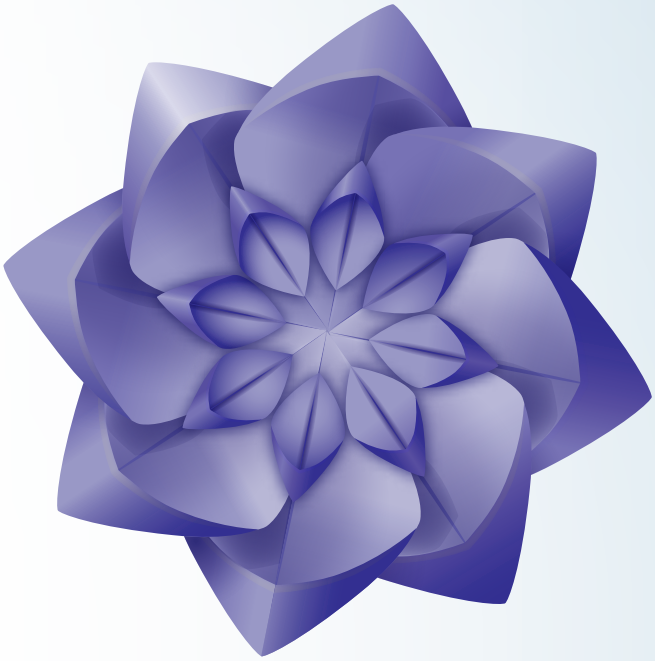

Opening Minds

Interim Report

November 18, 2013

www.mentalhealthcommission.ca

Mental Health Commission of Canada

Commission de la santé mentale du Canada

Acknowledgements

This report was prepared by the *Opening Minds* team, with contributions from principal investigators (in alphabetical order): Carolyn Dewa, Keith Dobson, Bonnie Kirsh, Terry Krupa, Bianca Lauria-Horner, Scott Patten, Heather Stuart, and Robert Whitley, and Mental Health Commission of Canada researchers and staff. The report summarizes the work of four research teams, as well as additional work being carried out by, or in conjunction with, *Opening Minds* to reduce stigma toward mental illnesses in Canada.

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The views expressed herein solely represent the Mental Health Commission of Canada.

Michael Pietrus: *Opening Minds Interim Report*, Calgary: Mental Health Commission of Canada, 2013.

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Contents

Introduction

PURPOSE

This interim report on the activities of the Mental Health Commission of Canada's *Opening Minds* anti-stigma initiative, is intended to summarize activities to date, comment on lessons learned, and identify future work and challenges.

ABOUT *OPENING MINDS*

In 2006, Canada's Standing Senate Committee on Social Affairs, Science and Technology completed a national review of mental health and addiction services in Canada. It was the most extensive study of the mental health system ever undertaken in Canadian history. One of the key observations in its final report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness, And Addiction Services in Canada,* was that there was a lack of national focus on mental health issues. To address this gap, the Committee recommended that the Government of Canada create a Mental Health Commission.

The Mental Health Commission of Canada was then established in 2007 with the support of all federal parties. Funded through Health Canada, the Commission has a 10-year mandate to act as a catalyst for improving mental health systems and changing the attitudes and behaviours of Canadians with respect to mental health issues. In its role as a catalyst, the Commission has created partnerships to focus on key projects and make recommendations to governments, service providers, community leaders, and more.

In 2001, the World Health Organization declared stigma as the "single most important barrier to overcome." *Opening Minds*, one of the Commission's major initiatives, was created in response to the knowledge that stigma is also a major barrier to people seeking help. Many describe stigma as more life-limiting and disabling than the illness itself.

Opening Minds recognizes that stigma is primarily a problem of behaviours resulting in the unfair and inequitable treatment of people with a mental illness and their family members. Thus, the goal of the initiative is to effect change that will result in tangible improvements in the day-to-day lives of those living with a mental illness.

The Hallway Group

To truly understand how harmful stigma can be, you need to talk to the people who have experienced it. And to really beat stigma, you need to go back to those same people for help.

Opening Minds knew its work to reduce stigma could never succeed unless it regularly consulted directly with the people it was doing this work for — Canadians living with mental illnesses and their families.

For that purpose, *Opening Minds* led the development of the Hallway Group. It consists of 10 people from across Canada with lived experience of a mental illness. Together, they provide us with feedback and suggestions about the work we are doing. Their support and advice is of incredible value to us.

The group is named for the informal conversations that continue in the hallways between formal meetings. Not surprisingly, those casual chats are often considered to be the most productive, and they happen around the table when the Hallway Group meets.

Additionally, our initiative is helping Canada to meet international obligations. The United Nations Convention on the Rights of Persons with Disabilities, to which Canada is a signatory, requires parties to raise awareness about the rights of people with disabilities, foster respect, combat stereotypes, prejudices, and harmful practices. *Opening Minds*, through its anti-stigma activities, helps Canada meet its obligations under that Convention.

WHAT IS STIGMA?

Opening Minds identifies stigma as a complex social process involving many parts, all of which work together to marginalize and disenfranchise people with a mental illness and their family members. Based on the recognition that stigma is primarily a problem of behaviours resulting in unfair and inequitable treatment, *Opening Minds* is working in part to cultivate an environment in which those living with a mental illness feel comfortable seeking help, treatment, and support on their journey toward recovery.

Stigma is enacted at three levels: self-stigma; public stigma; and structural stigma[2].

Self-stigma occurs when people with a mental illness accept and agree with negative cultural stereotypes. They feel ashamed, blameworthy, and try to conceal their illness from others. This may include avoiding situations that may elicit stigmatizing responses. Stigma avoidance is thought to be one of the key reasons why the majority of people who meet the criteria for a mental illness do not seek care[3].

Public stigma encompasses the prejudicial attitudes and discriminatory behaviours expressed toward people with a mental illness by members of the public. Public stigma is based on deeply held prejudices that are, by definition, resistant to change. Cultural attributions that fuel public stigma include the ideas that people with a mental illness can never recover; they are violent and unpredictable; they are blameworthy and could control their illness.

Structural stigma occurs at the level of institutions, policies, and laws. It creates situations in which people with a mental illness are treated inequitably and unfairly, for example when they are denied their basic human rights, or when policy agendas do not give mental health issues high priority.

Developing an Approach

Where and how does one begin to tackle such a pervasive and challenging problem as stigma?

If *Opening Minds* was to follow in the footsteps of a number of countries, the answer would have been to launch a large, expensive social marketing campaign. And yet, such campaigns often end up with little in the way of results to show for their hard work and many dollars spent.

When the Mental Health Commission was first developing the *Opening Minds* initiative, it planned to incorporate a media campaign in its efforts, and began with a small, public education campaign launched in 2009. During this campaign, *Opening Minds* reached out to a variety of media sources to transmit positive messages concerning people who have a mental illness.

The results were disappointing and we knew it would not be cost-effective to undertake a larger, long-term media campaign when there was no hint from our data that we would achieve positive results. In the interim, we had discovered there are already hundreds of anti-stigma programs being delivered in communities across the country. Few of these had ever been formally evaluated to see if they were actually working, and in that we recognized a tremendous opportunity. We knew what *Opening Minds* needed to do; identify these programs, evaluate their effectiveness, develop anti-stigma program tool kits based on these findings, and work with partners to replicate these programs across the country. There is also evidence suggesting that anti-stigma initiatives need to be tailored to the audience being targeted — and we have incorporated this finding into our work.

In comparison with social marketing and public awareness campaigning, our more focused, grass-roots approach is much more cost-effective and sustainable over time. And unlike the former, this approach is actually capable of getting the results needed — changes in Canadians' attitudes and behaviours toward people with a mental illness.

PROGRAM EVALUATIONS

In order to build on these existing programs, *Opening Minds* has coordinated and is funding a series of evaluation projects. These projects evaluate anti-stigma programs aimed at one of three target groups: youth, health care providers, and the workforce. The goal is to understand the best or promising practices in the field, then create resources and toolkits that could be made available on a national (or international) scale to other communities and stakeholders who wish to begin their own anti-stigma efforts. In this way, the central operating tenet of the *Opening Minds* initiative has been to identify, document, and disseminate leading practices in stigma reduction using networks of existing programs as community leaders.

Opening Minds recruited principal academic investigators for each target group and assigned research associates to support the evaluation activities. Program representatives agreed that projects delivering similar interventions would use similar evaluation strategies with common assessment tools (questionnaires). In this way, outcomes could be compared across settings to help determine which program activities would yield the greatest effects.

Participants would be tested before and after their exposure to the anti-stigma intervention being evaluated. In some cases, they were tested again a few months after participating in the program to determine if the changes were sustained.

CHOOSING TARGET GROUPS

The stigma surrounding mental illnesses touches Canadians in every demographic and in every corner of the country. Anyone can stigmatize and anyone can experience stigma. *Opening Minds* had the challenge of deciding which of these many individual groups to begin targeting with its anti-stigma work, while keeping in mind the goal of effecting positive change in the lives of all Canadians with mental illnesses.

Based on feedback received in the 2006 national consultation undertaken by the Senate Committee on Social Affairs, Science and Technology, the Mental Health Commission of Canada identified youth and health care providers as key audiences for anti-stigma efforts. Two more groups were later added, resulting in these four initial target groups:

Youth 12-18

The majority of adults living with a mental illness say their symptoms developed before they were 18 years old. Young people are at a high risk of being stigmatized and the fear of stigma often delays diagnosis and treatment; therefore, early intervention can make an enormous difference in the quality of life of an individual. A major survey conducted by *Opening Minds* in partnership with Statistics Canada found that youth are the group in the Canadian population most affected by stigma. Nearly 60% of youth 25 years of age and under, treated for a mental illness in the past year, reported being affected by the impact of stigma compared to fewer than 20% of adults 45 years of age and over.

It has been estimated that one in five Ontario youth will meet the criteria for a mental disorder each year[4]. There is also some evidence that Canadian youth may experience higher levels of emotional distress than youth in other countries. In a multi-country study conducted by the World Health Organization, Canadian students were among the most likely to report feeling depressed for a week or more, with estimates ranging from a quarter to over one third, depending on age and gender[5].

In our work to identify, evaluate, and then replicate successful anti-stigma programs for young people, we are hoping to create help-seeking and supportive environments for our youth in their schools and among their peers.

Health Care Providers

People who seek help for mental health problems report that they often experience some of the most deeply felt stigma from front–line health care personnel. Research shows stigma and discrimination in health care to be a major barrier to access, quality care, treatment, and recovery. For example, people using mental health services often say they feel "patronized, punished or humiliated" in their interactions with health professionals[6].

This stigmatizing behaviour is often unintentional, as many health care providers are unaware that the language they use or the actions they take can be harmful to people with lived experience of mental illness. Negative attitudes and stereotypes, prognostic negativity (pessimism about a person's chance of recovery), diagnostic overshadowing (the tendency to misattribute unrelated symptoms and complaints to the person's mental illness), marginalization (not wanting to treat psychiatric symptoms in a medical setting), lack of training and insufficient skills are among the key concerns for this target group[6,7,8,9,10].

The News Media

Research from across the western world indicates that the public relies on the media as one of its main sources of information about mental health and mental illnesses[11]. This includes newspaper articles, television broadcasts, radio broadcasts, and internet sites.

The accumulated findings of this research suggest that the news media play an important role in creating and maintaining some of the popular stereotypes that are associated with

people with a mental illness. Such stereotypes can influence societal reactions to people with a mental illness[12]. On the one hand, a glut of articles about crime and violence vis-a-vis mental illnesses may lead to fear and avoidance of people living with a mental illness by the general public. On the other hand, a series of articles that focus on recovery and rehabilitation of people with a mental illness may lead to a more kindly and compassionate reaction.

The Workforce

One out of every four or five employees is affected by a mental health problem every year. Many individuals may experience anxiety, depression, and other mental health problems during their prime working years[13], resulting in sick leave and limited productivity. And many workers choose to go untreated rather than risk being labeled as "unreliable, unproductive, and untrustworthy".

In concert with the toll that mental illnesses have on individuals and their families, their effects on the Canadian economy are enormous, estimated to be at least $50 billion per year. Short-term and long-term disability claims related to mental health account for 30% of all work-related disability claims[14] and cost organizations approximately double the average ($18,000 vs. $9,000) of a non-mental health related disability claim.

The Mental Health Commission of Canada recently identified improving mental health in the workforce as one of its key priorities moving forward in its mandate. This year, it launched the *National Standard of Canada for Psychological Health and Safety in the Workplace*, a voluntary standard to help employers foster healthier work environments. Additionally, the Commission's Mental Health First Aid program continues to expand its reach into more businesses and organizations to train employers and employees how to recognize emerging mental health problems or crises and provide early help. *Opening Minds* works in collaboration with these and other initiatives targeting the workforce to help ensure stigma is considered in every aspect of our approach.

DEVELOPMENT OF MEASURES

As a building block to evaluation, one of *Opening Minds*' first major tasks was to develop reliable and valid methods of testing peoples' attitudes and behavioural intentions toward people with a mental illness before and after exposure to an anti-stigma program.

Researchers collected and studied many of the homegrown questionnaires that grassroots anti-stigma programs were already using, as well as those reported in scientific literature, when available. Each research team (health care, youth, and workforce) developed and strategically tested a number of different assessment measures (questionnaires).

Youth: The youth research team developed two 11-item scales. The first measured stereotypic attributions (controllability of the illness, potential for recovery, and potential for violence and unpredictability) and the other measured behavioural intentions related to social acceptance (desire for social distance and feelings of social responsibility for mental health issues). Questions were worded to be accessible to a grade six reading level.

Health Care Providers: In developing a questionnaire for this target group, it was important that we would be able to capture attitudes and behavioural intentions in relation to phenomena unique to that target group, such as diagnostic overshadowing and prognostic negativity, as mentioned previously. It was also important to be able to learn their perceptions of competence and personal control among people living with mental illnesses, and the extent to which the health care providers feel they have a role or responsibility as advocates for such.

Workforce: In the case of the workforce, two separate questionnaires were ultimately developed and used. The first is a 23-item questionnaire to assess employees' stigmatizing attitudes, beliefs, and behaviours in the workplace towards co-workers who may have a mental illness. The second questionnaire was derived from existing items from various studies[15,16,17] and assesses stigma-related attitudes specific to the supervisor role. The latter was considered necessary as a separate questionnaire, as supervisors have distinct duties and challenges when dealing with an employee with mental health issues.

A questionnaire for each target group is included as an appendix in this document.

FORGING PARTNERSHIPS

Opening Minds identified potential partner programs targeting youth and health care professionals by issuing a Request for Interest (RFI). In 2009, the RFI was distributed widely through various mental health networks, institutions, associations, and individuals. We received nearly 250 requests; 44% were programs focusing on youth audiences and 56% focused on health care professionals.

To review the applications, *Opening Minds* formed an impartial selection committee comprised of national and international experts, including people with lived experience of a mental illness, family members, researchers, policy makers, mental health advocates, and anti-stigma experts. Based on knowledge of promising practices in the literature, priority was given to programs that:

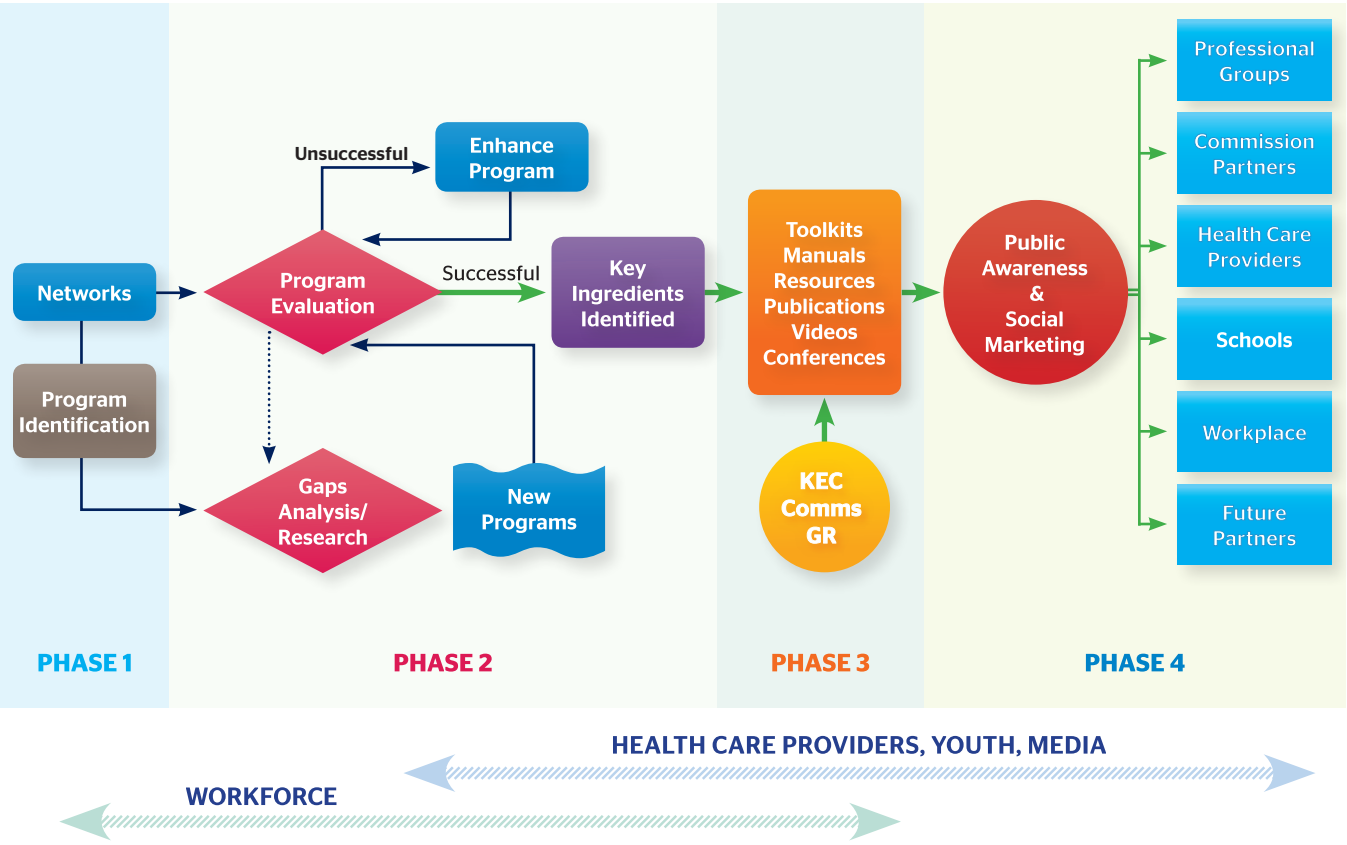
- Were contact-based interventions in which people with lived experience of a mental illness were involved in the delivery of the program. Typically, contact-based education involves trained speakers who share their personal story of recovery and engage audiences in active discussion.
- Had stable funding so that the program would not be in jeopardy of closing during the life of the *Opening Minds* initiative. Just over half (54%) of the youth programs and 57% of the health care provider programs indicated they had stable funding.
- Had been evaluated and shown to be effective. Unfortunately, less than half of the programs responding to the RFI indicated they had been evaluated. Of the programs that had undergone evaluation, the majority had examined customer satisfaction rather than changes in stigma.
- Had the potential to be widely disseminated if demonstrated to be effective.

In terms of forging partnerships with the media over a three year period, we tried numerous approaches, including owners, publishers, associations, and unions. We finally made a connection with the Canadian Journalism Forum, which was doing related work with journalists in the area of looking at post-traumatic stress disorder.

Forging partnerships with businesses and organizations to evaluate workforce anti-stigma programs proved to be considerably slower and much more challenging. We have largely developed partnerships with employers through existing partners, for example Alberta Health Services, or by directly canvasing groups and employers we knew had an interest.

The *Opening Minds* process model in Figure 1 below summarizes the phased-in approach taken.

Figure 1: *Opening Minds* Process Model



In Phase 1, programs are identified.

In Phase 2, evaluations are conducted and work undertaken to enhance programs. This phase in the process also enables us to identify potential gaps and difficult-to-reach groups. Ingredients key to the success of programs are identified.

In Phase 3, toolkits, manuals, and other resources are developed based on the most successful approaches identified in the evaluations.

In Phase 4, when successful products are available, we will use techniques such as social marketing and public awareness campaigns to make these products widely available and to assist in replicating successful programs throughout Canada.

BUILDING NETWORKS OF PRACTICE

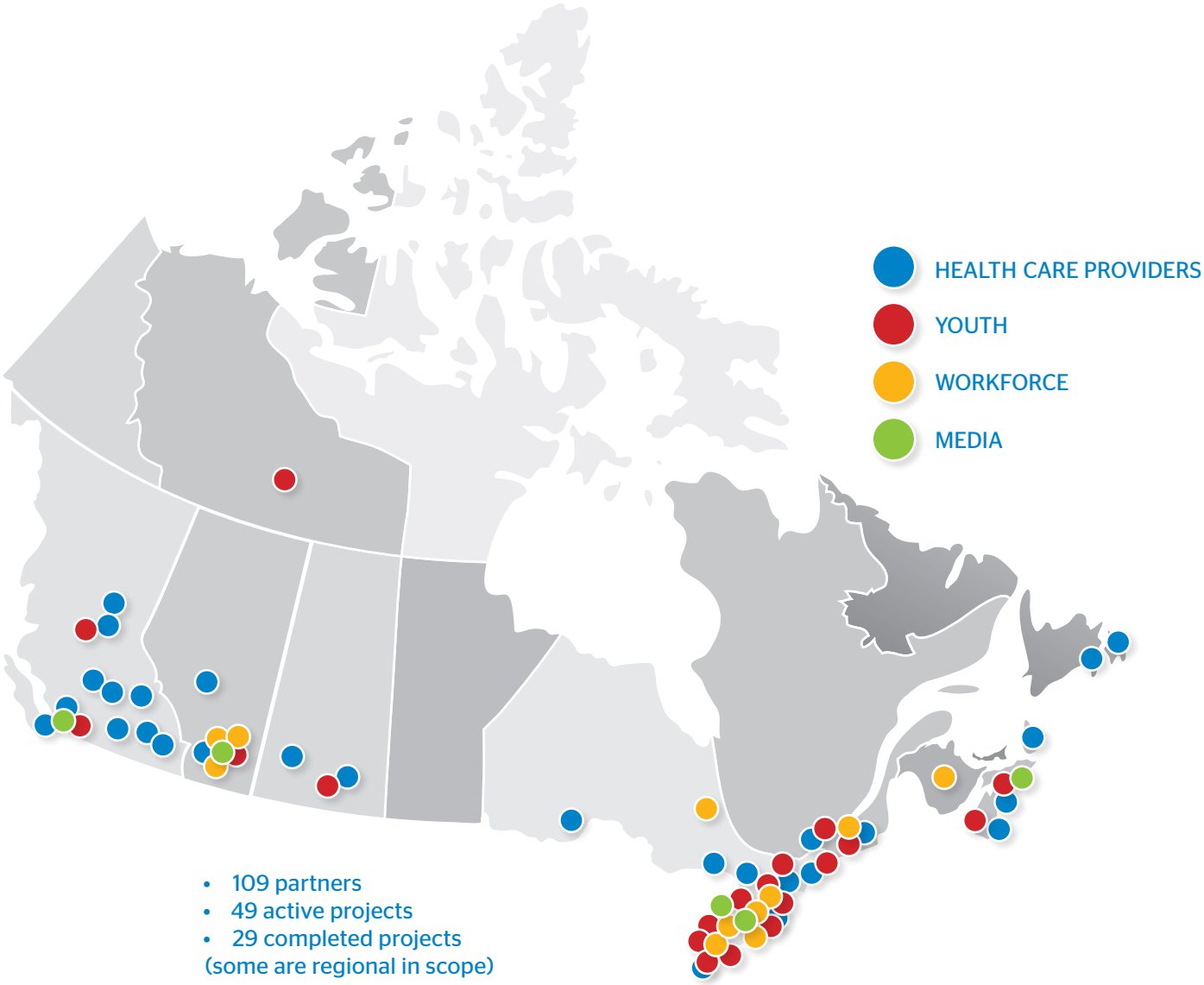
Opening Minds determined that a key element of its approach would be to foster networks of practice, so local programs that were demonstrated to be effective could develop a wider reach and contribute to a national effort, and program leaders could act as mentors to newly developing programs.

Opening Minds is now working with more than 100 partner organizations. At least half of those partners are or have been involved in developing and evaluating contact-based anti-stigma programs that have the potential to be broadly disseminated once they have been demonstrated to be effective.

Fostering grassroots initiatives and working with university-affiliated researchers to develop evaluation networks are key components of the *Opening Minds* strategy. We have partnered with a multi-disciplinary team of junior and senior academics at The University of Calgary, Queen's University, the University of Toronto, McGill University, and Dalhousie University. This is the only anti-stigma program worldwide with such a broad base of academic support. For a list of all of *Opening Minds*' more than 100 partner organizations, please refer to Appendix D.

Figure 2 below illustrates the dozens of program partnerships occurring across the country. A list of all of the programs and the status of their evaluations can be found online at **http://www.MentalHealthCommission.ca/English/OM-Programs-by-Province**

Figure 2: Geographical Breakdown of *Opening Minds* Projects



Target Group: Youth

ACTIVITIES AND FINDINGS TO DATE

The *Opening Minds*' youth research team is nearing completion or has completed evaluation and data analyses of more than 20 anti-stigma programs and surveys of 10,000 Canadian youth. The researchers have identified a number of programs that have shown positive results, and *Opening Minds* has already begun work on replicating some of these programs in other communities.

COMMUNITY DEVELOPMENT APPROACH

Opening Minds has partnered with programs that are currently in the field delivering anti-stigma messages to students. By involving them in an evaluation network, we have encouraged them to critically reflect on their evaluation data in a way that will strengthen their interventions. Based on their findings, two programs discontinued their approach, another made important changes to the speaker selection and training, and the remaining programs deliberately tried to improve areas where they considered they were not achieving the desired level of improvement. Based on their experiences, program personnel have become leaders for their peers. This approach promotes sustainable development.

LARGEST EVALUATION DATASET

Our evaluation work is based on the largest dataset of its kind for this work, with more than 10,000 students from across Canada represented. This means that results are more generalizable than results from smaller, local efforts.

All programs are implementing similar interventions (contact-based education), but are doing it in slightly different ways. The variation that is visible by using the same questionnaire for each program has allowed us to begin to understand what activities and supports are needed to maximize positive outcomes.

HIGH LEVEL RESULTS

Figure 3 on the next page shows the results on the Stereotype scale for 15 programs. It shows the proportion of students who received an A-grade (reflecting 80% of the questionnaire items correct) on the pre- and the post-test. The difference between the bars illustrates the amount of improvement. It shows that large changes (25-30%) occurred for several programs, which highlights them as the best in class. It also shows that several programs did quite poorly with little or no change.

70% of adults living with a mental illness say the onset occurred before age 18

Early intervention can make a dramatic difference in a child's quality of life

Only one in six children diagnosed with a mental health problem will get treatment

40% of parents say they would not admit to anyone, not even their doctor, that they had a child with a mental illness

Figure 3: Proportion of Students Who Received an A-Grade (80% correct) on the Stereotype Questionnaire by Program

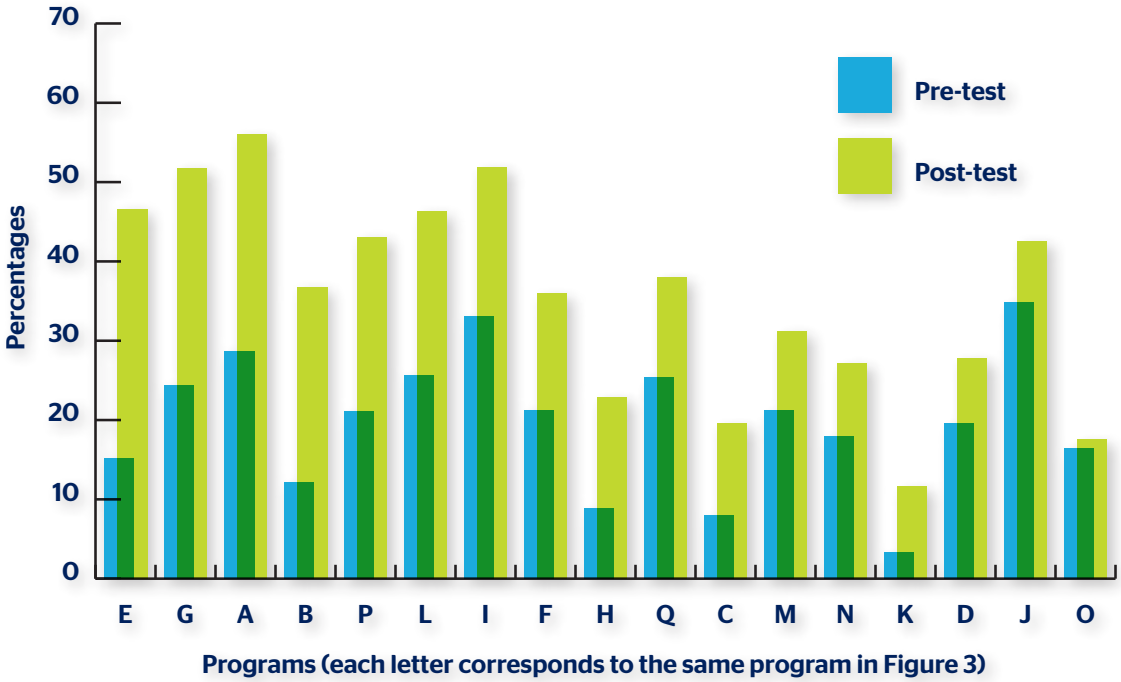
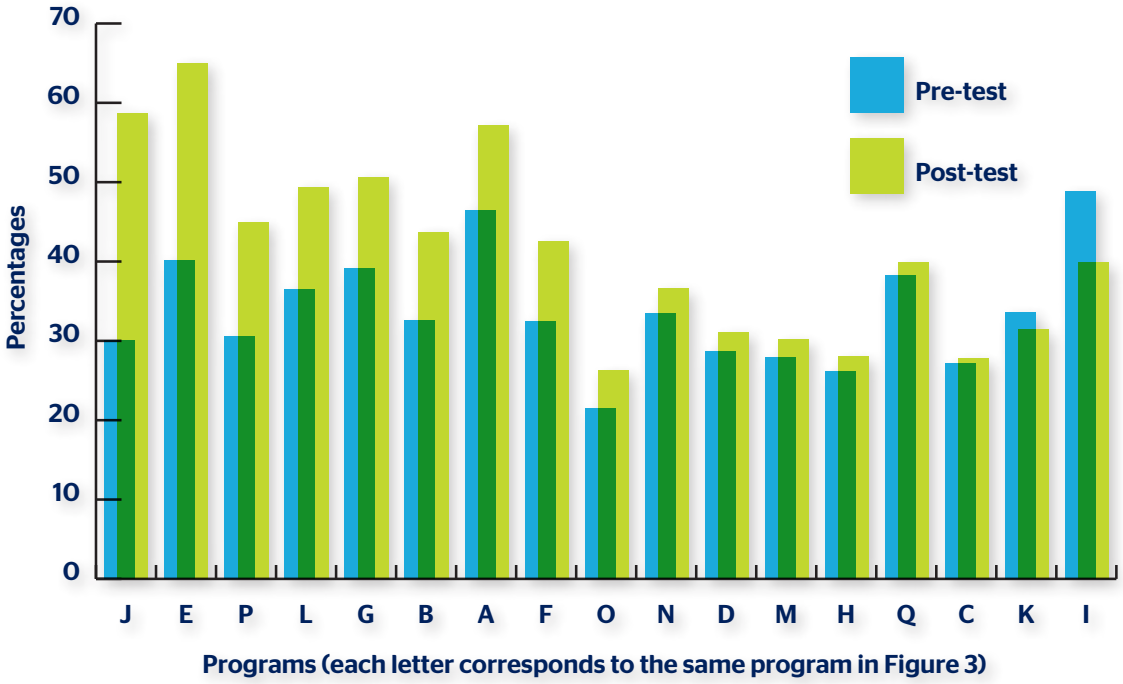


Figure 4 on the following page shows the results on the Social Acceptance Questionnaire for the same 15 programs. It shows that, on average, the changes in social acceptance were smaller than the previous measure. It also shows that two programs were able to create large changes, in the order of 25% to 30%. These programs were also the ones that showed the largest change in the Stereotype Questionnaire, making them the most effective, overall, in reducing stigma. It also shows that several programs were unable to improve social acceptance.

> "...when [students] see us and when they meet us ... they can see that we're just like everyday average citizens. They have a live example in front of them of what is ... a person with mental health issues. We just need to tell them that stigma is wrong, you know, it's morally wrong."
>
> **Speaker with lived experience of mental illness**

Figure 4: Proportion of Students Who Received an A-Grade (80% correct) on the Social Acceptance Questionnaire by Program



IDENTIFYING A NEED FOR SUPPLEMENTAL PROGRAMS

Though we have been unable to collect follow-up data, we have every reason to believe that effects of individual programs will dwindle over time. For this reason, the research team has recommended that, in addition to a solid foundation of contact-based education, schools should consider implementing additional 'booster' activities that occur at regular intervals throughout the year to consolidate and improve effects.

ROLLING OUT SUCCESSFUL PRODUCTS AND REPLICATING PROGRAMS

Opening Minds is already disseminating its research on youth anti-stigma programs so that other groups and organizations may benefit from what we are learning. We are also planning to roll out some of the most successful products and replicating some of the most promising programs in communities across the country.

Below are examples of just some of the high-performing programs that have been identified by the *Opening Minds* research team, along with information about how we are helping to expand their reach into other communities across the country.

1. **Durham Talking About Mental Illness (TAMI) Coalition –** While this multi-faceted program was originally developed by the Centre for Addiction and Mental Health in Toronto more than a decade ago, this particular version has been enhanced over the years by the Ontario Shores Centre for Mental Health Sciences in Whitby, Ontario, with help from a strong local coalition of organizations. One part is a five class learning curriculum for grades 7-12, that includes a professional development workshop for teachers. Another program is a stigma summit, a one-day event bringing together students and teachers from various high schools to receive education and experiential exercises. Contact-based education with speakers who have lived experience of mental illness is central to all program components.

Our activities – *Opening Minds* has replicated the Durham TAMI five class curriculum program in elementary and high schools in Yellowknife and Winnipeg. Plans are in development for a major national summit to facilitate the upscaling and replication of this model. We are also working to incorporate the best elements from other TAMI/contact-based education programs (such as CMHA Champlain East and Beautiful Minds) into our overall process model and toolkits.

2. ***Iris the Dragon*** **Series –** *He Shoots. He Scores* is one of the *Iris* books for children that were created in Perth, Ontario, to address children's mental health challenges in a non-threatening and supportive way. It uses the personal story of the main character to simulate contact with someone who has had a mental health challenge (termed 'indirect contact'). It showed positive results in reducing stigma among students. The *Iris* books help educate readers about mental health and wellness, at the same time showing how a caring community can support children to reach their potential, tackling several topics, including Bipolar, Anxiety Disorder, ADHD, and Asperger's Syndrome.

   Our activities – *He Shoots. He Scores* is now available online and free of charge, so *Opening Minds* is beginning to promote and share it with schools across the country.

3. **Partnership Program –** This is a panel presentation for high school students in Saskatoon and Regina, Saskatchewan, that aims to reduce the stigma and misconceptions associated with mental illness. Teams of three people — a person living with schizophrenia, depression or bipolar disorder, a family member who has an ill relative, and a mental health professional — share their personal stories. The mental health professional also provides a clinical overview of the illness. A discussion follows.

   Our activities – *Opening Minds* will share the successful results of the Partnership Program with other Schizophrenia Societies across Canada, and other similar stakeholder organizations.

4. **Dream Team –** This Ontario-based program is delivered by a group of people with lived experience in mental health and addictions issues. Dream Team members take their message to youth in schools and universities, as well as other populations, to increase awareness about the lives of people with mental health issues and their contributions to the community.

   Our activities – Dream Team is a program that is unique to Toronto, but one that could serve as a model to other community groups in Canada. *Opening Minds* will connect any interested group directly with the Dream Team.

5. **mindyourmind –** This youth website based in London, Ontario, developed an online program for Grade 11 students that provides information about mental illness, resources, first person stories, and interactive coping tools. The objective is to improve knowledge about mental health and reduce stigma and other barriers to youth seeking help.

   Our activities – There are proprietary challenges surrounding this program, but we are working with mindyourmind to determine how it can be shared broadly. The program will be incredibly useful to schools throughout the country; students in any school can do it and the content can be easily tailored for different youth populations and school requirements.

Detailed reports on each of these programs are available at **http://www.mentalhealthcommission.ca/English/initiatives-and-projects/opening-minds**

SOME LESSONS LEARNED SO FAR

The research team has already identified some key lessons from its evaluations and data analysis. Some of these lessons are listed below.

- Not every program is successful and some can do harm by concretizing negative stereotypes and provoking negative change.
- Short one-off interventions don't allow for the engagement and the active participation that is needed to maximize change. Programs need to think about sustainable change using the in-class portion as one component of a whole-school anti-stigma strategy, including booster sessions and other student-led activities.
- A cornerstone of contact-based education is a story told by someone who has experienced a mental illness, but we have learned that not every story is a good story. Stories have to have a consistent theme of hope and recovery.
- Not every person is a good storyteller. The best storytellers can engage their audience and allow for active participation through questions and discussion. They are psychologically ready to share their experiences and open to discussion. This takes considerable training and support.

These and other lessons learned with respect to mounting a successful school-based anti-stigma program are summarized in a logic model, an example of which appears in Appendix E. It was developed following detailed qualitative inquiry of 18 programs from across Canada, and in-depth interviews with three speakers with lived experience and one family member. The logic model will be further developed to create a set of quantitatively-verified criteria that can be used by new and existing programs to assess their fidelity to the best or promising practice in contact-based education. This work is expected to be completed in the fall of 2013. The model and toolkits will be made available on the *Opening Minds* website.

In both youth surveys, students are presented with a number of statements and asked to indicate whether they agree or disagree, and to what degree.

Sample statements from the Stereotype Questionnaire:

- People with serious mental illnesses need to be locked away.
- You can't rely on someone with a mental illness.
- Most people with a mental illness get what they deserve.

Sample statements from the Social Acceptance Questionnaire:

- I would be upset if someone with a mental illness always sat next to me in class.
- I would not be close friends with someone I knew had a mental illness.
- I would try to avoid someone with a mental illness.

FUTURE DIRECTIONS

The logic model and large database of program outcomes make it possible for the research team to use quantitative analysis to better identify the key characteristics that make a successful anti-stigma youth program. The resulting criteria can assist new and existing programs to ensure that they are in line with best or promising practices.

As *Opening Minds* helps to further replicate successful programs, we have an opportunity to work with schools to collect comparative data. This will allow us to strengthen our inferences regarding program effects. One school district in Winnipeg has already agreed in principle to let the program staff collect data on children who have not received the intervention (a wait list control).

We don't know why some students change more than others (and some not at all). In future work, it will be important to isolate predictors of change so that programs may be more precisely targeted to students' learning needs.

Now that we have identified successful program approaches, it will be important to assess the business case. This means we will have to be able to document the cost of presenting a successful program, as well as the return on investment for students and schools. *Opening Minds* has an economist on its team, so the major challenge will be finding a school that will let us access its student data in order to determine costs and returns.

The research team has not had much opportunity to study primary school students, but believes it is important to reach children as early as possible, before stereotypes become concretized. We need to think about how contact-based principles could be incorporated into elementary schools in age-appropriate ways.

We have also identified a number of additional populations for which specific and tailored interventions do not exist (including Aboriginal youth and multi-cultural youth). Future work will need to translate the successful contact-based approaches so that they are appropriate for these additional populations.

Target Group: Health Care Providers

ACTIVITIES AND FINDINGS TO DATE

Opening Minds' health care providers research team is nearing completion or has completed evaluation and data analyses of more than two dozen anti-stigma programs targeting this group. The researchers have identified many programs that have shown positive results in reducing stigma within this group. *Opening Minds* has already begun work on replicating some of these proven programs in other communities.

The researchers have incorporated a qualitative component into their evaluation to examine anti-stigma programs in greater depth and detail. So in addition to the questionnaires given to participants before and after their exposure to a program, researchers are conducting in-depth interviews with the program facilitators, program developers, people with lived experience of a mental illness, and more. This is enabling us to better identify best or promising practices and processes, and to gain further theoretical understanding of the process of building a successful anti-stigma program for health care providers.

PROGRAMS SHOW POSITIVE RESULTS OVERALL

There is strong overall evidence of positive change for the health care provider programs we are evaluating. Thirteen of the programs have shown to have led to statistically significant improvements in participants' intended behaviours. All but two programs have demonstrated some level of positive change from pre-to post-program.

Among the programs evaluated to date, those which emphasize social contact with people with lived experience of a mental illness, as well as programs emphasizing skills training for health care providers in treating and interacting with people who use mental health services, have both been shown to be effective. Skills training might work well with other groups, for example, teachers, police, and leaders in the workplace, but, as yet, we have no data to support this theory.

Stigma is one of the key barriers preventing many people from getting help

Many say living with stigma is worse than the illness itself

Some of the most deeply felt stigma comes from front line health care professionals

Many people who seek help for mental health concerns feel disrespected and discriminated against by them

Some Other Key Findings

Short programs can work just as well as longer programs, if designed and delivered properly.

Programs may be more likely to be successful if they make use of multiple forms of contact-based education, such as live personal testimony, as well as video.

"One-off" programs are unlikely to sustain the positive change, so programs should hold additional sessions over time.

Successful programs tend to have some type of incentive or expectation for participation, such as education credits, paid-for time, or position back-filling.

Preliminary findings from our qualitative research provide some possible key factors for successful program design, regardless of whether the program is focused primarily on contact-based education or skills training. Some of these emerging key factors include the following:

Put the person ahead of the illness. Combating stigma requires health care providers to make the connection and see the person behind the diagnosis.

Demonstrate recovery and competence. If anti-stigma programs are to be effective, they need to highlight that recovery is both possible and probable. One way to do this is through social contact with people with lived experience of a mental illness who can speak about their own journey of recovery.

Teach health care providers what to do. Another emerging theme is that health care providers often feel ill-trained in the field of mental illness; they don't know how to help. Healthcare providers' sense of helplessness is likely to contribute to stigma[9].

Find a passionate champion who models anti-stigma. A program's success may also have something to do with the champion(s) designing and delivering the program.

PROGRAMS MAY HAVE GREATER IMPACT IF FOCUSED ON A SPECIFIC ILLNESS

Programs targeting a specific type of mental illness may see a greater reduction in stigma towards that specific illness rather than towards mental illness in general. For a program on borderline personality disorder, researchers used both the original questionnaire they had created for health care providers, and a second version in which each instance of the term 'mental illness' was replaced with the term 'borderline personality disorder'. The program showed a statistically significant positive effect on both versions of the questionnaire. However, the amount of change after exposure to the program was much greater for the specific illness of borderline personality disorder than it was for mental illness in general.

DISCOVERING DIFFERENCES AMONG PROGRAMS

The research team is finding considerable differences among the various programs being evaluated, such as their amount or type of social contact provided. This diversity provides a valuable opportunity to learn about what contributes to successful programs and initiatives.

REACHING SOME ADDITIONAL POPULATIONS

To begin to reach additional populations we are partnering with three large Community Health Centres (CHCs) in Toronto, which are developing and implementing an anti-stigma and pro-recovery intervention, with particular focus on immigrant populations from Africa, Latin America, the Caribbean, and other minority

populations including Asian and South Asian. The CHCs will clarify the stigma of mental health problems and substance use issues among these populations, and use their findings when developing the program which *Opening Minds* will evaluate.

REACHING PHYSICIANS

Physicians in particular have been a challenging group to reach. The researchers have observed that many of the anti-stigma programs designed for health care providers in hospitals and/or community health care settings are not well attended by physicians. As such, we have had to seek out partners specifically interested in designing, delivering, and evaluating programs targeting this particular group.

As an example of how well that can work, *Opening Minds* is collaborating on a randomized control study of a special program designed for family physicians in Nova Scotia. Originally developed in British Columbia, the Practice Support Program has been shown to reduce stigma and increase the skills and confidence of doctors treating patients with mental health problems. The study will look at stigma reduction, effect on emergency room visits, visits to specialists, pharmaceutical costs, and other economic factors. The partnership includes the Nova Scotia Department of Health, Nova Scotia College of Family Physicians, Doctors Nova Scotia, and the British Columbia Medical Association.

ROLLING OUT AND REPLICATING SUCCESSFUL PROGRAMS

Below are just a few examples of some of the high-performing programs that have been identified by the *Opening Minds* research team, along with information about how we are helping to expand their reach into other communities across the country.

1. **Central Local Health Integrated Network (LHIN) Program –** The Central LHIN, north of Toronto, created and delivered this program to hospital workers and support staff in its region. During the two-hour program, people with lived experience of a mental illness talk to frontline workers about their illness, the impact stigma plays on their recovery and what helps to make a positive difference. These firsthand stories complement and reinforce other content of the training course, such as a PowerPoint presentation, a video/DVD, interactive activities, and a discussion with people with lived experience.

   Our activities – *Opening Minds* has already replicated the program in seven community hospital emergency rooms in Interior British Columbia, as well at the IWK Children's Hospital in Halifax, Nova Scotia, three other LHINs in Ontario, and in an Alberta Health Services webinar for all mental health care providers in Alberta. In fall 2013, we are replicating the program for the Vancouver Island Health Authority, following a day-long workshop we supported to train facilitators to deliver the program. The DVD we helped to create is being used as a discussion tool by program facilitators around the country to reduce stigma.

2. **University Programs –** We have identified a number of promising programs already being delivered in universities. These include the University of Alberta Occupational Therapy curriculum, Brandon University Psychiatric Nursing Program, Pharmacy Curriculum (the universities of Dalhousie, Memorial and Saskatchewan), and the Mind Course at the University of Calgary's School of Medicine.

   Our activities – *Opening Minds* will be contacting other universities throughout Canada that offer health care training in these areas, with the hope of sharing these potential tools and promising programs to reduce stigma among even more students.

3. **Practice Support Program (PSP) Mental Health Module and Cognitive Behavioural Interpersonal Skills (CBIS) –** The in-depth PSP Program was created in British Columbia to help increase the knowledge and skill level among family doctors. Research by *Opening Minds* shows it also reduces stigma. CBIS is one section of the PSP Module which provides physicians, as well as other health care providers, with skills and tools to help treat people with lived experience of mental illness. These result in individuals becoming more empowered, more active, and more relaxed with improved cognition. Physicians are also taught interviewing and assessment skills.

   Our activities – *Opening Minds* has helped to bring a scaled-down, day-long version of the PSP program to a family physicians conference in Montréal. We will also be replicating the full PSP training program in Nova Scotia, where it will undergo a randomized control study. Additionally, parts of the PSP program have been used in the online continuing medical education program for family physicians, created with support by *Opening Minds* in partnership with several organizations including the Canadian Medical Association and the Mood Disorders Society of Canada. We have also replicated CBIS as a webinar for Alberta Health Services mental health employees.

Detailed reports on each of these programs are available at **http://www.mentalhealthcommission.ca/English/initiatives-and-projects/opening-minds**

FUTURE DIRECTIONS

Opening Minds' next main priority is to further understand what exactly makes some anti-stigma programs for health care providers and health care providers-in-training more effective than others. Researchers will be looking for answers to the following questions:

- What are the main differences and similarities between programs that have shown more positive evaluation results and those that have shown less positive results?
- What are the critical components of effective anti-stigma programs aimed at health care providers/health care providers-in-training?
- Do critical components differ depending on health care provider type (e.g., student versus practicing professional; physicians versus nurses, etc.) and/or institutional context (e.g., hospital versus university; ER department versus other hospital department)?
- What are the underlying processes responsible for bringing about changes in mental illness attitudes and/or behavioural intentions?

Additional themes regarding the key components for effective anti-stigma programming for health care providers will continue to emerge and be refined as the *Opening Minds*' health care research team furthers its work.

Upon completion of remaining evaluations and data analysis, researchers will create a logic model for developing effective anti-stigma programs for health care providers and health care providers-in-training.

The next step is building a full toolkit for successful anti-stigma programming for health care providers, including the logic model, whole programs proven to be effective, facilitator guides and other relevant resources. The completed logic model — and its accompanying report — will become one of the core tools in the health care provider anti-stigma toolbox. This research is approximately halfway to completion. Draft results will be delivered in 2014. *Opening Minds* will help to disseminate the findings and toolkit, making knowledge, tools, and resources available and accessible as widely as possible.

Our network of health care partners is steadily growing. Universities, health regions, hospitals, and other health care provider partners are approaching us looking for opportunities to collaborate and co-operate. This is a great strength for *Opening Minds*' ability to replicate successful programs in other jurisdictions and contexts, to continue to build our evidence-based approach, and to help identify the most important policy goals/legislative changes in the area of stigma aimed at changing behaviours, and promote the value of these changes.

Another key strength is our partners. Many of our health care partners are willing to freely share their anti-stigma programs, tools, and resources. Most partners are also enthusiastic evaluation collaborators, using the evaluation results provided to them to further improve and refine their programs and/or to promoting their programs for greater sustainability or growth.

The media has considerable influence on shaping public opinion

Words have power – they have the power to soothe or hurt, honour or insult, inform or misinform

The media is the public's main source of information on mental health and mental illnesses

More than 40% of Canadian news stories about mental health focus on murder and violent crimes

Target Group: News Media

ACTIVITIES AND FINDINGS TO DATE

Opening Minds is taking an approach with the news media that differs from the work it is doing with its other three target groups. We are trying to better inform current and future journalists about mental health, mental illnesses, and stigma, so they can avoid using stigmatizing language and assumptions in their reporting that can perpetuate the many misconceptions surrounding these issues.

We're also studying exactly how, and how often, the news media in Canada portrays people living with mental illnesses in its coverage. The preliminary findings indicate there is much need for improvement.

MEDIA RESOURCE GUIDE

Opening Minds has contracted The Canadian Journalism Forum on Violence and Trauma to research and write a new media resource guide. It is called *Mindset, Reporting on Mental Health*. Also partnering on the project is the Canadian Broadcasting Corporation (CBC).

The Media Resource Guide will include information about:

- the problems created by stigma and discrimination
- statistics and information about mental illnesses
- symptoms of different kinds of mental health issues
- myths perpetuated about mental illnesses
- research findings about stigma in Canadian news stories
- suggestions on how to cover stories about violence
- language use in news stories
- contacts who can help journalists preparing news stories
- references
- examples of stories that help reduce stigma

Journalists as a whole strongly resist being told how to cover the news by outsiders. *Opening Minds* has worked diligently to get senior journalistic leaders onside, who would be willing to create the guide. Once the guide is completed it will be tested at CBC for its effectiveness.

The guide will be available in a print and digital form, and will be ready for dissemination in early 2014. An internet site will be created to house the downloadable guide, with extensive links to other resources and in-depth case studies. This website will be updated regularly and contain a blog and forum for journalists and editors.

JOURNALISM SCHOOL SYMPOSIA/NEW JOURNALISM SCHOOL CURRICULUM

Over the last few years, *Opening Minds* has held symposia at a number of university journalism schools, taking the message about stigma to journalists-in-training. The media research team completed an evaluation on the pilot symposium at Mount Royal University and a comparison evaluation conducted at King's College School of Journalism at Dalhousie University. Results from both show symposia are effective at reducing stigma.

Delivering live programs each year to journalism students at the 14 university and 25 college journalism programs in Canada is not feasible, so *Opening Minds* is now turning its attention to creating an online curriculum for use by faculty and students that will include video, discussion topics, and suggested assignments. Some videos already exist for a toolbox, and early in 2013 *Opening Minds* held one additional symposium at Mount Royal University to videotape speakers to augment and update the curriculum. Speakers include a reporter who specializes in heath policy, a Canadian news media research expert, a forensic psychologist/lawyer with experience dealing with media, two young people with lived experience of a mental illness, and a family member.

Because no Canadian research was available for the first "pilot" journalism symposium, a media expert from the United States illustrated stigmatizing news stories from that country. Some members of the faculty and the student body took offence to Canada being compared to American news coverage, unconvinced that Canadian news reporters were stigmatizing. The need for Canadian data was clear, prompting *Opening Minds* to establish the media monitoring project.

"It really did change my perception of mental illness. A lot of the stuff like misconceptions I really didn't know about."

Journalism student after an *Opening Minds* symposium

MEDIA MONITORING PROJECT

Given the lack of research regarding the media's coverage of mental illnesses in Canada, *Opening Minds* established a media monitoring study with researchers at McGill University to examine trends in such coverage in Canada from 2005 to the present. This ongoing study is the largest of its kind in the world, and will extend to 2015, giving us more than 10 years of data to compare and contrast.

So far, researchers have collected and analyzed more than 11,000 French and English language newspaper articles from 2005-2011 and are in the process of analyzing more from 2012-2013. The time frame is interesting inasmuch as the Mental Health Commission of Canada was launched during this period (September 2007),

with an aim of promoting mental health and reducing stigma. This means we will be able to compare and contrast media coverage before and after the creation of the Commission, and *Opening Minds*, in order to assess the impact on media coverage of mental illnesses.

WHAT THE MEDIA MONITORING PROJECT IS TELLING US

Because of the previous literature on the topic, and the risk of stereotyping, the researchers considered danger, violence and criminality the key message to focus on in their analyses of the articles. They found that this was a direct theme in many newspaper articles.

When examined in detail, mental illnesses in these articles are frequently presented in the context of crime, prisons, police, deviant behaviours, and the courts. In a few cases, journalists wrote openly sensationalized and titillating accounts of events or people that they directly associated with a mental illness. Stigmatizing language such as 'crazy' and 'psycho' were used in these articles to describe people living with a mental illness. The researchers also noted that psychiatric labels were quickly assigned to people suspected of shocking crimes without any solid evidence that these people actually had a mental illness.

These figures are similar to those found in other countries, and the Canadian media appears to share the characteristics of British and American media when representing mental illness.

Among the findings so far:

- 40% of Canadian newspaper articles negatively associated crime, violence, and danger with mental illness
- only 17% of articles included the voice of someone living with a mental illness
- only 25% include the voice of an expert
- treatment is only discussed in 19% of articles
- only 18% discuss recovery or rehabilitation

The findings give cause for concern because they do not accurately reflect the realities of life for people with a mental illness. For example, much research shows that people with a mental illness are much more likely to be a victim of crime and violence rather than a perpetrator. Factors such as crime and violence are being over-reported, while those factors which are frequently associated with mental illnesses, such as recovery and rehabilitation, are being considerably underreported.

When considering all this information, it is vital to note the existence of much variation between individual newspapers and individual journalists. The researchers are currently conducting a sub-analysis, comparing individual newspapers regarding the quality and accuracy of their reporting. They are seeing that some newspapers, and individual journalists, are taking a progressive and balanced stance regarding mental illnesses, while others continue to use mental illnesses as an opportunity to dramatize, sensationalize, and titillate, in the process buttressing stigma and negative stereotypes about people with a mental illness.

Examples of some of the articles commonly seen are given in Table 1 on the following page.

Table 1: Examples

OVERT STIGMATIZATION	"Henderson — who is mentally ill and requires medication to manage his condition — went on a sex-tinged spree which saw several city women inappropriately groped in very public places. In one case, Henderson took pictures of a woman with his phone as she bent over a produce display at a grocery."
IMPLIED STIGMATIZATION	"Det. John Campbell asked anyone with information to come forward and warned the public to be vigilant in case there is a 'mentally ill person out there with a knife, arbitrarily stabbing anyone.' "
POSITIVE WRITING	"Rachel Scott-Mignon, 28, stood in front of a crowd of 600 strangers and gently hammered them with a dark secret: She suffers from bipolar disorder. 'I know first-hand what it is like to be in pieces, sometimes broken ... to be sad,' she said. 'But I also know what it is like to be whole, hopeful, to be in the moment, to be happy, to be in love. Sometimes this happiness gets out of control and it's like a carnival in my head. Everything's fast and out of control. That's what living with bipolar disorder is all about.' "

FUTURE DIRECTIONS

The media monitoring project indicates that there is currently scope for improvement in coverage of mental health issues in Canada. We are trying to disseminate this message through academic papers, workshops at journalism schools, online videos, and public outreach events (Cafés Scientifique), as well as other related events.

In comparing media coverage between 2005 and 2010, the researchers have not observed any improvement in reporting. This might be expected, given that the Mental Health Commission of Canada has a 10-year mandate, and much of its anti-stigma work is being progressively implemented over time, with the more visible work of the Commission (for example, its national mental health strategy) launched more recently. It might be that the impact of the Commission will only be felt a few years down the line. Indeed, previous studies of changing attitudes regarding factors such as race suggest that a time period of around 10 years is necessary to effect positive industry-level change in tone and content.

As the project proceeds, we hope to see changes in coverage of mental health in the media. Indeed there is a proud tradition of social justice journalism in the Canadian media, for example the role it has played in bringing to light the difficult conditions faced in certain First Nations communities.

It is hoped that newspapers, broadcasters, and journalists take an active role in championing the cause of people with a mental illness, and join the broad front that is working to bring mental illness out of the shadows, forever.

Target Group: Workforce

Every day, half a million Canadians are absent from work for psychiatric reasons

One out of every four to five employees is affected by mental health issues every year

Every year mental illnesses cost the Canadian economy an estimated $50 billion (at least) annually in absenteeism, disability claims, and medical services used

Many workers choose to go untreated rather than risk being labeled as "unreliable, unproductive, and untrustworthy"

"Stigma affected me in the workplace in what to me was the worst way possible; I got fired from a job I absolutely loved and was fantastic at."

Person with lived experience of mental illness

ACTIVITIES AND FINDINGS TO DATE

The *Opening Minds* workforce research team is partnering with programs and workplaces across Canada to identify and evaluate existing anti-stigma programs targeting the workplace, with the goal of determining the effectiveness of these programs and their potential to be rolled out nationally.

The Mental Health Commission of Canada has recently identified the workforce as a key focus area moving forward, and *Opening Minds*' work is complementary to other Commission programs and initiatives aimed at this target group. One example is Mental Health First Aid Canada, a program designed to train people to respond to mental health problems that is also believed to reduce stigma (see page 26). Another example is the *National Standard of Canada for Psychological Health and Safety in the Workplace*, which in part encourages organizations to understand and respond to the nature and dynamics of stigma.

PARTNERSHIPS TAKE TIME

Workplace anti-stigma programs have the potential to alleviate the heavy personal and financial costs associated with mental illness, benefitting both employee and employer. We have now been able to form strategic partnerships with more than a dozen organizations, such as Alberta Health Services and the Nova Scotia Public Service Commission. Evaluations of anti-stigma programs within these organizations are all at varying stages.

Forging these kinds of partnerships has taken more time than with other target groups. Several levels of approval within the organizations are often required, and the implementation of anti-stigma programs is often delayed due to competing priorities. We have also noted that one of the largest factors affecting uptake by a company or organization is the extent to which the executive level acknowledges the potential impact of the stigma of mental illness and psychological health and safety in the workplace.

VARIETY OF WORKFORCE PROGRAMS

Given the vast number of workforce settings and the enormous variety of workforce cultures, *Opening Minds* set out to try to create a wide range of workforce and program partnerships. This would allow us to better understand how stigma occurs and how it can be prevented in different workplaces — for example, a private corporation as opposed to a public organization.

Following are three examples of programs which illustrate the variety of the evaluation work being undertaken with this target group.

Program for government employees: Mental Health Works (MHW) is a national initiative of the Canadian Mental Health Association dedicated to workplace skills enhancement, awareness, education, and stigma reduction.

A version of the MHW program was customized for management training at the Peel Region municipal government in Ontario. The program involved three modules and was offered to more than 500 supervisors of the organization throughout 2011. Our program evaluation included assessment of changes in attitudes, knowledge, behaviour, and self-confidence of supervisors.

Participant scores on our general workplace stigma questionnaire indicated low levels of stigmatizing opinions to start. As a result, there was not much room for big improvements, or statistically significant findings to be seen. There were, however, specific items on the questionnaire where attitudes seemed to become even more positive (i.e., less stigmatizing) over time. Statistically significant changes in attitudes were seen on the workplace attitudes questionnaire, specific to the supervisory role.

With the positive response to the training program and feedback from managers that the program needed to be delivered to all employees, the employer made it available to the entire staff of approximately 5,000 people. The staff training program was modified to consist of just one 45-minute module, and group discussion sessions are facilitated by a supervisor who has previously received training. Data collection is underway for this piece of the evaluation.

Program for business leaders: *Mind Matters* is a full-day workshop developed by the Mood Disorders Association of Ontario (MDAO). The program focuses on steps business leaders can take to create healthy workplace environments and implement practices fundamental to managing mental health problems in the workplace. The program can also be tailor-made to the organization.

Opening Minds' evaluation results of a 2011 workshop indicated a significant decrease in stigmatizing attitudes. Participants also increased their knowledge about mental illnesses as indicated by the significant increase in the number of correct responses on the knowledge quiz. Since our evaluation, the *Mind Matters* program has evolved, and we are currently in discussions with the MDAO regarding an evaluation of the modified program potentially being delivered to a large organization in the fall of 2013.

Program for managers and employees: The Department of National Defence's (DND) Road To Mental Readiness (R2MR) program was developed to increase resiliency and mental health in its soldiers and civilian staff. It categorizes signs, symptoms, and behaviours of good to poor mental health under a four colour continuum: green (healthy), yellow (reacting), orange (ill), and red (injured). This continuum model bypasses the need for labels and the stigma attached with these labels.

The RCMP in New Brunswick are participating in an evaluation of the program specially tailored for their use. The RCMP in Nova Scotia, Prince Edward Island, and Newfoundland have expressed an interest in using the program and will also become test sites.

The Calgary Police Service, working in collaboration with *Opening Minds*, Alberta Health Services, and DND, has developed an adaptation of R2MR for municipal police forces. Training is scheduled to begin fall 2013. A number of police forces across Canada have expressed an interest in using this version of the program. These include the Ontario Provincial Police, Peel Regional Police, Vancouver Police Department, and Ontario Police College.

Opening Minds decided it would be more efficient to adapt the already successful R2MR program for a general workplace audience. That adaptation, being carried out by researchers and a person with lived experience, is called *The Working Mind* program and it is geared towards managers and employees.

Thirty trainers working for three major employers successfully completed training in Halifax in September 2013, and will begin delivering *The Working Mind* to managers and employees. The organizations that participated in the program include the Nova Scotia Public Service Commission, the Capital District Health Authority, and Nova Scotia Community College. The University of Calgary is next in line to take the training in fall 2013.

Mental Health First Aid Canada

Mental Health First Aid (MHFA) is a program of the Mental Health Commission of Canada. It trains people to recognize the early signs of a mental health problem or crisis in themselves or others, and to provide initial help.

MHFA training is being held just about everywhere in Canada, including in businesses and organizations, and for both employees and employers.

The program is also believed to help reduce stigma among training participants, and *Opening Minds* will soon be evaluating MHFA to determine its effectiveness in this area.

SOME EARLY FEEDBACK AND LESSONS

While these are still early days in our evaluations of workforce programs and quantitative data is under analysis, we are already gaining valuable feedback from our qualitative data about some of the characteristics necessary for developing successful anti-stigma programs for this target group. For example, participants in one program suggested higher levels of interaction amongst group members, case scenarios specific to their workplace, and the need to make videos engaging and exciting. One of the most important lessons gleaned so far is that there needs to be not only general approval from senior executives, but also actual endorsement of any anti-stigma initiative; the message must be that the program is valued and that participation is expected. If this precursor is not present, the researchers and program providers need to obtain executive-level endorsement so that the partnership and subsequent actions progress more smoothly. Lack of 'buy-in' from management, and organizational or personnel changes, may also apply after a partnership has formed.

ECONOMIC ANALYSIS OF THE IMPACT OF MENTAL ILLNESS IN THE WORKPLACE

Mental health problems present a significant societal cost in terms of health care service use, lost work days, and work disruptions – estimated to be at least $50 billion per year. About 35% of the societal cost of mental illnesses is related to work disruptions.

While there has been growing awareness of the staggering social and economic costs of mental disorders in the workplace, there is little information about the magnitude of these costs to businesses. One of the challenges researchers face is the lack of data to pursue these inquiries.

Estimating costs and rates of disability for mental illnesses for various groups of workers requires data that not only contain information about workers who have a specific type of disability claim, but also those who are healthy and do not.

The purpose of this study is to build the 'business case' for addressing the stigma surrounding mental illness in the workplace. Through economic analyses, we will estimate the return on investment (ROI) that small-, medium- and large-size organizations can realize through the implementation of anti-stigma and mental illness awareness programs. The main idea is that stigma reduction may lead to more effective reduction of a major source of disability costs (i.e., those from mental illness).

This year, one of the steps toward building the business case involved developing an economic model to estimate the breakeven point for workplace-based anti-stigma programs. These types of economic models can be used to understand how much a company should invest in an anti-stigma program given its effectiveness. The estimates from the model can be used as a launching point to discuss how organizations can think about investing in an anti-stigma program (e.g., when is it economically worthwhile for them).

The economic model building activity involves using administrative data from the organizations participating in *Opening Minds* to further enhance the model and understand the differences in the returns on investment for the different types of organizations. The model is flexible enough to incorporate 'contextual evidence' (e.g., a company's specific ratio of managers to non-managers). After the model has been fully specified, different assumptions can be explored to determine under what circumstances mental health or anti-stigma programs are cost-effective. In addition, the results can be explored to see how sensitive they are to various assumptions. In this way, economic modeling can be used to make the business case that mental health and anti-stigma programs are not only good for health, they are also good for business.

STIGMA AND SOCIAL BUSINESS STUDY

Social businesses (or social firms) are businesses that combine conventional market activities with a social purpose. In the case of mental illnesses, the social business approach has been applied widely in Canada, particularly for individuals who have experienced long-term detachment from the community labour market. In addition to improving employment prospects, social businesses have the potential to reduce stigma in a variety of ways.

This study has the following objectives: 1) to explore social business processes that influence stigma, and 2) test whether employment in a social business for a person who has a mental illness, influences how employers rate hireability.

The first objective is being addressed by a multiple case study design that is exploring stigma in the context of social businesses located in three Canadian communities. Analysis is expected to be completed in early 2014.

The second objective is being addressed by the vignette technique to elicit survey data. Participants will be employers who will each view employment résumés and letters of reference for two job candidates, followed by short videos involving these candidates in a job interview. One employee will have recent experience working in a social business. Employers will be asked to rate each job candidate on three aspects of perceived hireability. Open ended questions related to the perceived hireability of characters depicted in the vignettes will also be used. Data collection for this study is expected to be complete by the end of 2013, with findings available by the spring of 2014.

Supporting The Aspiring Workforce

The Aspiring Workforce are people who, due to a mental illness, have been unable to enter or re-enter the workforce, or who are in and out of the workforce due to episodic illness. In many cases, stigma and discrimination are among the major barriers keeping them from gaining employment.

The Mental Health Commission of Canada has recently identified improving mental health in the workforce as a priority, and as part of its efforts, the Commission is collaborating with its partners to help the Aspiring Workforce achieve its right to work.

In collaboration with the Centre for Mental Health and Addiction, the University of Toronto, and Queen's University, the Commission recently produced a series of reports called *The Aspiring Workforce: Employment and Income for People with Serious Mental Illness.* Among the recommendations is developing, implementing, and promoting anti-stigma initiatives in workplaces.

Opening Minds is helping to support this recommendation through its evaluation and replication of anti-stigma programs aimed at employers and employees.

FUTURE DIRECTIONS

Conducting evaluations in a workplace setting can be a difficult endeavour as barriers exist at each part of the process. Applied research, as opposed to experimental lab research, generally involves an added layer of complexity as researchers have to accommodate and be flexible to the context where the research takes place. Despite this, future *Opening Minds* evaluations, and workplace evaluation research more generally, should move beyond current procedures and methods, adding another layer of complexity to the research.

All *Opening Minds* workplace evaluations involve the measurement of attitudes and social distance towards people with mental illnesses as the standard indication of stigma. Although this method is clearly the most popular in the research literature, there is a need to move beyond measuring attitudes to measure behavioural indications of stigma and discrimination[18,19,20]. Put otherwise, evaluations need to move beyond asking people what they will do, to observing what steps they actually will undertake to reduce stigma.

It will also be important to understand more fully how problems related to mental health and mental illness are expressed in the workplace specifically, the meaning of these situations for the workplace and the individual, and strategies to address these issues while positively contributing to attitudes and opinions.

Evaluations should also examine the financial ramifications of anti-stigma programs, through administrative data sets, such as short- and long-term disability claims, absenteeism, and benefits utilization. These types of analyses can show the financial impact and the return on investment (ROI) of interventions in companies and organizations. Currently, *Opening Minds'* workplace evaluations at a number of sites are utilizing this type of administrative data analyses. However, more evaluations of this type would add to the literature and potentially make an even more compelling argument for companies and organizations to institute anti-stigma programs.

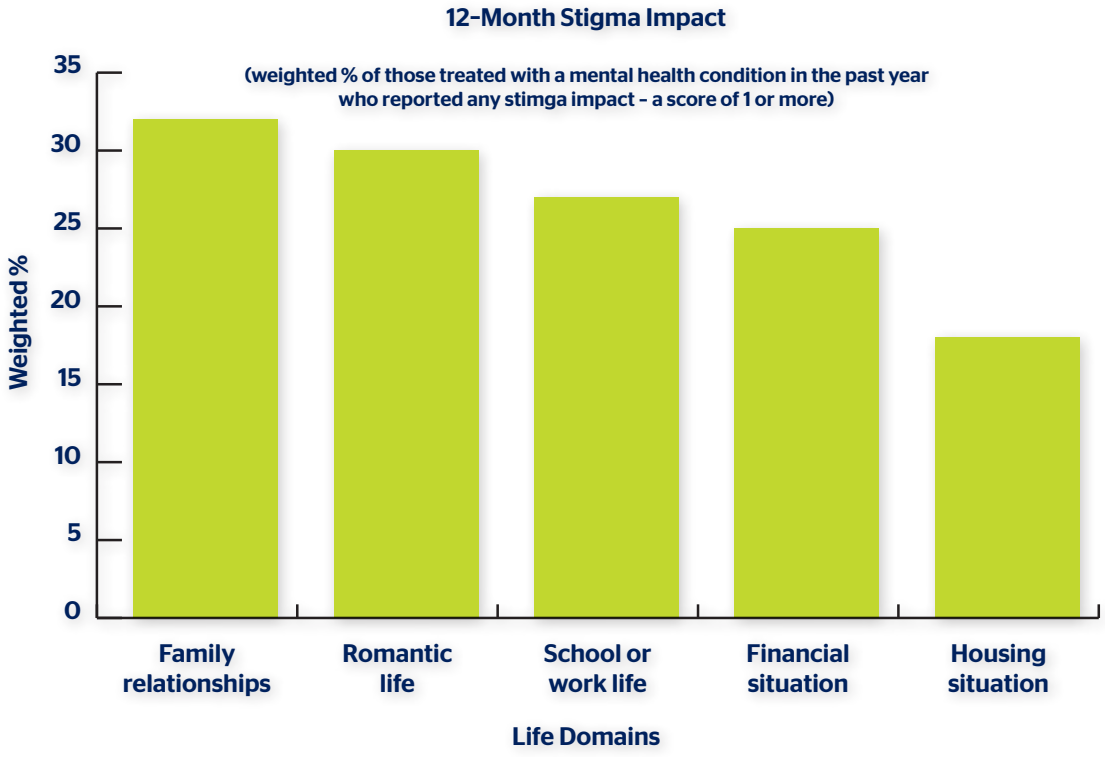
Development of a Rapid Response Stigma Module

The importance of evaluating and replicating successful programs cannot be understated. However, to understand whether these efforts are making a difference to people who have a mental illness on a population level requires a different approach. What we need to know is whether the stigma experienced by people living with a mental illness reduces over time.

Opening Minds collaborated with Statistics Canada to develop and test a stigma module that could be included in national population surveys. The three-minute module consists of six questions and was based on work completed at Queen's University[21]. The module measures the frequency and impact of stigma experienced by people who have received treatment for a mental illness along several important life domains.

In 2010, *Opening Minds* funded a Rapid Response survey to be conducted by Statistics Canada, which allowed us to piggyback the stigma module on the annual component of the Canadian Community Health Survey. The rapid response portion was conducted in May/June 2010 and provided data on approximately 10,000 Canadians. Figure 5 shows the domains that were used in the Rapid Response module (an additional domain pertaining to health care has since been added). It shows the per cent of respondents who reported some stigma in the prior 12 months (defined as having been treated negatively or unfairly because of a past or current mental health condition). Analyses of these data are continuing.

FIGURE 5: DOMAINS USED IN RAPID RESPONSE MODULE



Statistics Canada has since incorporated the stigma module into the Canadian Community Health Survey (Mental Health) focusing on some 35,000 Canadians. While we don't expect there to have been any change in stigma experiences since the 2010 Rapid Response survey, the availability of these data will allow us to better understand how to target anti-stigma programs to groups in highest need, and will provide an opportunity to examine factors that may be associated with stigma resilience.

To our knowledge, this is the first nationally representative survey of personal experiences with stigma and it reflects an important structural improvement in the way national data are collected. It also helps Canada fulfill its monitoring obligations under the UN Convention on the Rights of Persons with Disabilities, as this module can be used repeatedly to determine whether stigma is being reduced over time.

One interesting preliminary finding is that older Canadians reported the lowest levels of personal stigma, while youth reported the highest. It may be that older Canadians develop better coping mechanisms over time. This finding is indicative of the rich data being provided from this module. We expect that as more information becomes available, it will spawn significant additional research into stigma, not just within *Opening Minds*, but among academics and post-secondary students across Canada. In its role as a catalyst, the Mental Health Commission of Canada is engaged in projects and initiatives that spark positive changes within systems, be they organizational or policy improvements. Successfully encouraging Statistics Canada to not only test, but to also embrace this module is a significant achievement regarding systems change.

Knowledge Exchange

The Mental Health Commission of Canada believes knowledge can be a catalyst for action and change, and ensuring that knowledge and information about mental health is conducted and shared is a key part of the Commission's mandate.

Each program and initiative of the Commission includes a strategic focus on getting its research into the hands of the people who can put it to use and accelerate change.

To that end, *Opening Minds* continues to undertake a number of activities to ensure our knowledge about stigma reduction is shared with a broad audience, which includes policy makers, mental health and health care professionals, advocacy groups, support workers, governments and academics, to name a few.

Below are just some of *Opening Minds'* activities in knowledge exchange.

Together Against Stigma International Conference

Opening Minds and the World Psychiatric Association co-hosted the *Together Against Stigma International Conference* in Ottawa in 2012. It was the largest event of its kind ever organized, more than three times larger than the last international stigma convention held in London, England in 2009.

The conference drew close to 700 delegates from 29 countries and attracted researchers, scientists, mental health professionals, policy makers, and people with lived experience of a mental illness. About one-third of the participants and a number of the principal speakers were people with lived experience, which greatly added to the positive atmosphere and success of the event.

The Honourable Lisa Raitt, then Minister of Labour, opened the conference with welcoming remarks from the Government of Canada and shared her own personal mental health story. Keynote presenters included actor Glenn Close and former CTV broadcaster Lloyd Robertson. Leading international stigma experts also presented during the plenaries, including Professor Heather Stuart, Queen's University, the Senior Consultant to *Opening Minds* and the Bell Canada Mental Health and Anti-stigma Research Chair.

The conference was an overwhelming success on many levels. This was reflected in comments from attendees and post-conference survey results. Delegates described it as "the best conference ever" and "life changing". It spawned extensive media coverage and led to the formation of a new international association of anti-stigma organizations, the *Global Alliance Against Stigma*.

The conference also generated considerable national and international interest in the work of the Mental Health Commission of Canada (MHCC) and *Opening Minds*. The MHCC, in collaboration with the Canadian Human Rights Commission, produced a book called, *Together Against Stigma: Changing How We See Mental Illness* summarizing the keynote presentations, breakout sessions, and posters. It also contains a collection of the most current stigma research taking place around the globe. To experience the online flipbook, please visit **http://files.mentalhealthcommission.ca/antistigma**

Global Alliance Against Stigma

One of the major outcomes of the *Together Against Stigma International Conference* was the formation of a new international association of anti-stigma organizations, whose working name is the *Global Alliance Against Stigma*. Micheal Pietrus, the Director of *Opening Minds*, is the current Chair.

The Alliance's steering committee held its inaugural meeting in June 2012, and a steady flow of information and research is already being shared among members. In September 2013, the Alliance held its second meeting in London, UK, and *Opening Minds* presented updates on its most recent findings to the more than 50 participants gathered from around the world.

Justice Symposia and Projects

Opening Minds has co-sponsored three symposia with the provincial criminal justice associations, and will present at the national Canadian Criminal Justice Association conference during the fall of 2013. These symposia explain the issue of stigma related to mental illnesses in the criminal justice system and introduce police, corrections and court officers, lawyers, judges, and more to research and first-person stories of people living with a mental illness who have been negatively impacted by stigma in the justice system.

Opening Minds is also partnering with and assisting organizations that are creating anti-stigma programs for individuals working in the legal area. Work began this summer on an education program and resources for Legal Aid Ontario, which is expected to have national relevance.

Cafés Scientifique

Opening Minds' media researchers at McGill University obtained two separate grants from the Canadian Institutes of Health Research to hold Cafés Scientifique in Montréal to discuss mental illness, stigma, and the media. Cafés bring people to a small, public venue to hear a panel discussion, with the intent of extending scientific discourse to the wider community, and these particular events put the spotlight on *Opening Minds'* research. Both were well attended and well received. Members of *Opening Minds* participated in the panel discussion and fielded questions from attendees.

Reports and Publications

Opening Minds' researchers are actively publishing their work in peer-reviewed journals and books. In addition to the list of publications that follows, they have also written reports about each of the dozens of anti-stigma programs evaluated.

General

Does Labeling Matter? An Examination of Attitudes and Perceptions of Labels for Mental Disorders
Szeto, A. C. H., Luong, D., & Dobson, K. S.
Published April 2013 in the journal *Social Psychiatry and Psychiatric Epidemiology*.

Paradigms Lost: Fighting Stigma and the Lessons Learned
Stuart, H., Arboleda-Flórez, J., Sartorius, N.
Published in May 2012 by Oxford University Press. The authors provided a free copy of this book to all of the attendees of the International Anti-stigma Conference.

Workplace

Reducing the Stigma of Mental Disorders at Work: A Review of Current Workplace Anti-Stigma Intervention Programs
Szeto, A. C. H., & Dobson, K. S.
Published April 2012 in the journal *Applied and Preventive Psychology*.

Malachowski, C. & Kirsh, B. *Workplace Anti-Stigma Initiatives: A Scoping Study*. *Psychiatric Services*. 2013 Jul 1;64(7):694-702. doi: 10.1176/appi.ps.201200409.

Mental disorders and their association with perceived work stress: An investigation of the 2010 Canadian Community Health Survey
Szeto, A. C. H., & Dobson, K. S.
Published April 2013 in the *Journal of Occupational Health Psychology*.

Health Care

The Development and Psychometric Properties of a New Scale to Measure Mental Illness Related Stigma by Health Care Providers: The Opening Minds Scale for Health Care Providers (OMS-HC)
Kassam, A., Papish, A., Modgill, G., & Patten, S. B.
Published June 2012 in the journal *BMC Psychiatry*.

Perceived discrimination among people with self-reported emotional, psychological, or psychiatric conditions in a population-based sample of Canadians reporting a disability
Kassam, A., Williams, J., & Patten, S. B.
Published February 2012 in the *Canadian Journal of Psychiatry*.

Effectiveness of Contact-based Education for Reducing Mental Illness-related Stigma in Pharmacy Students
Patten, S. B., Remillard, A., Phillips, L., Modgill, G., Szeto, A. C. H., Kassam, A., & Gardner, D. M.
Published December 2012 in the journal *BMC Medical Education*.

The Hidden Medical Logic of Mental Health Stigma
Ungar, T. & Knaak, S.
Published February 2013 in the *Australian and New Zealand Journal of Psychiatry*.

Mental health stigma and the mind-body problem: Making the case for strategic collusion
Ungar, T. & Knaak, S.
Published July 2013 in the *Australian and New Zealand Journal of Psychiatry*.

News Media

Trends in Newspaper Coverage of Mental Illness in Canada: 2005-2010
Whitley, R. & Berry, S.
Published February 2013 in the *Canadian Journal of Psychiatry*.

Book Chapter: "Stigmatizing Representations: Criminality, Violence and Mental Illness in Canadian Mainstream Media"
Whitley, R. & Berry, S.
In press, spring/ summer 2013, publisher University of Toronto.

Analyzing Media Representations of Mental Illness: Lessons Learnt from a National Project
Whitley, R. & Berry, S.
Published January 2013 in the *Journal of Mental Health*.

Reducing Mental Health Stigma: A Case Study
Stuart, H., Koller, M., Christie, R., Pietrus, M.
Healthcare Quarterly, 2011, 14(April Special Issue), 41-49.

Future Directions

Opening Minds is taking a novel approach to reduce stigma in Canada, a method that is both achieving positive results and attracting attention. Having learned from previous anti-stigma efforts undertaken worldwide, *Opening Minds* is now being recognized as a leader both nationally and globally. We have begun replicating programs and sharing leading practices which we have identified as being effective. Still, there is much more work to do.

We have demonstrated on an unprecedented scale that contact-based education is a key to successful anti-stigma programs. That comes with its own set of challenges: *Opening Minds* must now help develop a network of speakers along with appropriate video and web-based content that can be used in place of live presentations. This work is needed if we are to succeed in a national roll-out of the most proven effective programs.

To successfully reduce stigma, we know that programs must be tailored to each particular target group and that is what we are doing for health care providers, youth, news media and the workforce. However, we have identified many additional populations, such as Canada's indigenous populations and other minority groups, that may require an even more tailored approach than the ones currently in use within our existing target groups. Creating programs specifically for these additional populations will require more time and more resources.

There are also growing opportunities to work on cultural and organizational change. For example, we've identified some highly effective programs targeting youth, but their potential will be limited if we cannot convince ministries and boards of education to put these programs in their schools' health curricula. As another example, we have legislation to protect peoples' rights in the workplace, yet they continue to be stigmatized. Now that we have workplace voluntary psychological safety standards and anti-stigma programs that work, we can reach out to employers to encourage them to make the organizational changes necessary to help create stigma-free workplaces.

"The Mental Health Commission of Canada is very wisely viewing the stigma issue as one small battle and one small victory at a time."

Patrick Corrigan, PhD
World-renowned international expert on mental health stigma

When *Opening Minds* began, there were no leading practices to reduce stigma among the general population, let alone Canada's smaller minority group populations, and there was little research to guide our choice of best practices; thus, our initial emphasis on evaluation and knowledge creation. *Opening Minds* will now focus our efforts on completing research and developing models that can help improve existing programs or create new ones. At the same time, we will continue to promote and replicate programs we have shown to be effective. We will also create a business case for anti-stigma programs among the different target groups, to demonstrate the economic benefits of stigma reduction in hopes of encouraging greater program uptake.

Opening Minds is creating models which can be used in the future to reach additional populations. Stigma related to mental illnesses will continue to flourish in Canadian society unless efforts are made to reach every demographic and reach into every corner of the country.

Opening Minds has identified the following goals going forward:

Further position the Commission as an international leader in stigma reduction.

Our evidence-based approach is already garnering attention from organizations at home and abroad that are seeking our advice about dealing with stigma. This interest will only increase as we continue to identify the key components of successful anti-stigma programs, develop toolkits, and expand our reach among the target groups. The goal is to put research into action to promote greater positive change on the ground.

Opening Minds is disseminating the findings from its research while also acting upon it. We will continue to take what we are learning and translate that into projects, toolkits, programs, partnerships, and more.

One example of putting our research into action will be seen on a very large scale next year. In 2014, students and teachers from across Canada will meet for a large youth anti-stigma event in a Canadian city which is yet to be determined. The event will be based on an Ontario-based program that our evaluations showed to be successful at reducing stigma among young people. The participants will then return to their own communities and construct activities to reduce stigma, encourage help-seeking and foster a more supportive environment.

On the health care front, we will continue to reach out to universities and colleges across Canada to promote the incorporation of effective anti-stigma methods into their curricula, and will share programs we have shown to be successful in hospital settings and with professional associations.

Make Canadian workplaces a mentally healthier environment for all employees.

Given how much of our daily lives we spend at work, it is critical that our places of employment be mentally healthy and as free of stigma as possible. Workers need know their employers will support them, whether they experience a mental illness or are confronted with stigmatizing behaviours from their colleagues. *Opening Minds* will continue to reach this key target group through its evaluation and replication of anti-stigma programs, while supporting other Commission initiatives aimed at improving mental health among the workforce, including the Mental Health First Aid program, and the *National Standard of Canada for Psychological Health and Safety in the Workplace*.

Additional strategic goals

Additional strategic goals include:

- dissemination of an interim findings/leading practices report on knowledge acquired to date on “what works” and communicate this to the community;
- completion of the research on current programs;
- allowing the research to drive action going forward, by designing and implementing a phased rollout of successful programs and findings; and,
- replication of anti-stigma programs focused on youth, health care professionals, media, and workforce in 10 jurisdictions (to include at least 100 program replications).

Project Teams

The principal investigators listed below lead project teams that are supported by other researchers and work in collaboration with *Opening Minds* staff.

Heather Stuart: Senior Consultant for *Opening Minds* and Principal Investigator for Youth

Heather is a Professor at Queen's University and the Bell Canada Mental Health and Anti-stigma and Research Chair. Her main research interests are in the areas of psychiatric epidemiology and mental health services evaluations. Her main goals have been to undertake applied research that helps policy makers and planners solve day-to-day problems and make evidence-informed decisions. Heather has worked in both hospital- and community-based mental health treatment systems and on international projects with the World Health Organization, the Pan American Health Organization, and the World Psychiatric Association.

Carolyn Dewa: Principal Investigator for Workplace Mental Health Economics

Carolyn is a Professor at the University of Toronto in the Department of Psychiatry, as well as the Department of Health Policy, Management and Evaluation. She also heads the Centre for Addiction and Mental Health's Centre for Research on Employment and Workplace Health. Carolyn currently holds a Canadian Institutes of Health Research/Public Health Agency of Canada Applied Public Health Chair.

Keith Dobson: Co-Principal Investigator for the Workforce (West)

Keith is a Professor of Clinical Psychology at the University of Calgary. His research interests include psychological models of and treatments for various disorders, particularly depression. In addition, Keith has written about ethical and professional issues in mental health treatment.

Bonnie Kirsh: Co-Principal Investigator for the Workforce (East)

An Associate Professor in the Department of Occupational Science and Occupational Therapy at the University of Toronto, Bonnie's primary research focuses on community and work integration for persons with mental illnesses. Another area of research is workplace mental health, including trajectories of persons who experience depression at work and related issues of disability management and return to work.

Terry Krupa: Co-Principal Investigator for the Workforce (East)

Terry is a Professor in the School of Rehabilitation Therapy at Queen's University in Kingston. Her research, teaching, and practice have focused on ensuring the full and meaningful community participation of people who experience mental illnesses.

Bianca Lauria-Horner: Co-Principal Investigator for Health Care Providers

Bianca is a psychiatrist and assistant professor of psychiatry at Dalhousie University's Department of Psychiatry. Her interests include teaching and leading research projects, particularly the design and evaluation of community-based mental health awareness and promotion programs.

Scott Patten: Principal Investigator for Health Care Providers

Scott is a Professor at the University of Calgary. Scott teaches in the Department of Community Health Sciences. The focus of his work is on the longitudinal epidemiology of major depression, with the main goal of integrating epidemiologic estimates of incidence, recurrence, prevalence, episode duration, and mortality into a comprehensive epidemiologic picture. He also has expertise in methodological approaches to the analysis of longitudinal data.

Robert Whitley: Principal Investigator for Mental Illness and Media Project

Rob is an Assistant Professor in the Department of Psychiatry at McGill University and at the Douglas University Mental Health Institute. Rob has a particular interest in recovery from severe mental illness and the role of stigma and religiosity in enhancing or impeding recovery. He is conducting a systematic analysis of media coverage of mental illness in Canada in order to discern whether the media is taking a more positive approach to mental health.

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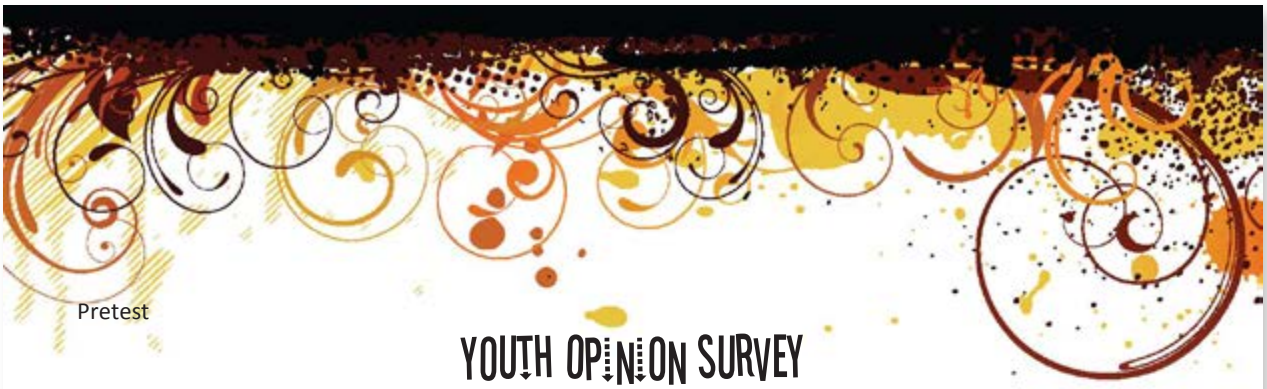
Appendix A – Youth Program Questionnaire



Pretest

YOUTH OPINION SURVEY

In preparation for an upcoming class, we are going to ask you a few questions about mental illnesses. This will help us in developing our class materials and allow us to meet your learning needs. Please answer the following questions to help us.

SOME GENERAL INFO ABOUT YOU:

Year of birth : _____ Month of birth : _____ Day of birth: _____ Female ( ) What grade are you in? _____
Male ( )

WHAT WORDS OR PHRASES COME TO YOUR MIND TO DESCRIBE SOMEONE WITH A MENTAL ILLNESS?

1. _____ 2. _____ 3. _____

THE NEXT FEW QUESTIONS ASK YOU TO AGREE OR DISAGREE WITH A SERIES OF STATEMENTS. PLEASE CHECK THE BOX THAT BEST FITS YOUR OPINION.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Most people with a mental illness are too disabled to work.	O	O	O	O	O
People with a mental illness tend to bring it on themselves.	O	O	O	O	O
People with mental illnesses often don't try hard enough to get better.	O	O	O	O	O
People with a mental illness could snap out of it if they wanted to.	O	O	O	O	O
People with a mental illness are often more dangerous than the average person.	O	O	O	O	O
People with a mental illness often become violent if not treated.	O	O	O	O	O
Most violent crimes are committed by people with a mental illness.	O	O	O	O	O
You can't rely on someone with a mental illness.	O	O	O	O	O
You can never know what someone with a mental illness is going to do.	O	O	O	O	O
Most people with a mental illness get what they deserve.	O	O	O	O	O
People with serious mental illnesses need to be locked away.	O	O	O	O	O

PLEASE TELL US WHAT YOU THINK YOU WOULD DO IN THESE DIFFERENT CIRCUMSTANCES.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I would be upset if someone with a mental illness always sat next to me in class.	O	O	O	O	O
I would not be close friends with someone I knew had a mental illness.	O	O	O	O	O
I would visit a classmate in hospital if they had a mental illness.	O	O	O	O	O
I would try to avoid someone with a mental illness.	O	O	O	O	O
I would not mind it if someone with a mental illness lived next door to me.	O	O	O	O	O
If I knew someone had a mental illness I would not date them.	O	O	O	O	O
I would not want to be taught by a teacher who had been treated for a mental illness.	O	O	O	O	O
I would tell a teacher if a student was being bullied because of their mental illness.	O	O	O	O	O
I would stick up for someone who had a mental illness if they were being teased.	O	O	O	O	O
I would tutor a classmate who got behind in their studies because of their mental illness.	O	O	O	O	O
I would volunteer my time to work in a program for people with a mental illness.	O	O	O	O	O

DO YOU, OR DOES SOMEONE YOU KNOW, HAVE A MENTAL ILLNESS?

- o No
- o Uncertain
- o Yes, a close friend
- o Yes, a close family member
- o Yes, someone other than a close friend or family member
- o Yes, I do

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

Appendix B – Health Care Providers Program Questionnaire

Mental Health Commission of Canada / Commission de la santé mentale du Canada

***OPENING MINDS* SCALE FOR HEALTH CARE PROVIDERS (OMS-HC)**

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1.	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	☐	☐	☐	☐	☐
2.	If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain or headache), I would likely attribute this to their mental illness.	☐	☐	☐	☐	☐
3.	If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.	☐	☐	☐	☐	☐
4.	If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	☐	☐	☐	☐	☐
5.	I would be more inclined to seek help for a mental illness if my treating health care provider was not associated with my workplace.	☐	☐	☐	☐	☐
6.	I would see myself as weak if I had a mental illness and could not fix it myself.	☐	☐	☐	☐	☐
7.	I would be reluctant to seek help if I had a mental illness.	☐	☐	☐	☐	☐
8.	Employers should hire a person with a managed mental illness if he/she is the best person for the job.	☐	☐	☐	☐	☐
9.	I would still go to a physician if I knew that the physician had been treated for a mental illness.	☐	☐	☐	☐	☐
10.	If I had a mental illness, I would tell my friends.	☐	☐	☐	☐	☐
11.	It is the responsibility of health care providers to inspire hope in people with mental illness.	☐	☐	☐	☐	☐
12.	Despite my professional beliefs, I have negative reactions towards people who have mental illness.	☐	☐	☐	☐	☐
13.	There is little I can do to help people with mental illness.	☐	☐	☐	☐	☐
14.	More than half of people with mental illness don't try hard enough to get better.	☐	☐	☐	☐	☐
15.	People with mental illness seldom pose a risk to the public.	☐	☐	☐	☐	☐
16.	The best treatment for mental illness is medication.	☐	☐	☐	☐	☐
17.	I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	☐	☐	☐	☐	☐
18.	Healthcare providers do not need to be advocates for people with mental illness.	☐	☐	☐	☐	☐
19.	I would not mind if a person with a mental illness lived next door to me.	☐	☐	☐	☐	☐
20.	I struggle to feel compassion for a person with mental illness.	☐	☐	☐	☐	☐

The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: the Opening Minds Scale for Health Care Providers (OMS-HC).
Authors: Kassam A, Papish A, Modgill G, Patten S.
Journal: BMC Psychiatry. 2012 Jun 13;12:62.
doi: 10.1186/1471-244X-12-62.

Appendix C – Workforce Program Questionnaire

OPENING MINDS SURVEY FOR WORKPLACE ATTITUDES

Mental Health Commission of Canada | Commission de la santé mentale du Canada

This survey was developed as part of the *Opening Minds* Initiative of the Mental Health Commission of Canada to assess opinions in the workplace towards co-workers who may have a mental illness. There are no right or wrong answers to these questions, as everyone will have different attitudes and opinions, based on their own experiences in life.

Please read each of the following statements carefully and decide how much you agree or disagree with each statement. Place an "X" in the correct column for each statement to indicate your response.

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1.	I would be upset if a co-worker with a mental illness always sat next to me at work.	☐	☐	☐	☐	☐
2.	Most employees with a mental illness are too disabled to work.	☐	☐	☐	☐	☐
3.	I would not want to be supervised by someone who had been treated for a mental illness.	☐	☐	☐	☐	☐
4.	I would not be close friends with a co-worker who I knew had a mental illness.	☐	☐	☐	☐	☐
5.	Employees with a mental illness tend to bring it on themselves.	☐	☐	☐	☐	☐
6.	The quality of the work performed by employees with a mental illness is unlikely to meet the expectations of the job.	☐	☐	☐	☐	☐
7.	Jobs with tight deadlines and high demands are harmful to employees with mental illnesses.	☐	☐	☐	☐	☐
8.	I would try to avoid a co-worker with a mental illness.	☐	☐	☐	☐	☐
9.	Employees with a mental illness could snap out of it if they wanted to.	☐	☐	☐	☐	☐
10.	Employees with a mental illness are often more dangerous than the average employee.	☐	☐	☐	☐	☐
11.	It would be better for employees with mental illnesses to participate in work activities that are outside of the paid labour force.	☐	☐	☐	☐	☐
12.	If I knew a co-worker who had a mental illness, I would not date them.	☐	☐	☐	☐	☐

13.	Employees with a mental illness often become violent if not treated.	☐	☐	☐	☐	☐
14.	I would not want to work with a co-worker who had been treated for a mental illness.	☐	☐	☐	☐	☐
15.	Most violent crimes in the workplace are committed by employees with mental illness.	☐	☐	☐	☐	☐
16.	I would tell my supervisor if a co-worker was being bullied because of their mental illness.	☐	☐	☐	☐	☐
17.	You can't rely on an employee with a mental illness.	☐	☐	☐	☐	☐
18.	I would stick up for a co-worker who had a mental illness if they were being teased.	☐	☐	☐	☐	☐
19.	You can never know what an employee with a mental illness is going to do.	☐	☐	☐	☐	☐
20.	I would help a co-worker who got behind in their work because of their mental illness.	☐	☐	☐	☐	☐
21.	Most employees with a mental illness get what they deserve.	☐	☐	☐	☐	☐
22	I would volunteer my time to work in a program for a co-worker with a mental illness.	☐	☐	☐	☐	☐
23.	Employees with serious mental illnesses need to be locked away.	☐	☐	☐	☐	☐

Szeto, A. C. H., Luong, D., & Dobson, K. S. (2013). Does labelling matter?: An examination of attitudes and perceptions of labels for mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 48,* 659-671.

Appendix D – *Opening Minds'* Partners

PROFESSIONAL ASSOCIATIONS

Alberta Medical Association

British Columbia Medical Association

Canadian Medical Association

Canadian Psychiatric Association

College of Family Physicians of Canada

Royal College of Physicians and Surgeons

Nova Scotia College of Family Physicians

Doctors Nova Scotia

Canadian Journalism Forum on Trauma and Violence

PROGRAM PROVIDERS

Canadian Mental Health Association
- Calgary
- Champlain East Branch, Cornwall/Ottawa
- Grand River Branch, Guelph
- Hamilton
- Ontario
- Thunder Bay Branch
- Toronto
- Winnipeg

Centre for Addiction and Mental Health, Hamilton, Ontario

Canadian Mental Health Association, Ontario

Centre for Building a Culture of Recovery, Penetanguishene, Ontario

Children's Mental Health Ontario

Digby Clare Mental Health Volunteers Association, Digby, Nova Scotia

Dream Team/Houselink, Toronto, Ontario

Elevated Grounds, Toronto, Ontario

Family Outreach and Response, Toronto, Ontario

Family Service Thames Valley, London, Ontario

Hands – TheFamilyHelpNetwork.ca

Healthy Aboriginal Network, Vancouver, British Columbia

Iris the Dragon (Charity), Perth, Ontario

Laing House, Halifax, Nova Scotia

Mental Illness Foundation, Montréal, Québec

Mike's Story, Montréal, Québec

mindyourmind, London, Ontario

Mood Disorders Association of British Columbia, Vancouver

Mood Disorders Society of Canada

Mood Disorders Association of Ontario, Toronto

Progress Place and the University Health Network (UHN), Toronto, Ontario

Provincial Centre of Excellence for Child and Youth Mental Health, CHEO

Schizophrenia Society of Alberta, Calgary Chapter

Schizophrenia Society of Saskatchewan, Regina Chapter

Schizophrenia Society of Saskatchewan, Saskatoon Chapter

Self Help Alliance, Guelph, Ontario

Stand Up For Mental Health, Vancouver, British Columbia

Workman Arts, Toronto, Ontario

HEALTH SERVICE PROVIDERS

Alberta Health Services, Alberta

British Columbia Interior Health, Castlegar, Kelowna, Williams Lake, Penticton, Cranbrook, Kamloops, and Salmon Arm, British Columbia

CAMH – Centre for Addiction and Mental Health, Toronto, Ontario

Capital District Health Authority, Halifax and area

Central East Local Health Integration Network (LHIN), Oshawa, Ontario

Central LHIN, Markham, Ontario

Centre hospitalier universitaire, Sherbrooke, Québec

Children's Hospital of Eastern Ontario, Ottawa, Ontario

Community Health Centres in Ontario: South Riverdale, Central Toronto, Unison

Izaak Walton Killam (IWK) Health Centre, Halifax, Nova Scotia

Lakeridge Health, Oshawa, Ontario

Louis H. Lafontaine Hospital, Montréal, Québec

North Bay Regional Health Centre, North Bay, Ontario

Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario

South East LHIN, Belleville, Ontario

St. Joseph's Healthcare, Hamilton, Ontario

Toronto Western Hospital, Ontario

United Health Network, Toronto, Ontario

Vancouver Island Health Authority, British Columbia

UNIVERSITIES/COLLEGES

Algonquin College, Ottawa, Ontario

Brandon University, Brandon, Manitoba

Carleton University, Ottawa, Ontario

Dalhousie University, Halifax, Nova Scotia

McGill University, Montréal, Québec

Mount Royal University, Calgary, Alberta

Memorial University, St. John's, Newfoundland

Nova Scotia Community College, Sydney, Nova Scotia

Queen's University, Kingston, Ontario

Ryerson University, Toronto, Ontario

University of Alberta, Edmonton, Alberta

University of British Columbia, Vancouver, British Columbia

University of Calgary, Calgary, Alberta

University of King's College Journalism School, Halifax, Nova Scotia

University of Saskatchewan, Saskatoon, Saskatchewan

University of Toronto, Toronto, Ontario

University of Winnipeg, Winnipeg, Manitoba

York University, School of Social Work, Faculty of Liberal Arts and Professional Studies, Toronto, Ontario

CORPORATIONS – PRIVATE

Husky Energy, Calgary, Alberta

Standen's Ltd., Calgary, Alberta

TELUS, Barrie and Scarborough, Ontario

GOVERNMENT AND PUBLIC ORGANIZATIONS

Alberta Environment and Sustainable Resource Development

Alberta Health Services

Calgary Police Service

Canadian Broadcasting Corporation

Canadian Forces

Department of National Defence

Government of Northwest Territories: Department of Health and Social Services, and Child and Family Services

Government of Ontario: Ministry of Education; Ministry of Colleges and Universities; Ministry of Government Services; Ministry of Community and Social Services

Health Canada, Alberta

Nova Scotia Department of Health

Nova Scotia Public Service Commission

Royal Canadian Mounted Police

Region of Peel, Ontario

Toronto District School Board, Ontario

OTHER

Alberta Criminal Justice Association

Bell Canada

Canadian Criminal Justice Association

Canadian Human Rights Commission

Manitoba Criminal Justice Association

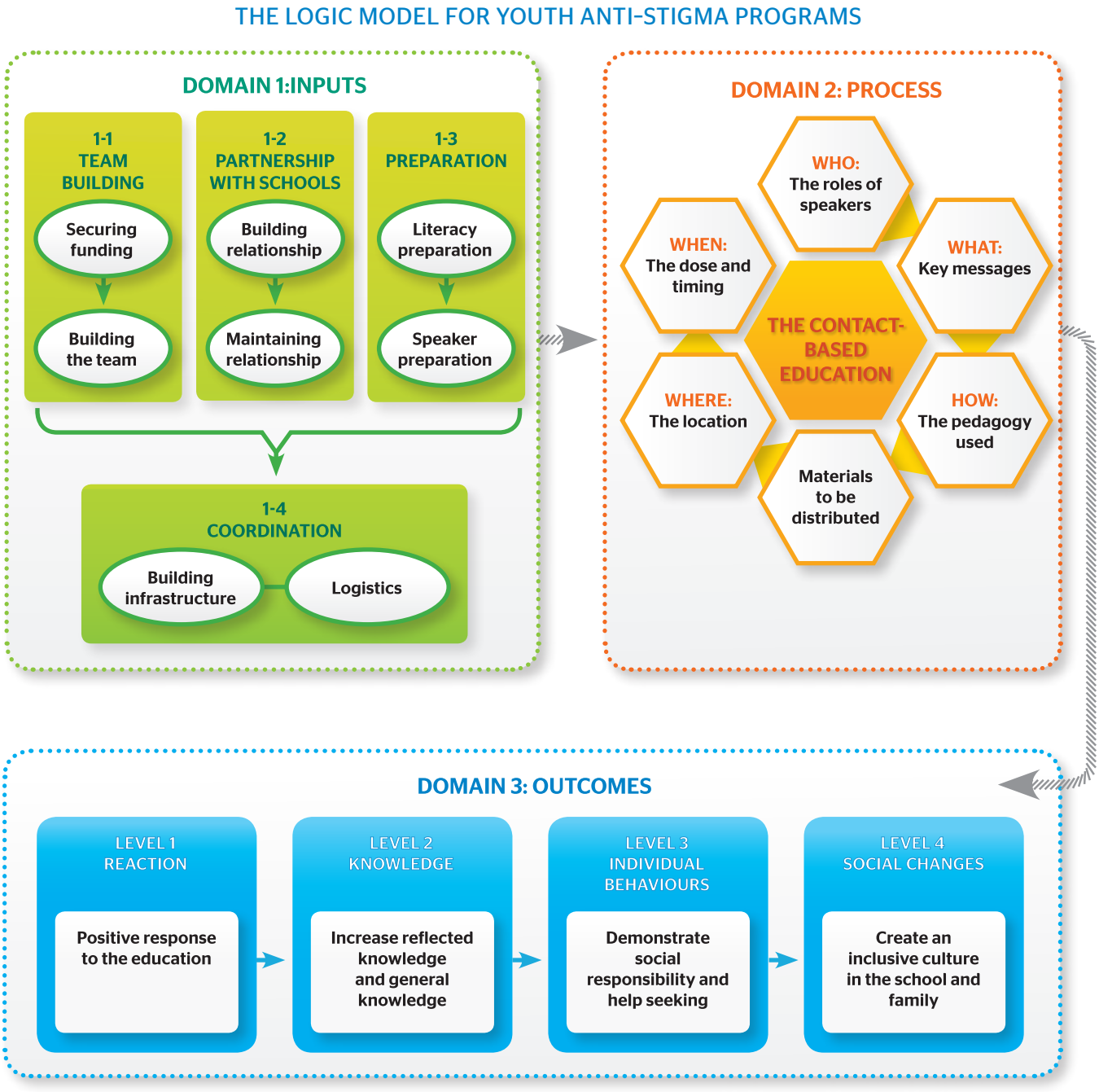
Statistics Canada

INTERNATIONAL

Global Alliance Against Stigma (examples: Time to Change, England; see me, Scotland; beyondblue, Australia)

World Psychiatric Association

Appendix E –
Logic Model For Youth Anti-Stigma Programs



Logic Model by Chen, Koller, Krupa, and Stuart, 2013

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