups, including shared experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage, engage other peers, and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps oneself. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery path. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer support for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks. An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover, who offer hope, support, and encouragement, and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, and employee) that led to a greater sense of belonging, personhood,

empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally based and influenced. Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recover. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is supported by addressing trauma. The experience of trauma, such as physical or sexual abuse, domestic violence, war, and disaster, is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster physical and emotional safety and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility. Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect. Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems, including protecting their rights and eliminating discrimination, are crucial in achieving recovery. There is a need to acknowledge that taking steps toward recovery may require great courage. Self-acceptance, developing a positive meaningful sense of

identity, and regaining belief in one's self are particularly important.

Conclusion

There are a number of ways in which inpatient psychiatric facilities can support the reduction of stigma. Creating an environment that supports recovery principles identified by SAMHSA is a significant first step. Another is involving peers in recovery in the hospital workforce. Peer support services are an integral part of assisting in individual's recovery process and need to be made available to all service recipients in inpatient psychiatric hospitals. Peer support specialists and care coordinators should be made an equal member of the treatment team.

It is important to note the fact that an inpatient psychiatric hospital is not a person's home. The focus of inpatient psychiatric hospitals needs to be on assimilating individuals back into the community quickly when they no longer meet inpatient criteria. Cultivating and fostering partnerships among inpatient psychiatric hospital personnel, service recipients, and community service providers is vital in the assimilation back to community and should be an on-going process that is integral to the individuals transition and discharge plan, and includes the community services that would be most helpful to the individuals transition back to community life. Leadership and a well-trained, professional and paraprofessional workforce are paramount in ensuring comprehensive, high quality care is timely, appropriate, and accessible to individuals who receive care in a state psychiatric hospital and the continuum care remains intact upon discharge and re-assimilation back into the community (Salgado et al. 2010).

There are also a number of specific programs that have been developed to combat stigma. Corrigan (2011) described a number of methods that are effective in marketing campaigns. Yanos et al. (2011, 2012) have introduced narrative enhancement and cognitive therapy techniques that are used in groups to treat internalized

stigma. Russinova et al. (2014) developed a peer-run antistigma photovoice intervention. Many of these techniques could be used in inpatient settings for individuals.

The National Alliance of Mental Illness (NAMI), an organization at the forefront of advancing mental health in this country, can be a major resource for hospitals and patients within hospital settings. NAMI has a plethora of supports, services, and treatment options for individuals who have to contend with a serious mental illness. Across the country, NAMI has thousands of trained volunteers that bring peer-led programs to a wide variety of hospital and community settings. With the unique understanding of people with lived experience of mental illness, these programs and support groups provide free education, skills training, and support.

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