

Chapter 1

Opening Minds in Canada: Background and Rationale

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Objective: To summarize the background and rationale of the approach taken by the Mental Health Commission of Canada's Opening Minds (OM) Anti-Stigma Initiative.

Method: The approach taken by OM incorporates a grassroots, community development philosophy, has clearly defined target groups, uses contact-based education as the central organizing element across interventions, and has a strong evaluative component, so that best practices can be identified, replicated, and disseminated. Contact-based education occurs when people who have experienced a mental illness share their personal story of recovery and hope.

Results: OM has acted as a catalyst to develop partnerships between community groups who are undertaking anti-stigma work and an interdisciplinary team of academic researchers in 5 universities who are evaluating the results of these programs.

Conclusions: Building partnerships with existing community programs and promoting systematic evaluation using standardized approaches and instruments have contributed to our understanding of best practices in the field of anti-stigma programming.



Changer les mentalités au Canada : contexte et raison d'être

Objectif : Résumer le contexte et la raison d'être de l'approche adoptée par l'initiative contre la stigmatisation, Changer les mentalités (CM), de la Commission de la santé mentale du Canada.

Méthode : L'approche adoptée par CM incorpore une philosophie de développement communautaire de base, a bien défini ses groupes cibles, utilise l'éducation par des contacts comme élément central de toutes les interventions, et a une solide composante d'évaluation, de sorte que les pratiques exemplaires puissent être identifiées, reproduites et diffusées. L'éducation par des contacts met en scène des personnes qui ont vécu avec une maladie mentale et qui partagent leur histoire de rétablissement et d'espoir.

Résultats : CM a servi de catalyseur pour former des partenariats entre les groupes communautaires qui entreprennent un travail d'anti-stigmatisation et une équipe interdisciplinaire de chercheurs scientifiques de 5 universités qui évaluent les résultats de ces programmes.

Conclusions : Former des partenariats avec les programmes communautaires existants et promouvoir l'évaluation systématique à l'aide d'approches et d'instruments normalisés ont contribué à notre compréhension des pratiques exemplaires dans le domaine de la programmation anti-stigmatisation.

In 2006, Canada's Senate Committee on Social Affairs, Science and Technology completed a national review of mental health and addiction services in Canada¹—the first national review since the report of the Royal Commission on Psychiatric Services published almost half a century earlier.² The Committee recommended that a mental health commission be created, which was subsequently established in 2007 with the full support of all federal parties. The MHCC was funded through Health Canada, with a 10-year mandate to act as a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians regarding mental health issues. The OM Anti-Stigma Initiative of the MHCC was launched on October 2, 2009. Our paper will provide the rationale for the approach taken and summarize the way in which programs were identified and engaged in this initiative.

Background

When OM was launched in 2009, several countries were already engaged in national anti-stigma initiatives using large media campaigns.³ When the MHCC was developing the OM initiative, a large media campaign was featured as part of the national plan. As a prelude, a short public education campaign was launched between September and November 2009. Various media sources were used to transmit messages emphasizing treatment and recovery, with first-person accounts from people who had experienced a mental illness, including major newspapers (*The Globe and Mail* and *La Presse*), television commercials during prime time (CTV and MuchMusic), and social networking.

An external survey firm conducted pre and post surveys from a large marketing panel of media-engaged Canadians

Clinical Implications

- National leadership for anti-stigma programming can be an important catalyst for change.
- A best practice in anti-stigma programming involves grassroots input, includes people with lived experience of a mental illness, and uses interdisciplinary partnerships with academics to promote evaluation and critical reflection of program processes and results.
- A targeted strategy for stigma reduction has been more promising and sustainable than universal mass media public education approaches.

Limitations

- The media campaign that was used may have been too brief to create noticeable change.
- Because OM is working with existing programs, certain gap populations (such as minority groups or Aboriginal populations), where no programs exist, are not yet represented.
- Scaling up local activities has yet to be undertaken.

(defined as those who reported regularly accessing various media), as they would be the most likely to have seen or heard the campaign's messaging. Using quota sampling, 2000 respondents were identified for the pre- and posttest. A total of 83.9% of respondents who were eligible to complete the survey returned a completed online questionnaire.

Results were disappointing (see online eTable 1). There were no appreciable improvements on any of the survey items. For example, only about one-third of the sample agreed that people with a mental illness could make a complete recovery (33.5%)—one of the central messages of the media campaign—and this increased by only 1.1% after the media coverage. Over one-half of the sample considered that the average Canadian would feel somewhat or very uncomfortable socializing with someone with a mental illness, and this showed no change. Based on these results,

Abbreviations

MHCC	Mental Health Commission of Canada
OM	Opening Minds

OM staff began to rethink the role of media messaging as their main intervention strategy and, instead, opted for a more intensive and targeted approach to stigma reduction.

Target Groups and Rationale

The Board of the MHCC ultimately identified 4 target groups. Youth and health care providers were the first, followed by the news media and the workforce. Youth were targeted because of the high prevalence of mental illnesses and the potential for stigma to delay help seeking. It is now well known that most mental illnesses begin in adolescence and that 1 in 5 youth will meet the criteria for a mental disorder each year.⁴ There is also some evidence to suggest that Canadian youth experience higher levels of emotional distress, compared with youth in other countries.⁵ Health care providers were identified because people who seek help for mental health problems report that they often experience some of the most deeply felt stigma from front-line care personnel.^{6–11} News media were targeted because they play a central role in creating and maintaining some of the most negative central stereotypes associated with mental illnesses,¹² and they are a major source of health and mental health information for members of the general public.¹³ The consequences of negative media images for people who have a mental illness can be profound. Negative imagery impairs self-esteem, promotes self-stigma, delays help seeking, and undermines recovery. While mental health advocates blame the media for some of the most denigrating images of mental illnesses, the media may also be an important ally in challenging public prejudices, initiating public debate, and projecting positive, human interest stories. Balancing news reporting of mental health-related incidents, including commentary from people who have a mental illness and mental health experts, is important, but rarely done. Therefore, changing the way in which the news is told and encouraging positive news stories are important anti-stigma strategies.¹²

Finally, about 17% of the working population report being treated for a mental illness, 7% in the past year.¹⁴ Mental illnesses have an enormous impact on the Canadian economy, conservatively estimated to be \$51 billion per year.¹⁵ Short- and long-term disability claims because of mental illnesses account for 30% of all work-related disability claims and, on average, cost organizations about double that of nonmental health disability claims (\$18 000, compared with \$9000).¹⁶ In workplaces, mental illnesses provoke numerous specific stereotypes, such as mental illnesses are licenses for avoiding work responsibilities, they compromise social interactions on the job, or they undermine one's ability to cope with demanding or stressful roles.¹⁷ These beliefs and assumptions, which comprise the workplace culture and climate, are important determinants of employment success for people experiencing a mental illness.¹⁸ Many workers choose to avoid or delay seeking treatment or will not ask for accommodations (of which they are entitled to) because they perceive workplace resistance and wish to avoid being stigmatized.¹⁹ Compared with physical health issues,

employers have less understanding of disruptions in work-related capacity associated with mental illnesses, and this can fuel stigma. For example, workers with mental illnesses may be offered work accommodations and other technical approaches to supporting their work participation without understanding and genuine respect, with the result that their sense of belonging and acceptance is undermined.²⁰ Employees with a mental illness may also face excessive supervision by bosses who doubt their competence and trustworthiness, may be passed over for promotions, and may be the brunt of hurtful comments by coworkers.²¹

Building Networks of Practice

Because the MHCC was mandated for 10 years to function as a catalyst, an early decision was made that anti-stigma interventions had to be sustainable after the sunset of the MHCC. This precluded creating and implementing new programs and further argued against undertaking a large media campaign. Recognizing that much anti-stigma work was already under way in Canada, OM staff sought out existing anti-stigma programs. The goal was to identify the most effective programs, replicate them in other areas, then scale them up so that they could be more broadly distributed. This could be done through knowledge translation activities, such as creating and disseminating best practice toolkits, coordinating training activities, and promoting the development of community networks and coalitions.

Preliminary investigation showed that most programs targeting youth and health care providers (the first target groups to be addressed) had never been formally evaluated, with the result that their effectiveness was unknown. Additionally, the staff in many of these programs, though interested in evaluation, did not have the funding or the expertise to conduct evaluations on their own. Therefore, to build on these initiatives and to more clearly identify best practices, OM funded a series of evaluation projects as the first phase of a nationwide anti-stigma strategy.

In March 2009, a Request for Interest was disseminated to a broad array of stakeholders asking if they would be willing to become pilot test sites for youth or health care provider programs. Programs had to agree to work with a coordinating centre to develop and conduct evaluations, provide a description of the structures and processes needed to mount the program, participate in the development of a logic model outlining how program resources and interventions were intended to bring about desired outcomes, quantify program outputs (such as the number of clients served), and collect standardized data to assess changes in stigmatizing beliefs. Two hundred and thirty-three submissions were received: 103 programs targeting youth and 130 targeting health care providers. An impartial selection committee of national and international experts, members of the MHCC's Board, senior staff, and people from the advocacy community who had experienced a mental illness recommended that the programs that should receive the highest priority for the evaluation pilot should be those

that used a contact-based intervention that directly involved people with a mental illness to deliver the intervention by telling personal recovery stories, that had stable funding (to not be in jeopardy of running out of funding and closing during the life of the evaluation), and that had the potential to be widely disseminated if demonstrated to be effective.

The characteristics of the programs that responded to the request are summarized in online eTable 2. Programs used various approaches. Less than one-third in each target group used a contact-based intervention, with slightly more youth programs using this as their intervention model. The bulk of programs reported that they did not include people with lived experience of a mental illness in either the delivery or program planning. Programs targeting health care providers were significantly more likely to use a traditional didactic educational approach rather than a contact-based intervention ($\chi^2 = 8.29$, $df = 1$, $P = 0.004$). Funding was a challenge for many programs. Just over one-half of the programs reported that they had stable funding at the time of the submission, with no differences between target groups. Noticeably missing from the list were programs targeting Aboriginal, multicultural, or French-speaking communities, and these continue to be important gaps. Less than one-half of the programs had been evaluated, and of those that had, a minority (3% to 7%) had a peer-reviewed publication describing the results. The panel invited 20 youth programs and 17 health care provider programs to be involved in the pilot evaluations, and since then, additional programs have been included.

In 2010, a different approach was used to engage workplaces and the news media. In terms of forging partnerships with the media, numerous approaches were tried, including reaching out to owners, publishers, associations, and unions. A connection was finally made with the Canadian Journalism Forum on Violence and Trauma, which was doing related work with journalists in the area of posttraumatic stress disorder. In addition, OM staff members were invited to provide contact-based seminars to journalism students in universities across Canada: Mount Royal University (Calgary), King's College (Halifax), Carleton University (Ottawa), Ryerson University (Toronto), and the University of British Columbia (Vancouver). Forging partnerships with businesses and organizations proved to be considerably slower and much more challenging—something that was previously experienced when trying to recruit business partners in the Canadian pilot program for the World Psychiatric Association's global anti-stigma program.²² Partners were identified by deliberately reaching out to companies known to be interested in the mental health of their employees.

OM is now working with over 100 community partners organized into evaluation networks, each with the support of researchers, post-doctoral students, and research associates across 5 universities: the University of Calgary (health care providers and workplace west), Queen's University (youth and workplace central and east), University of Toronto (workplace central and east), McGill University (news

media), and Dalhousie University (health care providers). Fostering these grassroots initiatives and linking them with multidisciplinary teams of researchers has become one of the hallmarks of the OM strategy and one that has distinguished it from other anti-stigma programs worldwide.

Strengths and Limitations

The benefits of this approach have been considerable. It has been possible to build capacity to undertake program evaluation in a broad array of stakeholder groups that were interested but that did not have the resources or expertise at their disposal. The university community partnerships that have developed have been rewarding, and programs have benefited from the reflective stance required by the evaluation enterprise. Based on their results, several programs have discontinued activities that were demonstrated to be ineffective and many more have significantly modified their approach. Researchers have taken considerable time to present findings in ways that are understandable to program staff, provide opportunities for discussion and reflection, and promote better practice alternatives.

Despite these benefits, this approach has not been without challenges. There was an absence of a large, publicly visible anti-stigma effort, as would have been the case if a large media campaign had been used. This opened the program to criticisms that it was not doing enough to reduce stigma. Second, many viewed the evaluation research as slowing down the process. Decision makers who felt intense pressure to do something often met the slower and more methodical evidence-based approach with frustration and criticism. Researchers were often under intense pressure to produce actionable results. Finally, the process of gaining institutional approvals to conduct research was foreign to many program partners who had been collecting their own pre- and posttest data without having to work within university-based research ethics processes. By building partnerships with existing community programs and promoting systematic evaluation using standardized approaches and instruments, OM has contributed to our understanding of best practices in the field of anti-stigma programming. The tools and publications that have resulted will leave an important legacy and will be instrumental in scaling up local anti-stigma efforts so that they become national in scope.

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