administration, and scoring process, (3) highlight lessons learned and strategies for practical application.
Methods Iterative, participatory action methods guided CTM development and use. The 40-item CTM captures three components of community transformation: Improvement, relationships, and equity. Eighteen coalitions used the CTM at four time-points, selecting areas for improvement deemed salient to their context. Each created action plans to address these areas. Ten semi-structured interviews assessed CTM use and contextual validity.
Results Coalition's CTM scores were averaged across three community transformation dimensions. This revealed wide variation in scores with context-specific strengths and weaknesses; with the exception of one outlier, no coalitions displayed consistent strengths across dimensions. Interviews revealed the CTM used as intended: collaboratively, inclusively, and for strategizing improvements. Users perceived the CTM's greatest value as a needs assessment that operationalized systemic change concepts into descriptive indicators.
Conclusions The CTM is an actionable collaboration tool for coalitions that has recently been adapted into a validated self-assessment for communities to understand improvements in health and equity. As the first translation of maturity models for coalition use, the CTM represents a promising structure for user-led, community-level planning.

15 OVERCOMING STRUCTURAL INEQUITY IN HEALTH CARE CONTEXTS FOR PEOPLE LIVING WITH MENTAL ILLNESS AND SUBSTANCE USE ISSUES

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Background Structural stigma arbitrarily limits opportunities and/or constrains the rights of people living with substance use issues and mental illnesses. It is difficult to see –because structural stigma, inequity, and systemic bias 'hides in plain sight,' and because we are just starting to develop measures and undertake research needed to bring structural stigma properly out into the open.
Objectives This presentation will describe the multiple layers of stigma as an inequity impacting quality care for people living with mental illness and substance use issues. It will also identify opportunities for interventions to improve and dismantle structural inequities within health-care organizations summarized in our framework to action.
Methods To better understand its effects and impacts, the Mental Health Commission of Canada Research Team conducted a comprehensive literature review, qualitative research among people with lived experience, and a promising partners report to identify key priorities and areas of focus for structural change in the health-care system.
Results Early findings demonstrate that addressing structural stigma in health-care contexts requires a multipronged approach, working towards cultural change by improving attitudes and practices of health-care practitioners, strengthening integration and coordination of care, using a stigma-informed lens to evaluate and revise policies and practices, prioritizing the meaningful inclusion of people with lived and living experience at all levels, especially within research, policy and service delivery, and establishing mechanisms to monitor structural stigma (figures 1 and 2).
Conclusions This research brought into focus a comprehensive picture of the problem of structural stigma inequity; how it is experienced, how it impacts on health and quality of life outcomes, and important strategies and approaches for reshaping the way health service delivery and care is provided for people with substance use and mental health problems. These include sharing innovative models of care, developing training modules, and developing measures to identify structural stigma.

Level of Stigma	**Institutional:** health-system organizations, medical and health-care training schools, organizations in the community sector, social services, and those responsible for health policy, standards setting, and monitoring
How Stigma Operates	People with lived experience (PWLE) being made to feel "less than" (deprioritized, undertreated, denied; lack of empathy from staff)
	Physical environment not inclusive or conducive to quality care
	Institutional policies that cause harm (unnecessary interventions that humiliate, denigrate, or compromise dignity; overuse of coercion, compulsion, punitive approaches; policies that restrict access to best-evidence care; failure to implement wellness/recovery-oriented models of care [including harm reduction]; fragmentation of service)
	Diagnostic and treatment overshadowing
	Inequitable investment in services and underfunding of research
	Inadequate training of health-care professionals (mental health and substance use [MHSU] care; cultural safety/culturally responsible care and trauma- and violence-informed care; stigma-informed care)
	Failure to measure and track (quality indicators for MHSU; equity of care for people with MHSU; attitudes and practices at the level of organizational culture; client satisfaction and perspectives)
	Lack of enforcement on existing human rights protections
	MHSU stigma in the workplace (staff feel unable to disclose MHSU problems; inadequate policies and protections; culture is hostile to staff with MHSU issues; inadequate training and support; MHSU providers feel less respected and valued than physical health-care providers)
Interventions to Address Stigma	Ongoing training targeting conscious and implicit bias for all (clinical and non-clinical) health-care staff (build programs on evidence-based key ingredients and implementation guidelines, including ample use of social contact;[i] implementation and evaluation frameworks should focus on the possibility for cultural change
	Implement cultural safety and humility models and provide training for staff.
	Workforce diversity initiatives
	Establish and adhere to resource equity for MHSU care and research.
	Institutional collaboration with the community; policies that support and fund meaningful engagement with PWLE (e.g., policy development, advisory, research, service delivery, peer support/navigation roles)
	Implement trauma- and violence-informed care models and training.
	Adopt and expand recovery-oriented models of care (e.g., integrated models of care, person-centred care, harm reduction models, meaningful involvement of PWLE, trauma- and violence-informed care).
	Implement accountability and monitoring frameworks that include structural stigma reduction indicators for MHSU (e.g., indicators for equity and quality, performance, patient satisfaction, culture change, accreditation standards).
	Conduct regular policy and practice reviews using a stigma-informed lens.
	Strengthen curricula and continuing education for all health-care providers in MHSU on social determinants of health, recovery-oriented care, harm reduction, and stigma-informed care.
	Strengthen and enforce human rights protections and provide easy avenues for client complaints and resolutions.
	Strengthen policies, training, and support for staff to encourage help seeking, protect staff mental health, and improve workplace culture.

Abstract 15 Figure 1 Combating mental illness- and substance use-related structural stigma in healthcare: A framework for action

Level of Stigma	**Institutional:** health-system organizations, medical and health-care training schools, organizations in the community sector, social services, and those responsible for health policy, standards setting, and monitoring
Potential Outcomes	An institutional environment that is inclusive, welcoming, diverse, and safe
	Organizations that can meet the needs of all populations, including PWLE
	A reduction in stigmatizing beliefs and attitudes among staff and across the organization
	Improved patient/client ratings of care, satisfaction, and trust
	Improved patient/client outcomes (physical and mental health for PWLE; quality of life for PWLE)
	Earlier engagement in care for PWLE due to earlier help seeking
	Better retention in care and treatment for PWLE
	More appropriate and best-evidence care provided to PWLE
	Greater compassion satisfaction among staff
	Improved mental health of health-care staff
	Less time off work; improved worker retention
	MHSU providers that feel valued and equitably compensated within the health-care system

Abstract 15 Figure 2 Adapted from "Table 2 - Action Framework for Building an Inclusive Health System," by the Public Health Agency of Canada, Addressing stigma: Towards a more inclusive health system, The chief public health officer's report on the state of public health in Canada (p. 41), 2019, Ottawa, Canada: Copyright 2019 by Her Majesty the Queen in Right of Canada, as represented by the Minister of Health