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[SPEAKER_01]

In this episode of Café Morel, Sarah Heen from the University of Stavanger in Norway talks with Will McCoven from Northumbria University in the United Kingdom about stigma, discrimination and the impact this has on the recovery of people who are suffering from mental health and substance use issues.

The discussion explores self-stigma, compassion fatigue amongst practitioners, and the importance of creating more empathic and inclusive services.

Finally, they discuss how research networks, practitioners, and people with lived experience can all work together to build local capacity and reduce stigma across different communities so that we not only not stigmatize, but we actively promote anti-stigma practices as well.

Welcome to Café Morel and conversations about stigma, discrimination and recognition.

I'm in the studio today with Will McCoven, an associate professor from the Department of Social Work, Education and Community Wellbeing at Northumbria University in the United Kingdom.

Will, welcome.

Thank you very much for talking to us over the North Sea.

[SPEAKER_04]

No problem.

[SPEAKER_01]

Yeah, so tell us a little bit about yourself.

[SPEAKER_04]

So I have a practice that's back around 14 years as a drug and alcohol mental health and social service worker.

A lot of time working in the voluntary and the community sector.

So I'm a very untraditional PhD student, if you like.

And I ought to support individuals who are using substances and who had mental and health families, but also young people and adults as well.

And the last part of my work was concerned with understanding the experiences of people when they engage with services, but also quite a lot of work around about recovery and how people got better.

So the majority of my work now is concerned with recovery barriers to participation for people in shaping and designing services, but also concerns with trauma and with stipend as well.

Coming to my PhD, my PhD was a PhD in sociology.

At Newcastle University.

And that was concerned with the social and psychological processes of recovery. The actual structure in the programming, the intervention to look at the social and psychological processes that are occurring as the intervention is occurring as well.

[SPEAKER_01]

I just wanted to pick up, especially because we're particularly interested in the group we are working with, the Morrell group that we're working with, about sort of stigma and discrimination.

You talk about these being one of the barriers to recovery of individuals with these challenges.

So I was wondering how you understood words like stigma.
What is stigma?
What is discrimination?

[SPEAKER_04]

Stigma basically relates to having a negative perception or a negative set of beliefs about groups or individuals.

We all, as individuals in life, we all have and understanding of who's deserving and who's not deserving in my mind and in some instances this is at the forefront of my mind I'm not saying because we're like saying you're deserving you're not deserving but we have a value set and a basis and a perception of people based on how they present to us and some groups are viewed very negatively in society I don't want to say that that's all right but

Because it isn't all right.

It is okay to have a negative perception of people.

It usually occurs through a lack of knowledge or understanding.

But stigma occurs...

When you have a negative perception of individuals or groups in society, prejudice then occurs when you have a negative emotional response to that group's error.

And it's the negative emotional response that's problematic because that's prejudice.

It is okay to maybe not understand a group, so have a negative view.

I suggest if you're sick like that just now, please go and make contact with that group.

Try and learn more about that group.

But stigma is basically the label.

Prejudice is the negative emotional reaction that people have to groups or individuals.

And discrimination occurs when that person or that group is treated differently.

And I know there's lots of different models that describe stigma processes, you know, corrugations, I think there's four stages to that.

As in self-stigma, people need to be aware of the stigma, they're aware of the labels, they engage in the behaviour, they identify and reflect on that.

But for me, stigma is a psychological and social process, then that means it's preventable.

Stigma comes in lots of different forms.

Many people think stigma is just about language and the language it's used.

When we speak about values, I'm speaking to a colleague about this for a day, and when an individual chooses to become involved in the care of others, you know, primary care, public health, social care, their values are intrinsically embedded in the idea that they want to help other people.

There might be a corresponding narrative about having a secure and stable job and doing what you do, but lots and lots of practitioners who I speak to come into this role of work and they have a strong value set and belief about involving people, empowering people, supporting individuals and making sure services are relevant.

What happens somewhere along the line, practitioners say to me in practice, is that those sites

they lose the focus of their work and they become overburdened.

I think the workforce, people get tired, they get fatigued.

In the UK, there's not a lot of resource and people get fatigued and tired

trying to support people who are accessing services.
What practitioners say to us on what anti-stigma course is,
I'm carrying a big caseload.
I don't have a lot of support.
Sorry, I'm going to say that there is lots and lots of really fine services,
but practitioners that come to us will say, I don't have a lot of support.
I carry a big caseload.
I don't have a lot of time to invest in people.
So my values don't really matter because what I would like to do is superseded
by my role in terms of what I have to do and what I have to record and how I
have to engage with people.
And practitioners tell the story and practice how they come to work, they get
tired, they get fatigued, they feel burdened.
They try to be compassionate towards the people who they work with, but the
systems that they work in don't support them enough.
They have less tolerance.
They find it difficult.
So their values as a caring professional clash and are affected by
compassion, fatigue, if you like, but then also having to work within systems
and develop meaningful relationships with people.
Everybody's stretched and everybody's stressed.
People's own values, if you like.
People don't just lose their sense of self or their self-concept.
People who use social media, people who suffer from medical ill health, realise
at some point that they're different.
They use all their lives.
socially isolated lives.
They realise they're different and they can engage in the process of
self-discreditation.
And self-discreditation is when you look at a behaviour that you have yourself
and you discredit yourself for it.
I cannot do this.
Again, a little example.
Imagine if you're walking somewhere and you don't eat your alcohol use to the
stresses and strains of walk.
Then you take some time off to look after yourself, but you find that you're
still drinking the same amount of alcohol.
You've removed that external source or that idea that you think is fueling your
alcohol.
You're saying you won't be left with yourself to blame.
So it doesn't become about your luck, it becomes about you.
When people engage in that self-discreditation,
That process is often compounded by social mortification.
I know that's a little bit wordy, but social mortification occurs when somebody
uses a negative label against you.
Deep, I'll use you because of the characteristics that you have.
And if that person's significant in your life,
then that has a compounded effect on your own self and how much you value
yourself.
And loads of people who I speak to in practice and loads of people who I speak
to as an academic tell me the story about being a burden to other people
not valuing yourself.
What do you value and what do you want?
Quite a lot of people get involved in different subcultures and different

contexts.

It can be difficult to actually identify what you actually want to do or where you want to go moving forward as well.

why should we challenge stigma and why should we tackle stigma?

There's a number of different imperatives really, isn't there?

So, you know, we can speak to a number of different audiences here.

You know, there's a moral imperative, there's a harm imperative, there's an economic imperative, there's a preventative imperative.

And why we should tackle stigma or why we should try and promote that anti-stigma practice is

stigma and the stigma experienced by different groups well the stigma that's caused by accessing services can actually be worse than the stigma that people experience in society so there's a prevention there's an idea of a prevention here that we should be trying to tackle stigma because morally

We know that stigma has an effect on people's social, psychological and physical well-being as well.

If people feel less stigmatised, they're more likely to engage with services, they're more likely to accept support to service, moral imperative service, and that's the thing that's important to me.

And aren't you saying what really simply is the right thing to do?

regardless approaching the people who you work with approaching services developing services creating policies should all be done with a level of empathy and understanding towards how people experience life but also how people experience services as well and when we talk about different types of stigma as well we tend to forget what's associated stigma

And there's courtesy stigma as well.

The associative stigma is the stigma I talk about carers and people who care for people who use substances.

So just because people are discriminated against because their father, son, daughter

person within their kinship group who's using substances, they're judged because of that.

That has an effect on them, on their psychological and social well-being as well.

But they also come with a stigma.

And this is the big elephant in the room for me.

This is the stigma that's felt by healthcare professionals themselves because of the mind of what they do.

And I've experienced this myself through

You know, the work that I've done with young offenders, why are you wasting your time working with that group?

You know, that's a lifestyle choice, that behaviour.

So if we look at areas for research, it'd be like, you know, how does practitioners own experiences?

I can't assist, I've no effect on practising what they do.

You know, I know, we have a big and a large recovery community in England and Scotland as well, four big organisations.

And they come to me on the anti-stigma course that we do and say, well, you know, it's really difficult to put your hand up.

It's really difficult to challenge this stigma when it's embedded in services because you don't want to be the voice of dissent.

You don't want to be that person, you know, that voice of negativity.

And what practitioners talk about, what's really important, Sarah, is how do you challenge stigma, but also maintain a positive working relationship with

people as well?

So, you know, within the drug treatment system, how do you call somebody out for stigma?

but also be able to come back to get support from the next person who's going to need support as well.

[SPEAKER_01]

You were talking about national indicators in the UK.

I wasn't sure, what are the national indicators?

[SPEAKER_04]

I'm part of the National Stigma Indicator Research Team in the UK.

here in England and what I can so I'm not leading the project but I am involved in the project so I could give you a little bit about what I think the project is about

The project very much, there's an international network and anybody, you know, it's being led in the UK by Professor Harry Sunderland, who's an amazing, you know, subject to expert and Professor Carla Trollier in Australia.

doing very similar work in Australia and the UK.

And the National Stigma Indicator is a two-year project that's running in England.

And it's about trying to develop a stigma indicator to identify where.

So there's two surveys in it.

One survey is about, it's aimed at professionals.

Do they know what stigma is?

Can they identify it?

Where do they see

and practice and other stigma indicators for people who have access and services for support with drug and alcohol issues and concerns so that that's the two main components of it and it's a two-year project it's due to finish at the end of this year and the findings will be published in december so you might need to come back to me or see if i can share the report with you and that's about identify where stigma is evident where it can be seen, who is affected by it, and to sort of lay a benchmark down.

Part of that work is the development of a training source as well, developed by people with lived experience.

I call it a training resource.

It's an online resource that can be used as well.

These aspects are not being evaluated.

They're just being developed as they go.

The team are trying to develop an range of resources as well.

But key to it, Sarah, and the key thing is, have you ever heard of the National Stigma Indicators being developed in six or seven local authorities in England?

The team who are going to do the research and the team that Harry's got together in each of the local areas are creating local forums.

of practitioners and people who are interested in stigma.

And this is another thing about research as well.

If you develop a survey, why don't you get a group of people together within that local area?

You know, people who are stigma curious, people, professionals who want to know about it.

And in each of the local authority areas, there's been attempts to develop a network of connected professionals for different areas to bring them together.

And the idea is that you build capacity,
Without services, there's a lot of good work that can be done in developing
different types of interventions and understanding stigma.
But if you can get into local communities, local systems and local networks,
you're able to build capacity.
And that's what research should be about.
How are you improving the lives of local communities?
Anybody that's thinking about doing a PhD, think about how can I do this piece
of work?
But is there a small or a larger piece of sustainable work that I can do as
part of this work by developing a network as part of my PhD?

[SPEAKER_01]

The network that we've tried to bring together to you as a member of the
Morrell project as well.
And I suppose in some ways we have the same thing.
We came into the project having perhaps not as a huge understanding of
discrimination and stigma, but with multiple people with multiple skills.
And actually what we're trying to do now is by talking to people like yourself
is to
build our local capacity here in Norway, but also in our partner countries.
So I think the overlap I'll put at the end of this podcast, actually, I'll try
and I'll find a link to the work that you said, Harry, when people were doing
and that you're involved in because it's
I think I like that idea both for us as a research network or as a research
consortium building our capacity, but for how our PhD students can actually
help us do that through much more action research maybe.
But you mentioned, I think, also an intervention that you currently run that's
aimed at, I think, community and health professionals.
Is that right?
I wonder if you could say a little bit more about that particular intervention
that you're working on.

[SPEAKER_04]

So in relation to the work that we're doing here, I finished my PhD in 2017 and
published a PhD, published a couple of papers after the PhD.
I had a very small piece of data, which I was interested in, and that was why
do people stay in self-help groups for 9 and 10, 11, 12 years?
And I wanted to know, so who is this group of people that stay about long term,
even after they stop using substances?
So I applied, I got together with my group and we applied for an IHR funding.
It was an individual career development award and I wanted to look at people
with co-occurring mental health and substance use issues and concerns.
Why were they hanging about groups for so long or attending groups?
They were actually supporting other people.
They didn't have a lot of resources.
They didn't have a lot of social networks.
So it's called sponsorship.
So people went to being a group participant, to being a sponsor.
So they went back or supported other people in the group.
Individuals with stigmatisation are something that's really important to me.
Do not have a lot of social credit.
You don't just stop using substances and then get better.
Lots of people do.

Lots of people do.

Your ability to get better and your ability to meet your own needs are going to depend on the networks that you have and your ability to attract other people to you and social relationships.

Why?

Well, people don't have a lot of social credit.

So we found that stigma was endemic across services.

Every interview that we did, I think we did 18 qualitative interviews post-PhD.

Wow.

with professionals and 12 interviews with people with lived experience and they all spoke about stigma and we had our provider the Newcastle City Council one of our partners on this so we had a public partner and we had revival as a lived experience group we sort of wanted partners to develop this work

So we presented it at a mental health conference and off the back of that we were asked to work with people who lived experience to develop an intervention for professionals.

That was in 2024.

So we get some resources that we had, we got some academics together, we get people who lived experience and we get professionals together and we wrote a one-day Einstein course that we piloted in Northern Ireland.

And the basic, based very much off the back of the National Stigma Indicator, we wanted to develop local forums.

We wanted to make people, make practitioners aware of stigma, help them to understand what stigma was, help them to understand what their values and priority areas were, and then to understand different types of interventions.

So we applied to NIHR again, the three schools of mental health, to do a process evaluation of how we implemented the intervention, you know, was it acceptable, who put themselves forward for it, the different professional groups, the mechanisms of change and the different activities that we use in relation to group work, presentations, case studies, but then to look at the implementation of it, sorry, not the implementation, the barriers over certain areas,

that inhabited professionals to implement in our stigma practice.

So that's the work that we are doing just now.

here in the UK.

It would be great if they could put a link to our website on there.

That would be fabulous if people were interested in reading it.

But I think I'm not taking a lot of the credit for what's going on here.

There's a whole international stigma indicator.

There's Liverpool, John Moores, Bristol, University of UCL, Durham University.

There's a whole raft of academics.

You've got massive teams.

that I'm involved in and people with lived experience.

The process evaluation will really quite probably do as well as in, and I think this would be the key thing that I would say to people who are thinking about getting a PhD in this area as well, is align yourself to somebody who shares your passion for this line of work or somebody who has the expertise to move you forward.

And don't be scared to ask professors

for more time you know and do not have all the answers to the questions you know having a basic idea is a really good starting point for moving forward so on the process evaluation that we have now we have

academics for Keele University, Bristol University, UCL, Newcastle as well.

And I can't remember what, there's three of us writing papers off the back of

our watches now.

[SPEAKER_01]

You were talking about one of the things that we're interested in is that there seems to be all this huge amount of research involved to people who are focused on mental health and discrimination against people with mental health issues on the one side.

And then you've got people looking at discrimination against people with substance misuse or substance use issues on the others.

And I suppose it's so often that these two conditions are off each other and that somebody will have both challenges.

Do you think that the intervention or the program that you're dealing with, could that be for discrimination against single attributes?

Or do you think there's something different about people that have both problems or have an intersectional list of problems, is there something that you would do differently if you're dealing with somebody with not necessarily a diagnosis but dual challenges or co-occurring challenges?

[SPEAKER_04]

When we talk about a mental health, mental health and substances.

Two of the things that, sorry, one of the things that became immediately apparent to us after we had done this was the applicability of the generalised nature of stigma.

It's really sad that it's so endemic in society.

And we are currently working, there's a stage one grant that I'm not leading on, that I'm in, being led by Dr Hayley Alderson, looking at father inclusive practice.

and try to think a little bit less traditionally about where stigma is experienced.

In healthcare, we do tend to think about mental health and substance use, but we don't tend to think so much about what would that mean if we looked at a fathering course of practice language on where are fathers involved, where are men involved in systems, and where are men discriminated against within criminal justice systems and with adult social care as well.

So that's going and we're currently working with a group of mothers in Newcastle and we're looking to develop a resource, if you like, for mothers who have experienced the grief of child loss and mothers whose children have been taken into care.

So we're at a very early stage of developing that work and developing the acts like my course to look at that area.

So the intervention, we're not saying that as the answer, but we say this on the course as well.

This isn't the answer to your problems.

This is a very small part, a larger process of change that has to occur in your area, right?

So that's what we're saying.

We are a range of practitioners, and this is something that NIHR have given us funding to do.

And what they have actually said is, yeah, we get it.

We get it.

And then I asked the substance use, how is that?

How would that statement be reduced by a housing support worker?

somebody in adult social care, somebody in primary care, how could they learn

from your course?

And there's two things here.

The first thing is that having a mix of professionals the different backgrounds, the different professional backgrounds and context is really good because it provides a sense of validation for people.

So say if I'm working in social care, you have to trust me here, if I'm working in social care, it's reassuring to know that a GP shares my concerns about stigma.

It's really important to know that somebody else shares my concerns.

It's not just me.

That's why I'm so strong here.

There was a sense of validation and a shared learning across a community of practice, if you like, where you have a group of people with values and beliefs who come together in this area.

And what we found is there's a whole people who are closer and people who work with

on a daily basis with people who use drugs and alcohol have a greater level, I don't want to say because we don't want to get into that scientific debacle, but they have a greater level of empathy towards the people who are in the workplace because they know their lives, they understand their lives and what's happening.

So maybe people in housing who can be really inclusive as well

But people for housing and people who work in domestic violence services will say, God, this has really made me think about my approach and the terminology that I use and how is this relevant to me and what I do.

And we don't necessarily... We try and give people some answers, but we don't necessarily give them the answers, a straightforward answer.

What we try to do is to get them to go away and think, think about the practice, think about the spaces that they work in.

I feel...

The book that myself, Michelle Addison, and my partner have written on drug stigma and identity, we recognise that professionals, healthcare professionals working one-to-one with the least powerful in relation to reducing stigma or particular types of stigma.

And I would suggest that the course that we have helps professionals understand how stigma is linked to their own self-compassion, their own self-awareness of themselves and the environments and the context and the pressures that we're working and practicing self-compassion.

We then look at interpersonal and interpersonal relationships and how they can reduce stigmas in others and self-stigma, but also in relation to their practices as well.

And we like to encourage

people to look at service level, operational, the touch that they have within teams and how they can affect the teams that they work in.

So the course that we do, I would like to say, it can be lifted, it can be used in a different context, which is something we're really excited about trying to do.

The people will have the experience because they need to be there for that.

But then also thinking about what are we doing right and what are we emphasising that we could improve on.

We spend a lot of time talking about the solutions to stigma, which are relatively easy.

Mm-hmm.

to implement, but we don't talk about the barriers that people face in practice

to get them to that point.

And I think that's going to be one of the key things that we are going to take forward as we develop the intervention, but also as we look to implement it, to do an implementation study as well.

[SPEAKER_00]

We would very much like to design or implement some of the anti-stigma interventions that you've worked on here. And we're not really sure if we should just do what already works, like learn for yourselves and replicate it in a written context or whichever context.

[SPEAKER_01]

But we're also particularly interested in, I suppose, the assumption or the hypothesis that a lot of stigma or perceived stigma or discrimination or perceived discrimination comes from people making decisions that are perhaps made in times where they haven't been able to articulate why they're making a particular choice.

So, for example, if a health professional is needing to make a choice about who to, they have to allow somebody to have access to a hostel.

And they have to make a particular choice.

And that choice, they may offer that hostile accommodation to a particular individual and deny access to another individual based on what we might say were because the person had a substance misuse issue, for example.

And we would say that was discrimination.

But we're pushing forward or trying to articulate that if somehow decision-making was articulated better or if the person was able, but if they were able to be given the competence to articulate the decision for themselves and for the person they're dealing with in a clearer way, that this might either reduce their own discrimination so that if their decision quality is better, discrimination would be less likely, or or actually if the person there that is receiving the discrimination understands why the decision has been made because there's a lot of stuff about procedural justice that they might actually think well actually this isn't about the fact that i'm a man and i've got substance misuse and i've also got a mental health condition it's because of other situations is it because actually that person there isn't a hostile place available but

But these are very early ideas, but I wondered if you had any sort of thought about if we're improving decision-making quality, if that would be interesting or is that naive?

Is that perhaps not feasible, not practical?

[SPEAKER_04]

This idea of procedural justice, which I don't know a lot of specifically, but I think I have a routine understanding of it.

And people who use, people who come into contact with services, what you have to understand, sorry, what we have to understand is that this person... may have been in contact with tent services or living services and experienced a lot of stigma and discrimination in their life.

And you had made the point earlier on about stigma getting under the skin and this is the idea that there's psychological and social impacts of stigma but the physical impact and the tiredness and fatigue that comes along with accessing services.

So you as a healthcare professional

Success by getting under the skin is about the physiological.

It's a metaphor for the physiological aspects of it.

Okay.

But if you're a professional, you're working with somebody, you're well-intended, you're doing the job you want to do, and you have to deliver some bad news to somebody, you need to understand that that person could have experienced enduring, enduring, damaging forms of stigma before in the past. And they may very well see it as rhetoric.

You might see it as a professional rhetoric.

It's not necessarily about stigma.

It's about not being able to articulate their own needs and being able to meet their own needs.

And if you tell somebody the example you gave was a hostel, but they can't get the accommodation, it's to understand that that person might then internalise that as a why me, why me narrative.

It's always me.

or I've really tried on this occasion today what I had to do and here I am again I'm using drugs but I'm still being judged still being judged and I'm still being punished and that's not being explained to me now what you do as a professional and I've done aspects of this work with men who are violent and it's to front load it's to front load the meeting and to front load that process and talk to them about

You know, what are we, what are we, what are we focused on in a relational context?

What are we going to do in this environment?

What can we do?

What will be a setback?

How you deal with a setback and how you respond to that setback.

There's a learning opportunity there for people because that is unfair.

And it will be felt as an unfair process for people if they're trying really hard to get where they want to be and if it is actually discrimination and they're being discriminated against.

And it's about working with that person.

Quite a lot of the time during the early days of health and social care work in my practice as well, I worked with people for a significant amount of time.

I felt that I never really moved them on.

And when I was staying there, Sarah, I was building a relationship with people.

Do you know what I mean?

I was getting to know people to understand them.

If you know about somebody's motivations, if you know about their ex-demos, if you know about their support networks, you're then able, when they don't get what they want, when they don't get what they need, because of stigma and discrimination, you can then support them.

You know how they're going to be affected.

You've discussed how they're going to be affected.

But you've already got the strategies there to talk to them about how they're going to get support on an ongoing basis.

It's a fascinating area.

We practitioners, what I say is to you, what we do is we tend to remove, in terms of like child, I'm not going to say these checklists or we have these risk indicators that we use for professionals to identify risk and to make decisions about people's lives, some of which are experienced in being highly discriminatory.

We don't understand about the emotional.

So as a practitioner, coming back to the very, very start again, if we think

about stigma, prejudice and discrimination, it's about asking our practitioner, are you having a negative emotional response to this person?

And if you are having a negative emotional response, do you understand the implications of that?

And are you the best person to deal in that situation?

The biggest thing that we have is introducing procedural justice because lots of practices are truly embedded in there.

We've got loads of practice experience to draw on.

And speaking as a practitioner myself, they can be quite reluctant to engage in that area of work and say, well, it's not about me.

I'm doing my job.

I've done this job for 20 years.

I'm drawing on my experience and values.

I'm a kind person here.

But if they haven't explored the emotional response and their self-prejudices against people, then chances are they're likely going to be prejudiced and discriminated because of the decisions that they're making.

I have seen this in practice as well, where I've had housing, I'm going to go back to housing again, I'm sorry, I've had housing professors who say, I've never thought about the way that my language or the way that I interact with this person could have been affecting my self-esteem or would have had to engage with me.

You know, that could be about anything, you know, like banter.

You know, some people would say, look at these people, they're trying to develop a relationship.

And I'm like, how are you, Lizzie?

Sorry, you want to get a job?

Come on, you can't spend the rest of your life doing this, you're in recovery.

And they don't see it.

It's a very mild example that I'm giving you, but they don't see that as, all right, okay, I get you.

[SPEAKER_01]

There's one key message that you would like people to come away with from today's conversation.

What would it be?

[SPEAKER_04]

The thing that I would like people to come away with is the fact that there's a difference between not stigmatising and promoting the idea of stigma practice. What do you mean by that?

Don't conflate these two ideas.

The first thing is that you can passively, I hate the word passively, but you can passively look at your own practice and your own self-law and say, you know, I don't stigmatize and I don't discriminate against people and I've got really good understanding of who I am in relation to these people, my values, and I strive to work in this area.

And that's something that I tend to do as an academic as well.

But there's a difference between knowing that and then actually promoting anti-stigma practice.

And anti-stigma practice is about getting out in your community, making a commitment to yourself to understand your inner self-compassion, how compassionate you are towards yourself, but also thinking,

When we talk about insiders, the key thing that I would say, as an insider, as

a researcher, as a professional, if you understand stigma, if you understand discrimination, the power, how power is differentiated within that in all different aspects.

If you think about inequality, if you think about fairness and discrimination, you have the skills and the knowledge to promote anti-stigma work.

You have the ability to understand it.

Stigma in its institutional forms, cultural forms.

So the thing that I would say is move beyond just treating people well, treating people kindly and fighting for people's rights and services.

Move beyond that and engage in anti-stigma practice and see where in your practice you can create opportunities to develop anti-stigma work.

be that promoting the recovery community advocating for people having compassionate conversations challenging policies you know bringing in training and conventions thank you for listening to an episode of Cafe Morel