

Annual Review of Clinical Psychology
Mental Illness and Substance
Use Disorder Stigma: Mapping
Pathways Between Structures
and Individuals to Accelerate
Research and Intervention

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Keywords

addiction, intersectionality, mental illness, substance use disorder, stigma, structural stigma

Abstract

Researchers, interventionists, and clinicians are increasingly recognizing the importance of structural stigma in elevating the risk of mental illnesses (MIs) and substance use disorders (SUDs) and in undermining MI/SUD treatment and recovery. Yet, the pathways through which structural stigma influences MI/SUD-related outcomes remain unclear. In this review, we aim to address this gap by summarizing scholarship on structural MI/SUD stigma and identifying pathways whereby structural stigma affects MI/SUD-related outcomes. We introduce a conceptual framework that describes how structural-level stigma mechanisms influence the MI/SUD treatment cascade via (a) interpersonal- and individual-level stigma mechanisms and (b) mediating processes among people with MI/SUD (i.e., access to resources, psychological responses, behavioral responses, social isolation). We consider intersections between MI/SUD stigma and stigma based on race/ethnicity, gender identity, and sexual orientation. Finally, we discuss the implications of this review for future research, interventions, and clinical practice.

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INTRODUCTION

Stigma increases risk for both mental illnesses (MIs) and substance use disorders (SUDs) and undermines every step of the MI/SUD treatment cascade. Evidence suggests that stigma associated with a wide range of social statuses (e.g., race, gender, sexual orientation, chronic illness) leads to MI symptoms (e.g., depression, anxiety, posttraumatic stress disorder, and others) and substance use (e.g., substance use initiation, frequency, and problems) (Hatzenbuehler et al. 2013). It further suggests that stigma undermines outcomes related to MI/SUD treatment (e.g., diagnosis, engagement, retention) and sustained remission and recovery (e.g., recurrence of symptoms, access to recovery capital) (Corrigan et al. 2014a, Earnshaw 2020). To date, most research on MI/SUD stigma has focused on the individual and interpersonal levels, for example, by examining how experienced or internalized stigma is associated with MI/SUD treatment-related outcomes. Yet, researchers, interventionists, and clinicians are increasingly recognizing the importance of structural stigma in MI/SUD risk and in undermining MI/SUD treatment and recovery.

Hatzenbuehler & Link (2014, p. 2) define structural stigma as “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized.” Unfortunately, there are many examples of structural stigma that may influence MI/SUD-related outcomes. These include legal restrictions on the rights of people with

MI/SUD, discriminatory laws and policies established during the US War on Drugs, stigmatizing language and stereotypes in news coverage of MI/SUD, the lack of integrated MI/SUD care, and others (Becker et al. 2023, Bhugra et al. 2016b, Corrigan et al. 2005a, Walters et al. 2023). Despite increasing recognition that these forms of structural stigma are harmful, the pathways that link structural-level stigma with MI/SUD-related outcomes have been understudied. A better understanding of these pathways could lead to innovative intervention strategies and evidence-based practices to address structural stigma and improve the well-being of people with MI/SUD.

In this article, we aim to address this gap by mapping the pathways between structural-level stigma and outcomes related to MI/SUD risk, treatment, and recovery. After introducing key concepts related to MI/SUD stigma, we summarize emerging research on structural-level MI/SUD stigma and identify pathways through which structural-level stigma affects MI/SUD outcomes. We introduce a conceptual framework summarizing the hypothesized pathways that link structural-level stigma with outcomes along the MI/SUD treatment cascade. We conclude by considering the implications of this review for future research, interventions, and clinical practice.

WHAT IS MENTAL ILLNESS AND SUBSTANCE USE DISORDER STIGMA?

Our scholarly definition of stigma has evolved since Goffman (1963) first introduced it more than 60 years ago. Below, we share a contemporaneous definition of stigma and describe ways in which stigma is manifested at the structural, interpersonal, and individual levels. We introduce a conceptual framework (**Figure 1**) to guide our review of the pathways through which structural-level stigma shapes outcomes along the MI/SUD treatment cascade. These pathways are informed by theory and empirical research linking structural-level stigma with health inequities across a range of stigmatized statuses (Bailey et al. 2017, Hatzenbuehler et al. 2024, Philbin et al. 2023). The MI/SUD treatment cascade is modeled after cascades of care developed for depression and opioid use disorder (Pence et al. 2012, Williams et al. 2019).

Stigma and Its Functions

In his seminal book on stigma, Goffman (1963) defined stigma as a socially devalued or discredited attribute and emphasized that stigma emerges within the context of interpersonal interactions. Importantly, definitions of stigma have evolved since Goffman introduced the term to the scholarly literature. Although scholars who cite Goffman's definition often describe stigma as something that individuals have, scholars relying on more contemporaneous definitions describe stigma as something that societies do. Link & Phelan (2001) defined stigma as a social phenomenon or process that emerges at the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination. They emphasized that this social process is reinforced by power. We use this definition of stigma to guide our review.

Like all social phenomena, stigma is theorized to exist because it serves functions in society. Phelan et al. (2008) theorized that some MIs are stigmatized because of an evolved drive to avoid people with perceived infectious disease (which may not always actually be infectious), who may threaten individuals' health and well-being. They further theorized that some other MIs and SUDs are stigmatized because of a societal attempt to enforce social norms. In this case, stigma is used to encourage conformity by punishing those who deviate from "normal" behaviors. Phelan et al. (2008) note that this function of stigma applies to behaviors that are perceived to be voluntary or under personal control. Importantly, individuals may have limited or no control over the onset, progression, and/or course of their MI/SUD, given that environmental, genetic, and

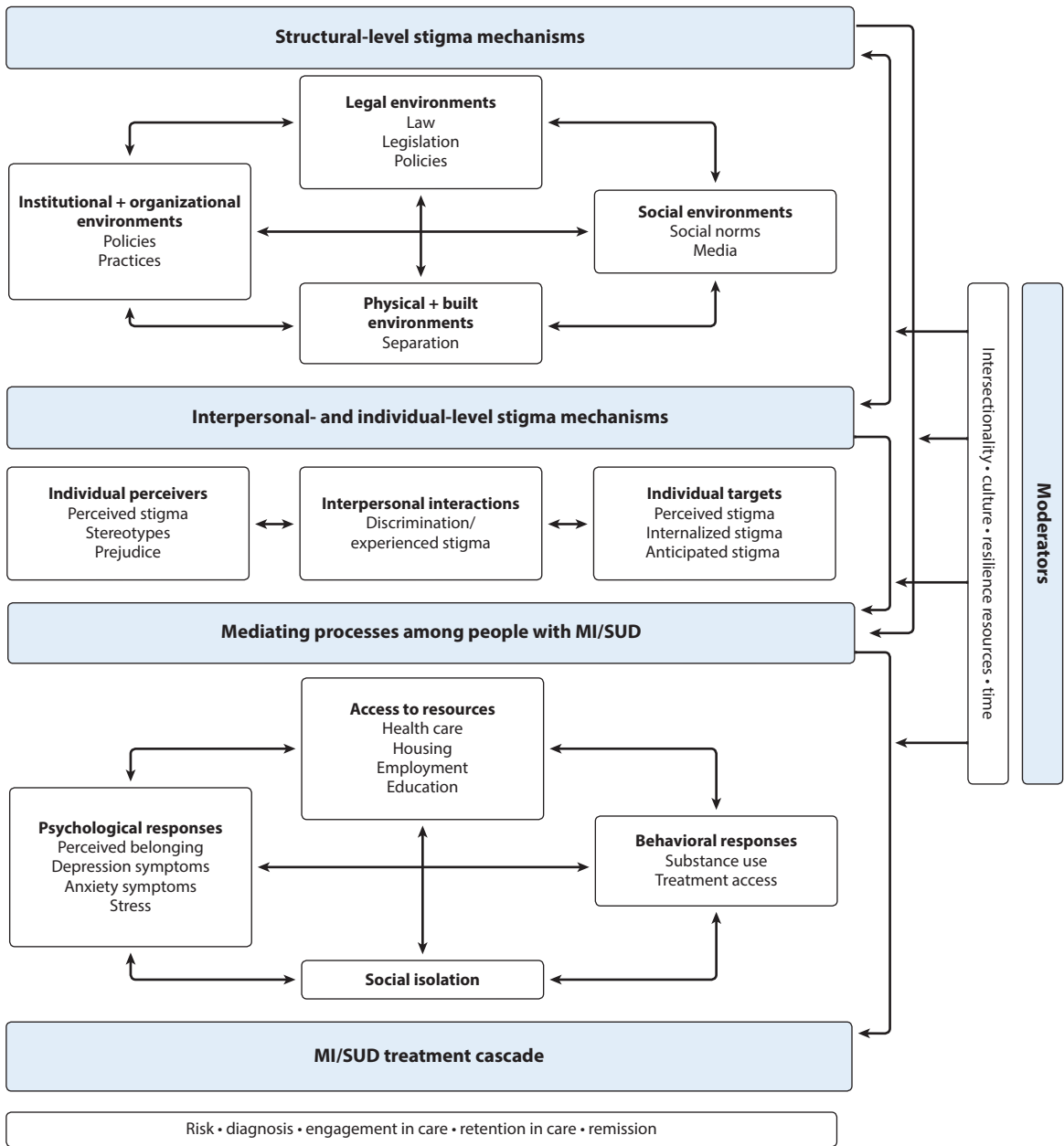


Figure 1

Hypothesized pathways linking structural-level stigma with outcomes along the mental illness and substance use disorder (MI/SUD) treatment cascade. Individual targets include people with MI/SUD, and individual perceivers include people not necessarily with MI/SUD (e.g., family members, friends, coworkers, employers, teachers, health care providers, police officers, and other community members). Bidirectional arrows between mediating processes indicate interconnection between these processes, and bidirectional arrows linking structural-level stigma mechanisms with individual- and interpersonal-level stigma mechanisms reflect their influence on one another.

social factors coalesce to increase individuals' risk of MI/SUD and undermine successful recovery (Volkow et al. 2016).

Despite this contradiction, public health campaigns have attempted to leverage stigma to promote health and well-being in the contexts of substance use and mental health (Brewis & Wutich 2019). For example, public health campaigns in the United States and elsewhere heavily stigmatized tobacco use in the second half of the twentieth century. This denormalization strategy, so called because it emphasized that tobacco use is not normal, has been widely critiqued for several reasons (Brewis & Wutich 2019). First, denormalization campaigns assume complete personal control over health behaviors, ignoring environmental, genetic, social, and other forces that shape behavior. Yet, as noted above, individuals do not necessarily have complete personal control over MI/SUD. Second, stigmatizing public health campaigns are designed to generate shame. Ironically, shame undermines rather than motivates positive health behaviors. People may cope with the shame of tobacco use via continued tobacco use. Finally, denormalization strategies often create and widen health disparities. In the case of tobacco, denormalization was more effective in reducing tobacco use among people with more socioeconomic resources than those with fewer socioeconomic resources. We therefore echo other scholars (e.g., Brewis & Wutich 2019) who caution against denormalization strategies that wield stigma in an attempt to promote public health in the contexts of substance use, mental health, and other areas of disease prevention.

Structural-Level Stigma

As shown in our conceptual framework (**Figure 1**), stigma is manifested at multiple social-ecological levels within society. Inspired by Link (2001) and consistent with our previous theory and research (Earnshaw 2020, Fox et al. 2018a), we use the term stigma mechanism to refer to the ways in which the social phenomenon of stigma is manifested, expressed, and/or experienced at these multiple levels, ultimately affecting people with stigmatized statuses. Consistent with earlier stigma theory (Hatzenbuehler & Link 2014, Link & Phelan 2001), our conceptual framework differentiates between stigma manifested at the structural level and at the interpersonal/individual levels. We briefly introduce broad categories of structural-level stigma mechanisms in this section, and then expand on these categories in the context of MI/SUD below.

At the structural level, stigma manifests within legal, institutional and organizational, social, and physical and built environments. Much research on structural stigma has focused on legal environments, which include discriminatory law, legislation, and policy within societies. Teitelbaum et al. (2021) note that laws and policies are interrelated but have different purposes. They define a law as “an established procedure, standard, or system of rules that members of a society must follow” (p. S265) and note that laws include constitutional law, statutes, regulations, and case law. Discriminatory laws are those that adversely target stigmatized populations (Underhill et al. 2024). Legislation generally refers to the process of preparing and enacting laws. Although most research has focused on associations between existing discriminatory laws and health outcomes, some work demonstrates that discriminatory bills under consideration and debate have negative impacts on people with stigmatized statuses (Hatzenbuehler et al. 2019). Teitelbaum et al. (2021, p. S265) define a policy as “a decision or set of decisions meant to address a long-term purpose or problem.” They further note that laws and policies exist at multiple structural levels, including federal, state, tribal, and local levels.

Structural stigma also manifests within other key aspects of the environment. In their paper introducing a framework for public health law research, Burris et al. (2010) define the environment as both social institutions and structures as well as the physical, including built, environment. Given the importance of these different aspects of the environment, and consistent with previous

theorizing on structural stigma (Hatzenbuehler et al. 2024, Philbin et al. 2023), our framework differentiates between three additional aspects of the environment. First, structural stigma manifests in discriminatory policies and practices of institutions and organizations, such as health care organizations, workplaces, criminal justice systems, educational organizations, and others. Second, structural stigma manifests in the social environment, which includes social norms as well as the media, including newspapers, television, Internet and social media, and other forms of communication (Corrigan et al. 2005a, Hatzenbuehler & Link 2014). Third, structural stigma manifests in the physical environment. The built environment includes aspects of the physical environment that have been shaped by human intervention (e.g., buildings, roadways and other forms of infrastructure, agriculture). Importantly, structural-level stigma mechanisms are interrelated. For example, Burris et al. (2010) suggest that law and policy can influence the environment via legal practices or through the implementation and enforcement of law and policy. Similarly, social norms can shape the legislative process, resulting in discriminatory laws targeting stigmatized groups.

Interpersonal- and Individual-Level Stigma

Stigma mechanisms exist among both individuals with the stigmatized status (including people with MIs and/or SUDs), or targets of stigma, and people who do not necessarily have the stigmatized status (such as family members, friends, coworkers, employers, teachers, health care providers, police officers, and other community members), or perceivers. Both perceivers and targets may perceive stigma. Perceived stigma includes the extent to which individuals believe a social status is stigmatized. Much research focuses on perceived stigma among individuals, including other perceivers and targets within one's community (Fox et al. 2018a, Link 1987). This research suggests that whether an individual possesses a stigmatized status may shape the extent to which they perceive stigma, and that perceived stigma can negatively shape outcomes among targets of stigma. Recent research has drawn further attention to the importance of perceived structural stigma, or the extent to which individuals perceive that stigma is manifested at the structural level within their distal (e.g., federal laws) and proximal (e.g., local social norms and organizational policies) environments (Lattanner & Hatzenbuehler 2023, Lattanner et al. 2021).

Perceivers experience, express, and enact stigma in their thoughts and feelings in several ways. Stereotypes are the cognitive component of stigma, encompassing thoughts, beliefs, or cognitive schemas about members of a stigmatized group (Corrigan 2005, Fox et al. 2018a). People with MI/SUD are broadly stereotyped as dangerous, responsible for their condition, and incapable (Feldman & Crandall 2007, Yang et al. 2018). Beyond these broad stereotypes, evidence suggests that stereotypes differ depending on the specific MI or SUD. For example, people with schizophrenia are viewed as more violent than people with depression, and people with alcohol use disorder are viewed as having worse character than people with opioid use disorder (Perry et al. 2020). Prejudice is the affective or attitudinal component of stigma, encompassing emotional reactions and feelings toward a stigmatized group (Fox et al. 2018a, Phelan et al. 2008). Research suggests that prejudice toward people with MI/SUD includes feelings of fear, anger, and anxiety and that prejudice toward people with MI includes feelings of pity (Fox et al. 2018a, Yang et al. 2018). Perceivers may hold stereotypes and prejudice explicitly, or with awareness, or implicitly, or without awareness (Dovidio et al. 2008).

Targets may also experience and express stigma in their thoughts and feelings. Internalized stigma involves endorsing negative beliefs and feelings associated with one's stigmatized status and applying them to the self (Earnshaw 2020, Fox et al. 2018a). Internalized stigma, which is also referred to as self-stigma, involves directing prejudice and stereotypes toward the self. Luoma et al. (2012) identified shame as the "emotional core" of internalized stigma and found that feelings of

shame are common among people with SUD. Research suggests that people with MI/SUD use stigmatizing language to refer to themselves (Blyth et al. 2023, Huggett et al. 2018). Anticipated stigma involves expecting to experience stereotypes, prejudice, or discrimination from others in the future due to one's stigmatized status (Earnshaw 2020, Fox et al. 2018a). Anticipated stigma involves metaperception, or perceiving how others view the self (Kenny 2019). Self-perceptions, which include internalized stigma, play a sizable role in the formation of metaperceptions (Kenny 2019). Anticipated stigma may also be shaped by individuals' past experiences of stigma as well as perceived stigma in their environment.

The interpersonal level of our model reflects interactions between perceivers and targets. Discrimination is the behavioral component of stigma and includes unfair or unjust behaviors that perceivers direct at targets (Allport 1954, Brewer 2007, Fox et al. 2018a). Some earlier theory and research used the term discrimination to refer to the stigma that perceivers enact and the terms experienced stigma, enacted stigma, and perceived discrimination to refer to the stigma that targets experience (Earnshaw 2020, Fox et al. 2018a). We therefore include both discrimination and experienced stigma within the model but recognize that they essentially refer to the same phenomenon. Discrimination can range from major, acute experiences, such as a perceiver firing someone because of their SUD or a target losing their housing due to their MI, to more minor, chronic experiences, such as a target experiencing daily hassles when accessing their SUD medication or a perceiver acting rudely toward a target with MI.

Moderators

Moderators can shape the extent to which a social status is stigmatized, the ways in which stigma mechanisms are expressed and experienced, and the pathways through which stigma mechanisms affect the MI/SUD treatment cascade. Researchers, interventionists, and clinicians are increasingly recognizing the need to adopt an intersectionality lens when seeking to understand and address stigma (Else-Quest et al. 2023). Berger (2004) introduced the concept of intersectional stigma in her research exploring the lives of women living with HIV, who may experience stigma due to their gender, HIV status, race and/or ethnicity, drug use, sex work, and/or other social statuses. Berger highlighted that intersectional stigma “represents the total synchronistic influence of various forms of oppression, which combine and overlap to form a distinct positionality” (p. 3), and results in the experience of a “qualitatively distinct form of stigma” (p. 4) that affects individuals’ “identity, resources, and participation” (p. 18). Therefore, people with MI/SUD may experience stigma associated with their other social statuses, which may fundamentally shape both their experiences and outcomes of stigma. Below, as we map the pathways through which MI/SUD stigma manifested at the structural level ultimately affects individuals, we pay special attention to intersections with race/ethnicity, gender identity, and sexual orientation in light of the MI/SUD disparities that affect members of minoritized racial/ethnic, gender (including cisgender women and gender diverse individuals), and sexual orientation groups.

Culture and resilience resources moderate experiences and outcomes of stigma. A rich body of literature has drawn attention to the important role of culture in MI stigma. In a recent study of more than 11,000 participants from 11 countries, Krendl & Pescosolido (2020) found greater MI stigma, including stereotypes, prejudice, and discriminatory potential, in Eastern versus Western countries. They also found that these differences were driven, in part, by participants' attributions of MI to a moral (e.g., bad character) versus biological (e.g., genetics) origin. Other research has suggested that cultural differences in beliefs about MI shape differences in MI stigma (Misra et al. 2021) and that individuals with MI in collectivist cultures may be more vulnerable to internalizing stigma that they perceive and experience in their environments (Yu et al. 2021). Resilience

resources are multilevel strength-based assets of individuals and their communities that can buffer individuals from the harmful impacts of stigma on health (Dulin et al. 2018, Earnshaw et al. 2013). Examples of resilience resources include identity processes, adaptive coping skills, social support, and neighborhood characteristics.

Experiences and outcomes of stigma also change over time (Earnshaw et al. 2022). For example, MI/SUD stigma has changed in somewhat complex ways over the past several decades. In Germany between 1990 and 2020, schizophrenia stigma became more severe and depression stigma slightly improved (Schomerus et al. 2022). The impact of stigma may also shift as people age; some research suggests that adolescence and emerging adulthood (when many people experience new onsets of MI or SUD) are sensitive periods for experiences of stigma (Earnshaw et al. 2022). Additionally, a growing body of research suggests that after gaining a new stigmatized status, such as MI or SUD, people appear to be vulnerable to internalizing stigma, which may undermine their well-being and act as a barrier to treatment engagement. After losing a stigmatized status, such as when people with SUD transition into recovery, the magnitude of the stigmatized identity may shrink and ultimately be replaced with other valued identities (Earnshaw et al. 2022).

WHAT IS STRUCTURAL MENTAL ILLNESS AND SUBSTANCE USE STIGMA?

Research on structural stigma has surged in popularity over the past decade. And while there is a continually growing and robust body of research developing around structural stigma for racial and sexual minorities, research on structural MI/SUD stigma is still in the early stages. Structural stigma changes over time, sometimes rapidly, particularly in the context of MI/SUD. For example, social norms and policies surrounding substance use and SUD continue to evolve in the United States as the opioid crisis continues to unfold and War on Drugs policies face growing critique (Perry et al. 2020). Below, we provide a brief review of the existing literature on structural stigma in the four environments identified in our conceptual framework (**Figure 1**): legal, institutional and organizational, social, and physical and built.

Legal Environments

Evidence of structural MI/SUD stigma can be found in the legal environment, which encompasses discriminatory laws, legislation, and policies focused on the rights and freedoms of individuals experiencing MI/SUD. Legal restrictions on the rights of people with MI/SUD occur around the globe. Only 21% of United Nations member states allow people with MI to enter into contracts (Bhugra et al. 2016b), and 36% deny people with MI the right to vote (Bhugra et al. 2016a). Bhugra et al. (2016c) found that more than one-third of United Nations member countries prohibit marriage for people with mental health problems, and in 11% of countries, a mental health problem could be used to void or annul a marriage.

In the United States, federal drug laws and policies have had a profound and disproportionate effect on individuals with SUD. In the 1970s, the United States declared the War on Drugs, which included the implementation of a series of strict laws for drug-related crimes and the founding of the Drug Enforcement Administration to enforce those laws (Walters et al. 2023). The 1986 Anti-Drug Abuse Act advanced the War on Drugs by providing more than a billion dollars in funding for enforcement and increasing both the number and length of mandatory sentences for drug-related offenses. As a result, the number of individuals incarcerated for substance-related offenses increased substantially, and by the 1990s, more than half of incarcerated people in the United States were estimated to have an SUD (Belenko & Peugh 2005).

The effects of the US War on Drugs extend beyond criminalization and mass incarceration. Cohen et al. (2022) argue that “drug war logic” has become embedded within other structures of life in the United States, prioritizing criminalization and punishment for substance use across a range of domains that affect health and well-being, including housing, education, and health care. Policies such as mandatory reporting, zero-tolerance workplaces and schools, background checks for housing, and compulsory drug testing mean that much of the surveillance, enforcement, and punishment for drug use has shifted from police and the judicial system to community institutions (e.g., employers, health care providers, landlords) (Cohen et al. 2022).

Historically, individuals with MI/SUD were also affected by a lack of health care insurance parity (NASEM 2016). Prior to the passage of the Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act of 2010, insurance companies could treat MIs and SUDs as preexisting conditions, deny coverage, use different reimbursement rates for mental and physical health care, and limit visits for in-network and out-of-network providers. The lack of parity created a financial burden for individuals with MI/SUD and likely played a contributing role in the decreased treatment seeking, worse physical health, and increased mortality experienced by individuals with MI/SUD. Although parity laws should have put MI/SUD care on an equal footing with physical health care in terms of insurance, critics have argued that employers and other health insurance providers continue to offer less coverage for mental health claims (Scarborough 2018).

Funding allocation for research and resources is another example of policy-related structural stigma. Social psychological research has demonstrated a link between individual-level stigmatizing attitudes and funding allocation decisions. For example, Corrigan et al. (2004) found that negative attitudes about people with MI were associated with resource allocation around mandated treatment. Similarly, DeLuca et al. (2017) found that attributions of blame and anger were positively associated with funding for vocational rehabilitation, while attributions of dangerousness and fear were negatively associated with funding support for supported housing, court supervision, and outpatient commitment. Around the globe, a general underinvestment in mental health underlies the lack of access to high-quality mental health care (Mahomed 2020).

Institutional and Organizational Environments

One of the most important sources of structural stigma for people with MI/SUD is the health care system (Pugh et al. 2015). Although provider attitudes can reflect individual-level stigma, they can also reflect the broader attitudes or culture of an institution, affecting the quality and quantity of health care provided to people with MI or SUD. The language used by health care providers to describe patients with MI/SUD is an important source of structural stigma. Weiner et al. (2023) used a large language model to analyze more than 500,000 medical notes for patients with substance-related diagnoses; they found that 61.6% of patients had at least one note containing stigmatizing language. Notably, the language health care providers use to describe patients (e.g., “substance abuser” versus “having an SUD”) can affect clinical judgments and the quality of care provided (Healy et al. 2022).

In their review of structural discrimination against people with MI, Voldby et al. (2022) note that although there is consistent evidence that people with MI receive worse physical health care compared with people without MI, most of this research has focused on patient-level predictors and not on macro-level factors such as provider attitudes and institutional policies and practices that likely affect health disparities for people with MI/SUD. Ungar & Knaak (2024) argue that in the call to address structural stigma in health care, there is a tendency to focus on addressing the relationship between social inequities (in, e.g., race, sexual orientation) and their impact on health

outcomes. However, there is an equally important need to address structural stigma around disease state inequity, which they define as the “inequitable deprioritization, devaluation, and othering of mental health and substance misuse health (compared to physical health) within our healthcare delivery, governance, knowledge building, and training systems” (p. 1446).

Evidence of structural MI/SUD stigma is also found in employment and housing contexts. Individuals with MI are more likely to be unemployed than people without disabilities, and recent data demonstrate that workplace discrimination claims related to having a mental disorder make up 30% of all claims (Appelbaum 2022, Moreno 2022). Experimental studies have demonstrated that individuals with MI are less likely to receive an employment callback (Hipes et al. 2016) or get an interview when they report having been out of work because of depression (Baert et al. 2016). Drug testing in employment settings can be a barrier to hiring or lead to termination among people who use drugs, have an active SUD, or are in the early stages of SUD recovery (Earnshaw 2020). Similarly, housing agency policies often deny services on the basis of current or past drug use, disproportionately affecting people with SUD (Earnshaw 2020).

As mentioned above, individuals with MI/SUD are disproportionately represented in the criminal justice system. More than half (56%) of people in state prison have a current or past mental health problem (Maruschak et al. 2021). A report from the Vera Institute of Justice notes that nearly three-quarters of people with a serious MI in jails also have an SUD, and 83% of individuals with an MI in jail do not receive treatment (Cloud 2014). Historically, in addition to the War on Drugs, one of the biggest contributors to the funneling of people with MI and/or SUD into the criminal justice system was deinstitutionalization. Driven by the perception that mental institutions were cruel, the prospect of new medications, and a desire to save money, state mental hospitals began closing across the United States in the 1950s and continued closing for several decades (Yohanna 2013). A series of legal decisions over the past several decades designed to grant and/or protect the rights of individuals with MI/SUD have also put restrictions on institutionalization, favoring a move toward community-based treatment (Yohanna 2013). However, deinstitutionalization was not accompanied by federal and state funding to support the short- and long-term care needs of individuals with serious MI. Instead, the number of people with MI and/or SUD who are incarcerated or unhoused has risen, and they are unable to access sufficient health care to support their well-being.

Social Environments

At the social environmental level, structural MI/SUD stigma manifests in social norms and the media. Research on social norms related to structural-level stigma often involves aggregating attitudinal data collected from individuals within specific geographic areas. For example, Evans-Lacko et al. (2012) found that individuals living in countries with less stigmatizing attitudes and higher rates of treatment seeking reported less self-stigma and experiences of discrimination. Relatedly, Bracke et al. (2019) found that in countries with more stigmatizing beliefs about MI, individuals encountered more barriers to seeking mental health care.

Newspapers and online media sources both reflect and shape the public’s attitudes toward people with MI/SUD. Studies examining newspaper articles for structural stigma find evidence of stereotype-driven content and negative portrayals of individuals with MI, with a focus on dangerousness and violence (Corrigan et al. 2005a, Voldby et al. 2022). Interestingly, Voldby et al. (2022) found that although there is evidence of negative portrayals of people with MI in newspapers, discriminatory coverage of MI has been decreasing over time. With respect to substance use, McGinty et al. (2019) analyzed news coverage of the opioid epidemic from 2008 to 2018 and found that nearly half of all articles included stigmatizing language. The language used

to describe people with MI/SUD reflects social norms and is in itself an important source of structural stigma. As noted above, stigmatizing language is common in health care settings (Weiner et al. 2023). Using Google Trends data from 2004 to 2021, Conway et al. (2022) examined the use of stigmatizing (e.g., “addict,” “junkie,” “substance abuser”) and nonstigmatizing words and phrases (e.g., “substance use,” “opioid use disorder”) related to substance use in Google searches over time. They found that Google searches containing stigmatizing language decreased over time, while the use of nonstigmatizing language increased, perhaps reflecting a gradual decrease in SUD stigma driven by the broader medicalization of SUD in recent years (Walters et al. 2023).

MI/SUD stigma is also reflected in social media. In an analysis of Twitter tweets posted in 2015 and 2016, Robinson et al. (2019) found that 12.9% of tweets about MI were stigmatizing. They further found that the prevalence of stigmatizing tweets varied by MI type, with more stigmatizing tweets posted about schizophrenia (41%) than depression and obsessive-compulsive disorder (less than 5%).

Physical and Built Environments

Physical space has been used as a tool for reinforcing the separation of “us” versus “them” that characterizes the stigmatization process. Creating and maintaining physical boundaries are key ways in which stigma is manifested toward people with MI/SUD. Traditional models of care for MI/SUD treatment have used a refer-out model, where patients with MI/SUD are provided referrals to specialty care. As such, treatment facilities for MI/SUD treatment are often in different physical locations than the acute care facilities (emergency rooms, urgent care, primary care offices) that people with MI/SUD may present at for initial treatment. However, patients who are referred out to specialty care are less likely to initiate care or continue care once initiated versus when MI treatment is integrated into primary care (Rowan et al. 2021). Within acute care settings, qualitative research focusing on the experiences of individuals who inject drugs suggests that the physical space in which care is provided is a source of stigma, with some describing it as a “prison” where they are constantly surveilled and prevented from moving freely around the facility (Rehman et al. 2024). Harris & McElrath (2012) found that patients who received medication for opioid use disorder reported that they received treatment in poorly maintained facilities, lacked privacy (e.g., received methadone in front of other clients), or were sequestered in makeshift areas (e.g., phone booth within a store, behind a temporary screen). Furthermore, the separation of addiction treatment from other health care services reinforces labels and stereotypes and contributes to negative public attitudes toward people with SUD (Becker et al. 2023).

Within local communities, “not in my backyard” (NIMBY) movements reflect the opposition and rejection of placement of mental health and substance use resources and facilities into the community. Despite the existence of evidence-based, effective treatment options for SUD (e.g., syringe exchange programs, drug checking, medications for opioid use disorder), NIMBY efforts often curtail access and availability of these services to those most in need (Becker et al. 2023). NIMBY movements often focus on the perceived negative effects of having treatment resources located in the community, including negative impacts on home values, increased crime, concerns around aesthetics, and overall costs to the community (Davidson & Howe 2014, Kolla et al. 2017).

Intersecting Structural Stigma

Structural MI/SUD stigma cannot be fully understood without consideration of the ways in which it intersects with other types of structural stigma, particularly those associated with race, gender, and sexual orientation. A robust and growing body of literature has documented ways in which structural racism contributes to health disparities (e.g., Bailey et al. 2017). Redlining and

residential segregation are powerful forms of structural racism that have led to racial minorities being concentrated in neighborhoods that differ from majority-White neighborhoods in terms of the economic, physical, and social environment, which in turn limits access to employment, education, and health care (Williams & Collins 2001). Other forms of structural racism that have received empirical attention include institutional racism in health care settings, state-sanctioned violence, political exclusion, and disproportionate exposures to environmental toxins (Bailey et al. 2017). Although the intersections of structural racism and MI/SUD stigma are arguably generally understudied (Kapadia 2023), scholars have long pointed to the ways in which structural racism and SUD stigma intersect within War on Drugs laws and policies. Throughout the history of the United States, laws and policies related to drug use have disproportionately harmed and incarcerated Black and Hispanic Americans (Walters et al. 2023).

Scholarship on structural sexism has focused largely on stigma manifested in legal, institutional and organizational, and social environments (Homan 2019). Laws restricting women's reproductive rights continue to be introduced and passed throughout the United States, and evidence suggests that females of reproductive age experience psychological distress after losing the right to legal abortion (Dave et al. 2023). Similar to underinvestments in MI/SUD research, there has historically been an underinvestment in women's health research, with funding disproportionately favoring diseases that affect men at the expense of those that affect women (Mirin 2021). Structural sexism in employment settings is reflected in pervasive income and wealth inequality as well as environments that foster sexual harassment (Homan 2019).

Research on structural stigma directed toward sexual and gender minorities is rapidly proliferating. Hatzenbuehler et al. (2024) recently reviewed this literature and found that more than half of studies have examined legal environments, focusing on the impact of discriminatory laws or policies (e.g., legal restrictions on the right to marry, "don't say gay" bills making their way through state legislatures). Other studies have examined aspects of social environments (e.g., aggregated attitudes, prevalence of bullying or hate crimes) or physical environments (e.g., prevalence of gender and sexuality alliances). Hatzenbuehler et al. found a consistent association between structural stigma and poor health, including in relation to mental health and substance use, among sexual and gender minorities. Gender minorities are currently being targeted in laws and policies that limit their access to gender-affirming care. Twenty-four states have introduced or passed bills that limit access to gender-affirming care for high school-aged youth, 25 states have laws that restrict sports participation for transgender youth, and 10 states have laws that restrict bathroom access in K-12 settings to sex assigned at birth (Redfield et al. 2024).

HOW DOES STRUCTURAL STIGMA AFFECT MENTAL ILLNESS AND SUBSTANCE USE DISORDER RISK, TREATMENT, AND RECOVERY?

Although there is increasing recognition that structural stigma harms the health of stigmatized populations, our understanding of how structural stigma affects health remains limited (Hatzenbuehler et al. 2024, Lattanner & Hatzenbuehler 2023). As shown in **Figure 1**, we propose that there are several pathways through which structural stigma ultimately shapes outcomes along the MI/SUD treatment cascade. Mediating processes among targets play a key role in these pathways, linking stigma mechanisms at the structural, interpersonal, and individual levels with outcomes along the MI/SUD treatment cascade. We build on theory from Hatzenbuehler et al. (2013) to identify categories of mediating processes, including access to resources, psychological responses, behavioral responses, and social isolation. These mediating processes are interconnected. For example, psychological responses to stigma (e.g., depressive symptoms) may lead to behavioral responses (e.g., substance use), which may ultimately shape SUD treatment- and

recovery-related outcomes. Similarly, structural-level stigma mechanisms and individual- and interpersonal-level stigma mechanisms are interconnected. Although much theory and research focuses on the influence of structural-level stigma mechanisms on individual- and interpersonal-level stigma mechanisms, individual- and interpersonal-level stigma mechanisms can also influence structural-level stigma mechanisms. For example, individuals create laws and policies as well as construct physical and social environments (Earnshaw 2020). Below, we define and summarize key findings related to each category of mediating processes among targets.

Access to Resources

Structural-level stigma mechanisms profoundly shape targets' access to resources that can promote positive outcomes across the MI/SUD treatment cascade. Discriminatory law, legislation, and policy can affect access to MI/SUD-related care as well as resources that promote recovery capital and well-being among people with MI/SUD, such as housing, employment, and education (Best & Hennessy 2022). For example, the lack of true health care insurance parity between physical and mental health conditions, despite some policy efforts to achieve parity, ultimately undermines access to and quality of MI/SUD care (Scarborough 2018). This lack of access to MI/SUD health care resources, in turn, undermines MI/SUD treatment-related outcomes. Similarly, laws and policies established during the War on Drugs era have led to an "epidemic of incarceration" that disproportionately affects people who have SUD (Wakeman & Rich 2015, p. 220). Access to evidence-based SUD treatment in jails and prisons is often limited or nonexistent, increasing risks of recurrence of substance use and overdose postrelease as well as drug-related deaths in custody among people with SUD (Wakeman & Rich 2015).

Structural stigma manifested in institutions, organizations, and environments also shapes access to resources among people with MI/SUD. As part of the job application process, many employers ask applicants whether they have ever been convicted of a crime and/or conduct background checks assessing previous criminal justice involvement. As noted above, people with MI/SUD are at increased risk of incarceration. A history of criminal justice involvement is a barrier to employment (Batastini et al. 2017), even in states with policies offering employment protections for people with a history of criminal justice involvement (e.g., ban the box and fair chance policies/guidelines) (Oselin et al. 2024). Rates of employment among formerly incarcerated people with SUD are low, and even lower if they have a co-occurring MI (Laudet 2012). Yet, employment can benefit SUD recovery given that it can help people engage in meaningful activities that contribute to positive identity and relationship development, as well as facilitate access to income and insurance (Sahker et al. 2019). As noted above, stigma can determine whether and where MI/SUD treatment is available, with NIMBY movements blocking the establishment of MI/SUD treatment and harm reduction facilities (Becker et al. 2023). Such actions can result in so-called treatment deserts, or locations with no MI/SUD treatment facilities (Cernasev et al. 2021). Patients report that transportation is a significant barrier to MI/SUD treatment access (Cernasev et al. 2021), and evidence suggests that individuals who have to travel farther to a treatment facility are less likely to access outpatient treatment following discharge from inpatient treatment (Schmitt et al. 2003).

Stigma manifested at the individual and interpersonal levels, which is fundamentally shaped by stigma at the structural level, also affects access to resources. Some research has focused on the ways in which stigma among perceivers in MI/SUD treatment settings undermines the quality of MI/SUD treatment provided. In a study of Veterans Administration providers, Corrigan et al. (2014b) found that providers who endorsed stigmatizing beliefs about a patient with schizophrenia were more likely to believe that the patient would not adhere to treatment and, in turn, were less likely to refer the patient to treatment or refill prescriptions. Moreover, experienced stigma from

treatment providers is associated with lower likelihood of treatment completion among patients with SUD (Brener et al. 2010). Similarly, research suggests that stigma among perceivers in the criminal justice system can shape MI/SUD treatment-related outcomes. For example, police officers who endorse greater stigma toward people who use drugs may be more likely to arrest people with SUD for drug-related misdemeanors rather than make discretionary referrals to treatment and harm reduction services (Del Pozo et al. 2021).

Psychological Responses

Psychological responses among people with MI/SUD play a role in mediating associations between structural-level stigma mechanisms and MI/SUD treatment- and recovery-related outcomes. Recent research has drawn attention to the importance of subjective appraisals of structural stigma, or the extent to which targets perceive that their rights, opportunities, and inclusionary status are constrained by structural-level stigma mechanisms (Lattanner et al. 2021). Research suggests that individuals who live in places with greater structural stigma perceive greater structural stigma (Lattanner & Hatzenbuehler 2023). Perceptions of structural stigma, in turn, undermine perceptions of belongingness, which are associated with more loneliness and less social support. As discussed further below, social isolation has important implications for MI/SUD treatment. Evidence also suggests that perceived MI stigma is associated with greater stigma-related stress and that stigma-related stress is associated with increased social anxiety and shame (Rüsch et al. 2009a,b). Perceived MI stigma is also associated with demoralization (Link 1987) and distress (Griffiths et al. 2008). Similarly, perceived SUD stigma is associated with depression among people in treatment for SUD (Luoma et al. 2010). Taken together, these studies suggest that perceived MI/SUD stigma may trigger or exacerbate MI symptoms.

A robust body of research demonstrates that experiences of stigma or discrimination at the interpersonal level are associated with negative psychological responses among targets. Meta-analytic evidence suggests that these experiences are associated with indicators of MI (e.g., symptoms of depression, anxiety, and posttraumatic stress disorder), psychological distress, decreased well-being (e.g., self-esteem, life satisfaction, happiness, quality of life), and stress (Pascoe & Richman 2009). Among people who use substances and/or have an SUD, experienced stigma is associated with more depressive symptoms and worse mental health (Young et al. 2005). Research guided by Modified Labeling Theory finds that having a label of MI places one at risk of stigma at the interpersonal level, which in turn affects psychological responses including mental health (Link et al. 1989).

Stigma at the individual level among targets is also associated with negative psychological responses. Meta-analytic evidence suggests that internalized stigma is associated with indicators of worse mental health (e.g., lower self-esteem, greater depressive symptoms, greater psychological distress) among people living with a range of stigmatized statuses, including MI (Mak et al. 2007). Research demonstrates that internalized stigma is associated with greater depressive symptoms, decreased self-esteem, and increased symptom severity among people with MI (Boyd et al. 2014) as well as greater psychological distress and lower quality of life among people living with or in recovery from SUD (Vilsaint et al. 2020). People with worse mental health, in turn, often have worse MI/SUD treatment- and recovery-related outcomes. More severe MIs, including depression, can be more difficult to treat (Druss 2007, Nemeroff 2007). Furthermore, co-occurring mental health problems present challenges for SUD treatment (Yule & Kelly 2019). For example, people with alcohol use disorder and co-occurring MI have a higher rate of relapse following residential treatment (Suter et al. 2011), and people with opioid use disorder and depression have a higher risk of overdose (Bohnert et al. 2012).

Behavioral Responses

Behavioral responses mediate associations between structural MI/SUD stigma and the MI/SUD treatment cascade. Although stigma is associated with a wide range of behaviors among people with stigmatized statuses (Hatzenbuehler et al. 2013), we focus on substance use and treatment access because they are particularly relevant for MI/SUD treatment- and recovery-related outcomes. Research has uncovered important impacts of War on Drugs laws and policies on substance use-related behaviors of people with SUD. For example, people who inject drugs are more likely to share needles when they are concerned about drug paraphernalia laws that place individuals at risk of arrest for possessing syringes, increasing their risk of blood-borne infections such as HIV (Bluthenthal et al. 1999). Moreover, evidence suggests that people with a wide range of stigmatized statuses, including people with SUD, cope with stigma at the interpersonal level by engaging in substance use (Earnshaw et al. 2024, Hatzenbuehler et al. 2013). Experienced stigma is associated with more severe negative outcomes of substance use, including overdose (Latkin et al. 2019). People in treatment for SUD also experience elevated shame, and shame is associated with more substance use-related problems (Luoma et al. 2019).

Structural stigma may also shape whether people access treatment via multiple pathways. As noted above, structural stigma shapes access to resources, including MI/SUD treatment. People receiving medications for opioid use disorder perceive substantial SUD- and medication-related stigma within their social environments, including their communities and neighborhoods, which leads to delays in seeking treatment, disrupts treatment access, and/or undermines retention in care (Brousseau et al. 2022). Similarly, people with SUD who experience more stigma at the interpersonal level from providers are more likely to drop out of treatment (Brenner et al. 2010). Stigma is additionally associated with treatment access among people with MI. Results of a meta-analysis identified internalized MI stigma and disclosure concerns (which can be driven by anticipated stigma) as barriers to help seeking for mental health problems (Clement et al. 2015). The meta-analysis theorized that structural stigma promotes stereotypes about people with MI, which in turn lead to disclosure concerns and internalized stigma among people with MI. Additional research mapping the pathways whereby stigma affects treatment has found that people with MI who anticipate greater stigma go on to internalize more stigma, and internalized stigma is associated with less MI treatment seeking (Fox et al. 2018b). In this study, associations between anticipated stigma and treatment seeking were stronger for people with more severe MI symptoms.

Social Isolation

Social isolation is a powerful mediator of associations between structural MI/SUD stigma and MI/SUD treatment- and recovery-related outcomes. Critics have argued that the War on Drugs and other forms of structural SUD stigma socially isolate people with SUD (Buchanan & Young 2000), and evidence shows that individuals with stigmatized statuses living in countries with more structural stigma report greater social isolation (Pachankis et al. 2021). Structural stigma may lead perceivers to socially reject targets at the interpersonal level, which is a pernicious form of discrimination. Moreover, evidence from daily diary studies suggests that targets living with some forms of concealable stigmatized statuses socially isolate on days when they experience stigma from perceivers (Hatzenbuehler et al. 2009).

Social isolation, in turn, undermines outcomes along the MI/SUD treatment cascade. Social isolation is associated with worse mental health (Rohde et al. 2016), which, as noted above, can undermine MI/SUD treatment-related outcomes. Moreover, individuals who are socially isolated have less access to social support, including comfort, assistance, and/or information from others (Wallston et al. 1983), which can promote MI/SUD treatment-related outcomes.

Among individuals with more serious MI, social support predicts greater engagement in MI treatment (Thoits 2011). Among individuals with SUD, social support promotes less engagement in substance use and greater retention in SUD treatment (Ariss & Fairbairn 2020, Kumar et al. 2021). Social isolation further increases risk of death from overdose among people with opioid use disorder. Although lifesaving medications are available to reverse opioid overdoses, it is nearly impossible to self-administer these medications when overdosing (Wojcicki 2019).

Role of Intersectionality

An intersectionality framework emphasizes that structural MI/SUD stigma converges with structural stigma associated with race/ethnicity, gender identity, sexual orientation, and other social statuses, fundamentally shaping the processes whereby structural stigma affects outcomes among people with MI/SUD. In their analysis of discriminatory laws associated with substance use, race, and ethnicity, Walters et al. (2023) observed that, since the founding of the United States, Black and Hispanic people who use drugs have been persistently and perniciously targeted by structural stigma on the basis of varying intersections of social statuses. They note that this structural intersectional stigma has led to health inequities among Black and Hispanic people who use drugs by increasing risk for disease and blocking access to health-promoting resources. Racial residential segregation is a pernicious form of structural racism manifested in the built environment that shapes access to a wide range of health care services (Bailey et al. 2017), including those related to MI/SUD. As examples, metropolitan statistical areas high in Latino isolation and centralization are more likely to have psychiatrist shortages (Dinwiddie et al. 2013), and counties with greater racial and ethnic segregation are less likely to have SUD treatment clinics that provide buprenorphine (an effective medication for opioid use disorder) (Goedel et al. 2021). Moreover, racial/ethnic minorities experience racism in health care settings, which shapes their health care-related behaviors and undermines health care access (Dovidio et al. 2008). Research also suggests that internalized stigma and disclosure concerns are stronger barriers to help seeking for mental health problems among racial/ethnic minorities with MI (Clement et al. 2015).

Sexism shapes MI/SUD-related outcomes for women. Structural sexism undermines women's access to key resources, including employment and housing, and women with MI may face increased risks of unemployment, poverty, and homelessness due to their gender and MI (Mizock & Russinova 2015). Evidence suggests that psychotherapy for commonly targeted MIs (i.e., depression, anxiety, conduct disorder, attention-deficit/hyperactivity disorder) may be less effective when there is more structural sexism in the social environment (i.e., as measured by aggregated sexist attitudes; Price et al. 2021). Results of qualitative studies suggest that sexism intersects with SUD stigma to undermine SUD treatment for women who use drugs, for instance, by leading to decisions to deprioritize funding for SUD treatment for women and exacerbating anticipated stigma among women with SUD accessing health care (Meyers et al. 2021). Other research suggests that women may be more vulnerable to the impact of social isolation on mental health (Rohde et al. 2016).

Finally, sexual and gender minority stigma shapes processes linking structural stigma with MI/SUD risk, treatment, and recovery. Sexual and gender minority stigma increases the risk of MI/SUD among sexual and gender minorities (Hatzenbuehler et al. 2024). In turn, sexual and gender minority stigma intersects with MI/SUD stigma to shape MI/SUD-related outcomes among sexual and gender minorities. Hatzenbuehler et al. (2024) identified pathways by which structural sexual and gender minority stigma affects the health outcomes of sexual and gender minorities. Their review proposes that, similar to structural racism and sexism, structural sexual and gender minority stigma undermines access to resources including health care, employment, and housing.

Notably, sexual and gender minority youth may be particularly vulnerable to the impacts of structural stigma on access to resources (Earnshaw et al. 2022, Philbin et al. 2023). The review also identifies relationship and family processes as a key pathway, drawing attention to the impact of structural sexual and gender minority stigma on family formation and partnership stability. The disruption of relationship and family processes may lead to further social isolation among sexual and gender minorities with MI/SUD.

DISCUSSION

Researchers, interventionists, and clinicians are increasingly recognizing the importance of structural stigma in MI/SUD-related outcomes. We have defined key concepts related to MI/SUD stigma, summarized research on structural-level MI/SUD stigma, and mapped pathways whereby structural-level stigma appears to shape outcomes along the MI/SUD treatment and recovery continuum. Additionally, we have introduced a conceptual framework (**Figure 1**) depicting ways in which structural-level stigma mechanisms are hypothesized to influence MI/SUD treatment- and recovery-related outcomes via interpersonal- and individual-level stigma mechanisms as well as mediating processes among targets. Below, we briefly discuss the implications of this review for future research, interventions, and clinical practice. Although we discuss these activities separately and refer to researchers, interventionists, and clinicians, we recognize that there is considerable overlap between these categories.

Implications for Future Research

Research on structural stigma is rapidly expanding, and it is arguably an exciting and generative time for researchers who want to better understand how structural-level stigma affects MI/SUD treatment outcomes. In particular, researchers have introduced new measures of structural MI stigma (Fox et al. 2025). For example, researchers have measured the legal environment by content-coding mental health-related bills (Corrigan et al. 2005b), the social environment by aggregating individual-level stigma mechanisms within communities (Evans-Lacko et al. 2012), and institutional policies by coding how topics related to mental health care are taught in medical schools (Sukhera et al. 2022). In the context of structural SUD stigma, researchers have measured the built environment by exploring where different forms of SUD treatment are offered (Goedel et al. 2021). Composite or latent variable models that allow researchers to include multiple indicators of structural MI/SUD stigma may be particularly useful for more fully capturing the multidimensional nature of structural MI/SUD stigma (Fox et al. 2025). We echo recommendations from the Mental Health Commission of Canada, which created a framework for assessing MI/SUD structural stigma in health care contexts (Livingston 2021). The Commission emphasized applying participatory, multimethod, and longitudinal approaches to the study of stigma as well as attending to intersectional stigma and multiple levels of the health care context.

As the field continues to develop innovative approaches to measure MI/SUD structural-level stigma, we will need research that examines associations between structural-level stigma and outcomes along the MI/SUD treatment cascade. In addition to introducing new measures of structural factors, researchers have been introducing and fine-tuning methods to study the impact of structural factors on individual-level outcomes (Fox et al. 2025). Multilevel modeling and structural equation modeling offer opportunities for exploring how changes in structural-level stigma mechanisms shape outcomes along the MI/SUD treatment cascade among individuals. Longitudinal mediation analyses can help clarify the pathways through which structural-level stigma mechanisms affect these outcomes, and latent variable, latent change, and multilevel structural equation modeling can be leveraged for such mediation analyses. Multigroup analyses can

be used to test for moderators of associations between stigma mechanisms, mediating processes, and outcomes. Additionally, qualitative methods can provide valuable insights into individuals' perceptions of structural MI/SUD stigma and the ways in which this stigma shapes outcomes. For example, PhotoVoice can provide unique insight into the ways in which structural MI/SUD stigma manifests within physical and built environments (Wang & Burris 1997), and qualitative life-course interviews can yield insight into how individuals perceive changes in MI/SUD stigma over time.

Implications for Interventions

On the basis of our conceptual framework (**Figure 1**), we make several recommendations for interventions to address structural MI/SUD stigma and improve outcomes throughout the MI/SUD treatment cascade. First, it is arguably always appropriate to attempt to directly change structural-level stigma, including by advocating for the repeal of discriminatory laws and institutional policies. Evidence suggests that the mental health of stigmatized populations improves after discriminatory laws are repealed (Hatzenbuehler et al. 2012). Researchers have roles to play in dismantling discriminatory laws and policies by continuing to provide evidence of their deleterious effects, supporting community leaders and organizations that are advocating for change, and directly advocating to policymakers and institutional/organizational leaders for change. The National Academies of Sciences, Engineering, and Medicine highlight promising interventions that shape stigma manifested in the social environment (NASEM 2016). These large-scale national campaigns, such as Time to Change in England and Beyond Blue in Australia, are delivered over long periods of time (e.g., up to 15 years), typically leverage several stigma intervention tools (e.g., education, contact) (Cook et al. 2014), and often target multiple social-ecological levels. Integrating MI/SUD care into general medical care settings represents a strategy for addressing structural stigma in the built environment. Although evidence supports the effectiveness of integrated care models for improving outcomes across the MI/SUD treatment cascade, policy-related barriers (e.g., financing mechanisms) to integrating MI/SUD care with general medical care persist (McGinty & Daumit 2020).

Given that the impact of structural stigma on MI/SUD treatment-related outcomes is at least partly mediated through stigma manifested at the interpersonal and individual levels among perceivers, addressing stigma at these levels is also important. We now have a stigma-reduction toolbox, or a collection of evidence-based strategies for reducing stigma at these levels (Cook et al. 2014). At the individual level, tools such as education (i.e., increasing knowledge of stigmatized groups) and skill building (i.e., enhancing competencies surrounding interactions with targets) reduce stigma among perceivers. Tools such as counseling (including cognitive behavioral therapy), belonging (i.e., increasing individuals' sense of belonging and connection), and values affirmation (i.e., enhancing salience and centrality of valued identities) reduce stigma among targets. At the interpersonal level, tools such as intergroup contact (i.e., promoting interpersonal interactions between targets and perceivers) reduce stigma. Moreover, behavioral design can address stigma at the interpersonal level by constraining the opportunities of perceivers to discriminate against targets (Bohnet 2016). Evidence suggests that many of these tools have successfully been adapted to the contexts of MI/SUD (Livingston et al. 2012, NASEM 2016). Yet, more research is needed to continue to tailor these tools to MI/SUD as well as to determine how to combine stigma intervention tools to best address stigma. Given that stigma at the individual level influences stigma at the structural level, we further hypothesize that stigma change among key individuals (e.g., voters, policymakers, health care providers, law enforcement) can ultimately lead to reduced stigma at the structural level.

Finally, interventions that seek to disrupt mediating pathways and/or bolster resilience resources among targets can help mitigate the impacts of MI/SUD stigma while we work to dismantle it at all levels. For example, interventions can strengthen access to resources that are threatened by structural stigma and undermine MI/SUD treatment- and recovery-related outcomes. Employment interventions for people with MI/SUD have shown promise (Magura & Marshall 2020, Noyes et al. 2018). Similarly, transportation interventions can promote the use of and retention in MI/SUD care, potentially helping people with MI/SUD overcome barriers to care in their built environment (Whetten et al. 2006). Interventions that target resources should attend to participants' intersectional social statuses to ensure that they reduce, rather than create or widen, disparities based on race, gender, sexual orientation, and other social statuses (Godkhindi et al. 2022). Interventions may also promote multilevel resilience resources, which may buffer individuals from the impacts of stigma mechanisms on MI/SUD-related outcomes. As examples, community empowerment interventions can expand community capacity to address problems resulting from stigma and mobilize community members toward social change, and social support interventions can help targets of stigma regulate emotional responses to and problem-solve in the face of stigma (Earnshaw et al. 2013). Recent theory suggests that strengthening resilience may be particularly important during historical time periods when structural stigma is pronounced and difficult to change (Earnshaw et al. 2022). Yet, theorists also caution against intervening to promote resilience among individuals at the cost of addressing socio-structural conditions (Suslovic & Lett 2024).

Implications for Clinical Practice

Clinicians have a critical role to play in both reducing structural MI/SUD stigma and mitigating its deleterious downstream effects. At the structural level, clinicians are often powerful advocates for social change. Clinicians have led efforts to educate the public about MI/SUD, share stories that humanize people with MI/SUD, and advocate for policy changes to dismantle structural stigma (e.g., Interlandi & Winter 2023, Kelly & Earnshaw 2021). Clinicians can also address structural stigma within their institutions and organizations. Given that stigmatizing language is commonly used by MI/SUD treatment providers and influences clinical judgments and the quality of care provided (Healy et al. 2022), clinicians can establish expectations regarding the language used within their practices. Healy et al. (2022) identified pejorative terms that they recommend be avoided in clinical communication, and introduced core principles for reducing stigma in clinical communication (e.g., use person-first language, do not blame patients).

Evidence is growing that existing evidence-based treatments can be adapted for stigmatized populations. As examples, cognitive behavioral therapy-based interventions have demonstrated promise for improving coping with intersectional stigma among Latinx men living with HIV (Bogart et al. 2021) and for reducing depressive symptoms and alcohol problems among sexual and gender minorities (Pachankis et al. 2023). Pachankis et al. (2023) recommend adapting existing evidence-based practices for sexual minorities to raise awareness of the impact of stigma and develop coping strategies and other resilience resources to buffer clients from stigma. Clinicians may similarly seek to adapt evidence-based practices to more directly address MI/SUD stigma. Clinicians may also support clients with MI/SUD who are engaging in activism and resistance aimed at deconstructing structural stigma.

CONCLUSION

Ultimately, a better understanding of the pathways through which structural stigma affects the MI/SUD treatment cascade can inform strategies to dismantle structural stigma in the long term as

well as promote the well-being of people with MI/SUD in the short term. As researchers develop a greater understanding of how structural stigma is manifested and influences MI/SUD-related outcomes, they may uncover new and innovative ways to intervene in it. Until structural stigma is dismantled, interventionists can develop strategies to protect people from its deleterious effects. Interventions that aim to disrupt the pathways through which structural stigma shapes MI/SUD-related outcomes, and/or strengthen resilience to stigma at all social ecological levels, may be particularly beneficial. Clinicians have many roles to play in addressing structural stigma, including by advocating for social change and supporting people with MI/SUD who are experiencing stigma. Because stigma is a social process, it can and does change (Earnshaw et al. 2022). Yet, multisectoral efforts are needed to both reduce structural stigma and mitigate its harmful sequelae.

SUMMARY POINTS

1. Despite increasing recognition that structural stigma plays a role in elevating the risk of mental illnesses (MIs) and substance use disorders (SUDs) and in undermining MI/SUD treatment and recovery, the mediating processes that link structural-level stigma with MI/SUD-related outcomes have been understudied.
2. Structural-level MI/SUD stigma manifests in legal, institutional and organizational, social, and physical and built environments.
3. Structural-level MI/SUD stigma ultimately shapes MI/SUD-related outcomes via key mediating processes, including by blocking access to health-promoting resources, causing deleterious psychological and behavioral responses, and promoting social isolation.
4. Structural MI/SUD stigma intersects with structural stigma associated with race/ethnicity, gender identity, sexual orientation, and other social statuses to shape the processes whereby structural stigma affects outcomes among people with MI/SUD.
5. Researchers, interventionists, and clinicians have important roles to play in furthering our understanding of the processes whereby structural stigma shapes MI/SUD-related outcomes, dismantling structural stigma and disrupting associations between structural stigma and MI/SUD-related outcomes, and supporting people with MI/SUD who are experiencing stigma.

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