House Human Services Committee Hearing
Eliminating Stigma in Mental Health
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Good morning and thank you for allowing me to speak with you today on the important issue of stigma and its impact on our communities. My name is Alyssa Schatz and I am the Director of Advocacy for the Mental Health Association of Southeastern Pennsylvania (MHASP) and, most importantly, a family member of someone living with a mental health condition. MHASP is one of the 3 largest MHA affiliates in the nation with more than 40 programs located throughout Southeastern Pennsylvania and Delaware. One quality that makes MHASP unique is our commitment to hiring people who are living with a mental health condition or are family members. As a result of this commitment, a significant majority of our employees identify as having some type of lived experience with the mental health system which is what drives the work we do. At MHASP the issue of stigma is very personal. Despite a wide body of evidence to the contrary, the general public still largely views individuals with mental health conditions as more being violent, unpredictable, and lacking intelligence. Today I'll discuss the consequences of these beliefs including social isolation, unemployment or underemployment, and poor physical health outcomes.

Social Isolation

A 2006 study found that when asked about their willingness to engage in various social activities with someone with depression or schizophrenia, a significant majority of people answered that they were unwilling. The study found more than ½ of people would not want someone with depression to marry into their family, nearly ½ would not want to work closely with them, and 1/3 of people would not want to socialize with them. The same study found that for someone living with schizophrenia the numbers drastically increase to nearly 70% of respondents not wanting them to marry into their family, more than 60% being unwilling to work closely with them, and more than ½ of respondents being unwilling to socialize with them[1]. So, as you can imagine, these beliefs are very socially isolating and have significant impact on the way an individual interacts with their community.

Employment Discrimination

One of the most meaningful ways we can be involved with and give back to our community is through employment. Unfortunately, despite research indicating that the majority of people with a serious mental illness would like to work, their unemployment rates remain drastically higher than the general population[2]. One contributor to these high unemployment rates is stigma in the

[1] Collins, R.L., Wong, E.C., Cerully, J.L., Schultz, D., & Eberhart, N.K. (2012). Interventions to reduce mental health stigma and discrimination. *RAND Corporation Technical Report Series.* Retrieved from: http://www.rand.org/content/dam/rand/pubs/technical_reports/2012/RAND_TR1318.pdf

[2] Marcias CLT, DeCario Q, Wang J, et al. Work interest as a predictor of competitive employment: policy implications for psychiatric rehabilitation. Adm Policy Ment Health 2001; 28:279-297.

work place. Surveys of employers have found nearly half are reluctant to hire someone with a history of mental health issues and 70% of employers would not want to hire someone taking an antipsychotic medication[3]. Further, people with mental health conditions who are working are more likely to be underemployed in menial jobs that require less skill than the qualifications they possess and are also less likely to be promoted once a psychiatric history is disclosed[4]. As a result, many people decline to disclose, and fail to take advantage of many of the employment programs that they are entitled to including requesting a reasonable accommodation underneath the ADA, utilizing the Family Medical Leave Act, Employee Assistance Programs, and requesting to use sick days for their mental health. Without accessing these available resources, many individuals become sick and stop working.

Discrimination in Healthcare

People with mental health conditions are also deeply impacted by stigma and discrimination in healthcare provision. A few years ago, a report was released that found people with mental health conditions die an average of 25 years younger than the general population. The primary causes were not self-harm or injury but preventable physical health conditions like heart disease and diabetes. Sadly, people with mental health conditions face greater barriers to accessing care and are more likely to experience discrimination once there. A survey conducted by The Mental Health Foundation found that 44% of respondents with a mental health condition felt they had been discriminated against by their physician and the most common complaint was that their physical health problems had not been taken seriously[5]. A 2012 study found that people with mental health conditions were less likely to be prescribed medication for common conditions like heart disease than their counterparts without a psychiatric history[6]. When self-reported physical health symptoms are not taken seriously it can truly be a matter of life and death. Additionally, despite the fact that people with mental health conditions have one of the highest rates of tobacco use, both physical and mental health providers are less likely to suggest tobacco cessation. Of course, none of this is rooted in ill will. Physical and behavioral health providers all pursued these careers to help people, but we need to make a commitment to taking these health disparities seriously and work to improve our practice.

In relation to interpersonal stigma and discrimination as I've discussed with the examples of employers and physicians, MHASP echoes The Scattergood Foundation's recommendation to invest in contact strategies which have been shown to be the most effective method of combatting interpersonal stigma.

In addition to the interpersonal discrimination individuals with mental health conditions experience, there is also institutionalized discrimination. Historically, people with mental health

[3] Scheid TL. Employment of individuals with mental disabilities: business response to the ADA's challenge. Behav Sci Law 1999; 17:73-91

[4] Stuart, H. (2006). Mental illness and employment discrimination. Curr Opin Psychiatry Retrieved from www.medscape.com/viewarticle/542517

[5] The Mental Health Foundation. (2002). Pull yourself together! Retrieved from: http://www.mentalhealth.org.uk/content/assets/PDF/publications/pull_yourself_togther_update.pdf?view=Standard

[6] Mitchell, A.J., Lord, O., & Mallone, D. (December, 2012). Differences in the prescribing of medication for physical disorders in individuals with v. without mental illness: meta-analysis

conditions have faced more barriers to accessing care than people with physical health conditions. Insurers imposed higher deductibles and co-pays, more restrictive treatment limitations, and more onerous paperwork requirements for mental health services. Fortunately, a 2008 federal law designed to remove this type of institutionalized discrimination called the Mental Health Parity and Addiction Equity Act was passed and signed into law by President Bush. This law stated that insurance plans providing a behavioral health benefit could not place more restrictions or barriers to care on behavioral health than they do on their physical health benefit. Unfortunately, enforcement authority has been left largely to the states and Pennsylvania is lagging far behind on enforcing this law. One way the general assembly can reduce institutionalized stigma is by passing a law supporting the enforcement of parity.

Thank you for your consideration of this important issue. I look forward to working with all of you to reduce interpersonal and institutionalized stigma against people with mental health conditions. I welcome any questions you may have.