Challenging stigma and discrimination
Practitioner level learning module
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Introduction

The Real Skill for challenging stigma and discrimination is:

Every person working in a mental health and addiction treatment service uses strategies to challenge stigma and discrimination and provides and promotes a valued place for service users.

Performance indicators - practitioner

By the end of this module you will be able to:

- articulate positive aspects of working in mental health and addiction treatment services to external groups
- use strategies to reduce stigma and discrimination, including promoting and facilitating social inclusion.

Preparation

To help you complete this module, please familiarise yourself with key national strategy and policy documents and the service provider guidelines relevant to your specific area of practice.

It is also recommended that you do some background reading on recent research and publications related to stigma and discrimination. In particular, the following New Zealand publications will help you in completing this module.


For your reference a list of recommended reading is included in this module.

The work in this module builds on the essential level of the challenging stigma and discrimination Real Skill. It is designed to capture your knowledge and the application of that knowledge as a practitioner in mental health and addiction. You will be expected to reflect on what you do, how you do it, and the key values and attitudes that underpin your work.
There are two main themes in this module. The first explores the concepts related to stigma and discrimination, and the impact of these upon you and the service users, external agencies and groups you work with. The second explores the ways in which you apply strategies that challenge stigma and discrimination, and promote and facilitate social inclusion.

In this module, you will draw on your experiences working with service users, and the strategies or plans you have implemented to support their recovery. It is suggested that before beginning this module of work, you consider service users you have worked with in the past or are currently working with, and the different forms of discrimination that they may have encountered.

To gain the maximum benefit from this module you are encouraged to think about how the learning module applies to you and your work context. When you have finished working through this module use the Learning Review Tool to help you reflect on how you challenge stigma and discrimination. This will enable you to identify where your strengths are, along with any areas you may need to further explore in your Individual Professional Development Plan.

Overview

Stigma, prejudice, and discrimination are interrelated and interconnected concepts that affect many people, and that can arise in response to many factors, including people’s age, religion, ethnic origin and socioeconomic status.

Stigma exists in all areas of our society and is not unique to mental health and addiction service users. However, due to its impact, it is of particular significance to those using and working within these services.

As stated in the essential level of the challenging stigma and discrimination learning module, stigma exists when people are recognised as different, and then labelled and identified as such. Invariably this process is linked to beliefs about what constitutes common norms and behaviours. Once populations have been identified as being other or different, then they are often collectively and individually subject to labelling, negative stereotyping, prejudices, isolation, ridicule, loss of status, loss of dignity and in some instances loss of basic human rights (Peterson et al, 2008).

In the context of mental health and addiction, public stigma is the reaction by the community or the public to those with mental health and addiction issues. Self-stigma is the prejudicial beliefs that people with mental illness or addiction issues formulate about themselves, often due to their experiences and underlying belief systems.

All human beings formulate judgements based on our own values and attitudes, and these in turn affect how we think about and behave towards others. Formulating negative beliefs and judgements about groups of people (stereotyping) and behaving in a way that is consistent with these negative beliefs can lead to prejudicial and discriminatory behaviours.
The term stereotype in fact derives from the Greek words στερεός (stereos), meaning solid or firm, and τύπος (tupos), meaning blow, impression or engraved mark, hence a combined meaning of solid impression.

Stereotypes can instigate prejudice and false assumptions about entire groups of people, for example about different ethnic groups, social classes, people with mental illness, drug dependent people, religious orders or the opposite sex. Examples of stereotyped beliefs would include statements such as “all children with emotional problems will grow up to be mentally ill”, “all drug addicts are criminals” and “all mentally ill people are dangerous”.

Tse (2009) offers the following food for thought when discussing the effects of discrimination and stereotyping in the context of ageism.

“Children are ignored. Adolescents are not trusted. Young adults are pressured with expectations or are seen to lack the experience. Middle-aged individuals are lazy and arrogant. Elderly people are incapable and dying...”

Prejudice can be put simply as an attitude toward the members of some group based solely on their membership in that group. Prejudice can be positive or negative.

Discrimination usually describes the behaviour, or actual positive or negative actions towards the objects of prejudice. Discrimination occurs when a person is treated differently from another person in the same or similar circumstances. Actual experiences of discrimination, and the anticipation of being discriminated against, are commonplace among service users with mental health and addiction issues (Peterson et al, 2008).

Research findings indicate when prejudice and discrimination are internalised by people with mental illness or addiction there may be significant shame, and a reluctance to seek help and gain appropriate treatment for their mental health or addiction issues (Mental Health Foundation, 2004; Corrigan and Rusch, 2002). It is also well established that prejudice and discrimination lead to the exclusion of people with mental illness and addiction, and their families, from activities that are open to those without such issues.

The World Health Organization (2004, p.32) recognises that “prejudice and discrimination against ... dependent people is one of the main barriers to their treatment. Everyone has the same rights to health care, education, work opportunities and integration into society”.

The social exclusion that results from stigma and discrimination has been variously described in the literature, and is recognised as one of the most significant barriers to recovery for people with experience of mental illness and addiction (Ministry of Health, 2008). For those with addiction problems, Rosenbloom (2007) described stigma and discrimination as the “meanest and most difficult aspects of addiction”.

Challenging stigma and discrimination - Practitioner level
Learning module - print version
Rosenbloom (2007) offers the following observation as an explanation of the processes involved in stigmatising attitudes towards those with addiction issues.

“...society imposes stigma - and its damage - on addicts and their families because many of us still believe that addiction is a character flaw or weakness that probably can't be cured. The stigma against people with addictions is so deeply rooted that it continues even in the face of the scientific evidence that addiction is a treatable disease and even when we know people in our families and communities living wonderful lives in long-term recovery.”

Florez (2003) describes the effect of stigma and discrimination as being, “social annihilation... constricting the lives of individuals... preventing them from fully reengaging in their communities and participating in the social activities of their groups of reference” (p.1).

In the New Zealand Respect Costs Nothing survey (Mental Health Foundation, 2004) 23 per cent of respondents said that they had been discriminated against by other health services (as opposed to mental health services), with this figure rising to 27 per cent amongst women. Being treated differently from people without experience of mental illness, when seeking help for their physical health problems, was an over-riding theme. A range of negative or unhelpful attitudes from health professionals were reported, from fear to annoyance for “wasting their time”.

Reports also included receiving poor treatment from hospital services for non-mental health problems. Examples included all symptoms being seen as related to mental illness, service providers exhibiting fear of mental illness, and people being treated as incompetent or drug-seeking.

Alongside the damaging effects of stigma and discrimination from the general public and service providers, the emotional effects of self-stigma (which has been subject to less research to date) have their own implications. International studies echo the findings of recent New Zealand-based research. A study from the United States, which involved interviews with service users who had experienced psychosis from across America, reported almost all (95 per cent) felt a lasting personal impact from their experiences of stigma, with over a half reporting that their self-esteem or self-confidence had suffered as a consequence. About a third of those interviewed found that they avoided social contact more than before, and a quarter reported that they were now less likely to make an application for a job (Thornicroft, 2006).

Those working in mental health and addiction services are also not immune to the effects of stigma and discrimination. As early as 1988, Lefley (1988) reported that 90 per cent of mental health professionals who had a family member with mental illness, frequently heard colleagues make “negative or disparaging remarks” about patients. The majority of these professionals stayed silent and did not disclose their relative’s illness. Anecdotally the situation for many professionals appears not to have changed.
In summary, the effects of stigma and discrimination are far reaching and can limit:

- access to employment and vocational opportunities
- access to adequate housing or accommodation
- treatment for health care (both in general, and associated with mental health or addiction problems)
- acceptance by family, friends and the community
- formulating and building social and intimate relationships
- engagement in leisure, recreation and social activities.

The New Zealand context
In New Zealand it is against the law for employers and people who provide services to discriminate against people with people with lived experience of mental health and addiction issues. Denying people access to employment, housing and health care, for example, violates human rights legislation.

As individuals in New Zealand we are generally free to say what we think, read what we like, worship where and how we choose, move freely around the country, and feel confident in the laws that protect us from discrimination and the arbitrary abuse of power.

Legislation ensures to some degree that most New Zealanders will experience the benefits of economic, social and cultural rights. These include a right to education, work, good health, and affordable, healthy housing. The legislation underpinning these rights includes the New Zealand Bill of Rights Act 1990 (Ministry of Justice, 1990) and the Human Rights Act 1993 (Ministry of Justice, 1993).

Human Rights Act
The Human Rights Act 1993 (Ministry of Justice, 1993), which came into force on 1 February 1994, replaced earlier human rights legislation, the Race Relations Act 1971 and the Human Rights Commission Act 1977. The act forbids discrimination on the grounds of sex, age, marital status, religious belief, ethical belief, colour, race, and ethnic or national origins. It also adds five further grounds of prohibited discrimination, namely disability (including having in the body organisms capable of causing illness), political opinion, employment status, family status and sexual orientation. Lived experience of mental illness falls under the category of disability within the act.

New Zealand Bill of Rights Act
The New Zealand Bill of Rights (Ministry of Justice, 1990a) protects individuals from the actions of anyone in government interfering with their rights. The Bill of Rights also protects the rights of non-natural persons, for example, companies and incorporated societies.
The bill of rights can protect your rights in two ways:

- the courts can recognise and enforce your rights
- under the act, the attorney general is required to report to parliament if any proposed law appears inconsistent with the Bill of Rights.

There are six main rights discussed in the Bill of Rights. These rights do not specifically relate to mental health and service users. For a full discussion on how these rights entitle individuals to certain types of treatment see the Ministry of Justice’s pamphlet on the Bill of Rights (Ministry of Justice, 1990b).

**New Zealand Disability Strategy**

The overarching aim of the New Zealand Disability Strategy (Ministry of Health 2001) is social inclusion. A valued place is reached when people are an integral part of safe, strong families, have equal access to education, employment, housing, transport, and goods and services, and are free to participate in the commercial, cultural, political, spiritual and recreational life of their communities (Mental Health Advocacy Coalition, 2008, p 28).

Stigma, prejudice, and discrimination against those with mental illness and addiction issues occur across all classes, ages, cultural and social groups. The discriminatory behaviours that are displayed, overtly and covertly, by the community at large (i.e. the general public) have repeatedly found to also be evident from family members and from those who work in the broader health and disability sector, including in mental health and addiction services (Mental Health Foundation, 2004; Peterson et al, 2008).

Along with other key legislation, the New Zealand Disability Strategy (Ministry of Health 2001), the New Zealand Bill of Rights Act 1990 (Ministry of Justice, 1990a) and the Human Rights Act 1993 (Ministry of Justice, 1993) outline a frame of reference for mental health practitioners to use to enhance their ability to work in ways that challenge stigma and discrimination.
1 Exploring stigma and discrimination

1.1 Consider the following terms and answer the questions that follow:

- discrimination
- stigma
- prejudice
- stereotyping
- social exclusion
- self-stigma.

1.1 Please explain in your own words the meaning of these terms.

1.2 What is the relevance of these concepts to your particular area of mental health and addiction practice?
1.3 Describe how stigma and discrimination has impacted on the people you work alongside? Describe three examples either from your own experience, or through discussion with a colleague, of how stigma and discrimination have been encountered in your practice environment.

In answering this question you will need to:
- write a brief narrative of the situation that arose
- consider the impact on both the service user and those around them
- describe what action you took (or would take in the future) to challenge the stigma or discrimination.

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<th>Example one</th>
<th>Impact on service user and others</th>
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<td>What action you took (or would take in the future)</td>
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<td>Example two</td>
<td>Impact on service user and others</td>
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<td>What action you took (or would take in the future)</td>
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<tr>
<td>Example three</td>
<td>Impact on service user and others</td>
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<td></td>
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<tr>
<td></td>
<td>What action you took (or would take in the future)</td>
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</tbody>
</table>
Reflecting on two of the three examples you have generated above, consider the following questions.

1.4 Were there any other factors involved such as race, culture, other disability, age or sexual orientation?

1.5 Are there other potential strategies you, or those you work alongside, can put in place to reduce the potential and actual areas of stigma and discrimination you have identified?

1.6 Would you do anything differently in the future if a similar incident occurred?
2 Overcoming social exclusion and promoting social inclusion

For those individuals and their families and whānau who experience social exclusion as a result of the stigma and discrimination surrounding their mental health or addiction issues, the impacts are far reaching. The range of challenges that people face are inter-related and in many ways mutually reinforcing, sometimes resulting in a fast moving, complex and vicious cycle, which has been described as an “excluded life”.

Sayce (2001, p.122) describes how the cycle of exclusion eventuates and is maintained.

“...the inter-locking and mutually compounding problems of impairment, discrimination, diminished social role, lack of economic and social participation, and disability. Among the factors at play are lack of status, joblessness, lack of opportunities to establish a family, small or non-existent social networks, compounding race and other discriminations, repeated rejection and consequent restriction of hope and expectation.”

The following diagram, illustrates how some of these factors interrelate (Social exclusion unit, 2004, Pg 20).

While not all people who experience mental health and addiction issues will necessarily experience the full downward spiral of exclusion, as represented in the model above, it may be a significant part of the experience of many service users.
The self-stigma experienced by many service users, which results in loss of self-esteem, self-confidence and feelings of worthlessness, can contribute to exclusion's development, and is acknowledged to worsen the experience of mental illness and make the cycle of exclusion worse (Health Scotland, 2008). Personal accounts of service users who have addiction issues, either alone or in combination with mental health issues, indicate that the experience of being stigmatised and marginalised are remarkably similar.

Overcoming the effects of stigma and discrimination, and the associated social exclusion experienced by service users, involves working collaboratively with others. To foster hope and a positive future in the face of these challenges is the responsibility of all who work within the mental health and addiction sector.

2.1 In the following stories, consider how each of these people may journey towards an “excluded life”.

**Mere’s story**

Mere is 22 years old. She lives in Strathmore, Wellington with her whānau. Mere used to play a lot of sport, including netball and touch rugby. She was a law student at Victoria University for a little while and had a large social group of friends.

Midway through the second year of her law degree, Mere began playing the pokies at the local bar, which she visited two or three times a week with her friends. She had a few wins and began to play more regularly, in an attempt to increase her winnings to help pay her living costs and pay off her student loan. Eventually, she began to miss out on social occasions and sport, and describes how “playing the pokies took over my life”.

Mere became increasingly isolative, missing lectures and failing to hand in assignments. By the end of the year she was depressed and withdrawn. Mere sought help from the university counselling service who suggested that she visit her GP and that she seek out help from Gamblers Anonymous.

Since becoming depressed, Mere has found it difficult to interact with people. She continues to isolate herself, attends university sporadically and does not play any sport. She has limited contact with her friends.

Mere feels that people judge her wrongly and think she is “a useless psycho”. One of her lecturers at university asked her if she would be, “okay to take the end of semester examination, because it lasts three hours”.

Her friends no longer ring or visit, giving a variety of excuses, and none of them return her calls. Mere has told you that she would “really like to get her life sorted”, but she finds it difficult to go to places where they know she has a problem. “It is as if they treat me differently. I mean, some of the language around me being a nutcase, and the looks, the looks just blow me away!”
Alan’s story

Alan is a 69 year old man, originally from Ireland, who settled in New Zealand in the 1960s. Nine months ago his wife Chrissy died suddenly from ovarian cancer, with only a few weeks’ warning.

Alan is a popular and jovial man who is a valued member of the local lawn bowls club. He enjoys a drink with his mates, smoking his pipe and “keeping an eye on the gee gees”, betting occasionally on the odd horse race.

Alan has experienced bouts of depression and intermittent anxiety throughout his life, and although he “coped well” with the death of his wife and the immediate aftermath of the funeral, he has become increasingly withdrawn and fearful, spending more and more time alone in his house, not answering the phone or responding to friends’ requests to join in with the social events at the bowls club.

Alan has reached the conclusion that life really is not worth living without Chrissy by his side, and expresses this repeatedly to his daughter, Olive.

Alan’s friends and family are very concerned and, after some considerable effort, Olive convinces her father to visit his GP. The GP prescribes antidepressants for Alan, and advises that he just needs “time” and support.

After six months, Alan has not improved at all and physically has become quite weak, having had two separate episodes of bronchitis and a fall resulting in a fractured wrist. He appears thin and frail and has lost a significant amount of weight. His family, led by Olive, are unwilling to be burdened by what appears to be Alan’s ongoing problems and decide that he may be better off living in a retirement village where he can be “better looked after”.

Alan goes along with their plans, although he is deeply unhappy about them. He is convinced that his children and friends feel he is useless and that they have “written him off” because he has a mental illness.

Mia’s story

Mia is a 13 year old girl of Samoan and European descent.

Mia is currently under the care of Child, Youth and Families. Three weeks ago she was removed from her family home in Avondale, where she lived with her mother and stepfather, and was placed in the temporary foster care of her Aunty Liz, who lives in Pukekohe.

At the time of Mia’s removal, there had been ongoing evidence of physical and emotional abuse. Mia’s mother has longstanding alcohol dependence and is currently receiving treatment for this and methamphetamine use.

Aunty Liz brings Mia to the emergency department of the hospital, reporting that Mia is “out of control”. Over the past few days, Mia has been repeatedly intoxicated, getting drunk on vodka and wine, but not saying where she has got this from. When Aunty Liz challenged Mia about her behaviour, she began throwing things, hitting, kicking and biting, and threatening to kill herself if she is not allowed to go back to Avondale and be with her Mum and her friends. Aunty Liz has also noticed that Mia has a number of superficial cuts on her arms and thighs, and that some appear to be very fresh. Mia says it is no big deal and that Liz should “butt out”.

Mia says that the reason that Child, Youth and Families decided she should live with her Aunty Liz was to “keep me out of trouble”. Mia is not happy about living in Pukekohe, as she misses her friends and hanging out with people she knows. Mia sums up her concerns as, “Now all my mates think I’m mental, with a psycho mum from hell… my life is ruined”.
2.2 For each of the stories, answer the following questions.

- What is the actual discriminatory behaviour that is being demonstrated in the story?

- What potential stigma and discrimination does this person face?

- What is the likely impact of stigma and discrimination on this person, their families and their community?

- What evidence is there of internalised stigma (self-stigma) in this person’s story?

- What is the likely impact of stigma and internalised stigma this on this person, their families and their community?
• What prejudice may this person face in the future?

• How is the cycle of exclusion evident in this person’s story?

• Give three strategies you could consider to help this person overcome any self-stigma they may be experiencing?

• Give three strategies you could implement to minimise the harm of exclusion and marginalisation for the individuals in the stories above?
2.3 Choose one of the stories and create an alternative cycle for this person, one of hope and inclusion, then rewrite the story to reflect a more positive future.
3   The impact of stigma and discrimination in our work

This section of the module focuses on the impact that stigma and discrimination have upon mental health and addiction staff and providers, then goes on to explore the positive aspects of working in mental health and addiction services and how these can be expressed.

In addition to the stigma and discrimination faced by service users, there is recognition in the literature of the negative effects that stigma has upon and among mental health and addiction staff and providers.

While the factors that generate negative views of those working within the mental health and addiction sector are unclear and warrant further research, factors might include the diminished status that mental health and addiction workers may be assigned by colleagues, or the negative public perceptions involved (Thornicroft, 2006).

Termed “stigma by association” common views of the work that psychiatrists do, which arguably extends to other professions within the mental health and addiction sector, are reported to include that:

“...psychiatrists 'have x-ray vision', can 'see into people's minds', read 'others people's thoughts', spend most of their time 'analysing' hypochondriacs who lie on couches, tend to be bearded (most psychiatrists in the UK are now women!) and are suspected of being somewhat eccentric if not mentally unbalanced themselves ('trick cyclists')” (downloaded from www.answerbag.com/q_view/1262125 on July 8 2009).

“Stigma related to work in mental health and addiction has a negative impact on morale, recruitment and retention of personnel” (Mental Health Commission of Canada, 2007 pg 11).

The World Psychiatric Association acknowledges the challenges presented by the negative image associated with psychiatry, and has included a goal in their current work plan:

“...to enhance the image of psychiatry worldwide among the general public, health professionals and policy makers, counteracting some negative messages - often biased by ideological prejudice - which are affecting the motivation of persons with mental disorders and their families to seek for psychiatric advice and help and to adhere to psychiatric interventions, as well as the motivation of medical students to choose psychiatry as a career” (World Psychiatric Association, 2008, p.128).
3.1 Think back to when you originally started working in the mental health and addiction sector, then answer the following questions.

- What attracted you to the job you do?

- What keeps you here?

- How do you describe your role to other people who do not work in the sector?

3.2 Consider the reasons you originally came into mental health or addiction, then list four of them in the space provided.
3.3 Consider the reasons you have stayed in mental health. List four of them in the space provided.

3.4 In your opinion, what are the three key benefits of your job? Explain your responses.

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<tr>
<th>Benefit</th>
<th>Explanation</th>
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3.4 In your opinion, what are the three key challenges of your job? Explain your responses.

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<tr>
<th>Challenge</th>
<th>Explanation</th>
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21
3.5 You have been asked to make a presentation based on the three key values and three key attitudes required for your role. In this exercise values are defined as a person’s beliefs in which they have emotional investment and attitudes are defined as a complex mental state that disposes people to act in certain ways.

Please fill in the diagrams below.

![Values Diagram](image)

![Attitudes Diagram](image)

3.6 You have been asked to submit an advertisement to employ someone for your role. Create the advertisement in the space provided.

**Advert for ______________***

...
3.7 Give three examples of the types of people who would apply for this position.


3.8 Give three examples of the types of people who would be suitable for this position.


3.9 In preparation for the recruitment, you have been asked to outline some of the key tasks of your role. Human resources has provided you with the following template.

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<tbody>
<tr>
<td><strong>Job title</strong></td>
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<td><strong>Clients working with</strong></td>
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<td><strong>Report to</strong></td>
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<td><strong>Term or time in role</strong></td>
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<tr>
<td><strong>Key tasks</strong></td>
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<tr>
<td><strong>Key responsibilities</strong></td>
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</table>
3.10 Consider the following statements, then choose three and explain what your response would be.

“Doesn’t it send you crazy after a while, being around those types of people?”

“Why work with addicts, they don’t change.”

“Wouldn’t want any of my children doing your job.”

“Wow you work there. How do you do it.”

“Ah, mental health, you must be very special to do that.”

3.11 What impacts would the three statements you have chosen have on service users? Please explain your answer.
References and recommended reading


Challenging stigma and discrimination – practitioner lever
Learning Review Tool and Individual Professional Development Plan
Learning Review Tool

Using the Likert scales below, rate your work in relation to challenging stigma and discrimination.

I have a variety of strategies on hand to use in challenging stigma.

<table>
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<tbody>
<tr>
<td>None actually</td>
<td>More than 10</td>
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I have a sound understanding of the impacts of stigma and discrimination.

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<tbody>
<tr>
<td>No idea at all</td>
<td>Absolutely</td>
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I can articulate confidently what social inclusion is and its benefits.

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<tbody>
<tr>
<td>No idea at all</td>
<td>Like I invented it</td>
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I understand and can explain the values and attitudes that are key to my role.

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<tbody>
<tr>
<td>No idea at all</td>
<td>Absolutely</td>
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</table>

Choose your response to one of the above statements, and explain why you made this response.
What new knowledge or insights have I gained from working through this module?

What are three things that I can put into practice or improve upon as a result?

A

B

C
Individual Professional Development Plan
Challenging stigma and discrimination (practitioner level)

One thing I can take personal responsibility for.

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Resources</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>What will I do?</td>
<td>When will I do this?</td>
<td>What or who will I need?</td>
<td>What barriers or resistance will I face?</td>
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</table>
One thing I can advocate for and work towards.

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Please retain this Individual Professional Development Plan: working with service users (essential level) to contribute to your summary action plan once you have completed all of the learning modules.