



An initiative of the Mental Health Commission of Canada

Selection of Anti-stigma Programs

Summary and Results



Une initiative de la Commission santé mentale du Canada

Acknowledgements

Catherine Yang and Michelle Koller, Queen's University who provided data management and analysis support.

Report Prepared by:

Heather Stuart, PhD, Queen's University, Department of Community Health & Epidemiology
November 2009

Financial Sponsorship

Opening Minds



An initiative of the Mental Health Commission of Canada

Background:

The Mental Health Commission of Canada was formed in 2007 by the Government of Canada. It has a ten-year mandate to provide national leadership in mental health and become a catalyst for change. One of the Commission's major initiatives is to reduce mental health related stigma and discrimination, which are viewed as a shared responsibility of all Canadians.

The resulting *Opening Minds* initiative has a broad mandate, but recognizes that stigma is primarily a problem of behaviours that result in unfair and inequitable treatment for people with mental illnesses and their family members. When placed in this light, the goal of the *Opening Minds* anti-stigma program is to effect change that results in tangible improvements in the day-to-day lives of people with a mental illness and their family members.

Based on the feedback received in a national consultation undertaken during the preparation of the *Out of the Shadows* report, two key targets were identified for the first year of the program's operation—health care providers and youth. Health care providers are often under pressure to see patients quickly and may not have the time or the training to adequately address mental health issues. People who seek help for mental health problems often feel disrespected and discriminated against by front-line health care personnel, even when this is unintentional. National health care organizations have expressed a high degree of interest in examining this situation and taking steps to promote a more recovery-focused system of care.

The second target group, youth, were unanimously identified as a key target group because mental illnesses typically begin during adolescence and because the fear of stigma often delays diagnosis and treatment. Youth peoples' attitudes are typically more malleable and so amenable to anti-stigma messages.

A Grass Roots Approach:

While much anti-stigma work is ongoing internationally which involves large-scale public education campaigns, *Opening Minds* staff recognized that there was important work ongoing throughout Canada at the grass roots level. If there was ever to be a national anti-stigma effort that would be sustainable after the life of the Commission's ten year mandate, and adaptable to local contexts, then existing programs would have to form the nexus of this effort. However, there was also recognition that many of these programs had never been formally evaluated, so their effectiveness was unknown. Also, the staff in many small programs, though interested in evaluation, did not have the funding or the expertise to conduct effectiveness evaluations on their own.

In order to build on these initiatives and provide an opportunity for program staff to access evaluation expertise and resources, the *Opening Minds* program planned to fund a series of evaluation projects as the first phase of a nation-wide anti-stigma and anti-discrimination strategy. Once best-practices could be determined, then tools and resources from these programs could be made available on a national scale to other communities and stakeholders wishing to begin their own anti-stigma efforts. Thus, the goals of this project became to identify, document, and then disseminate best practices in stigma-reduction using networks of existing programs.

In March of 2009, the Mental Health Commission sought expressions of interest from a broad range of stakeholders by issuing a formal "Request for Interest". In it, programs were invited to express their interest in becoming a potential test sites. Programs had to agree to work with a coordinating centre to develop and conduct comprehensive evaluations of their interventions, including a complete description of the structures and processes needed to mount the program; the development of a program logic model specifying how program resources and interventions were intended to bring about desired outcomes; quantification of the program outputs (such as the number of clients served); and quantification of program outcomes defined as changes in knowledge, attitudes, behaviours, or practices.

The Selection Process:

Programs registered their interest by completing an on-line survey. In addition to identification and contact information, the survey asked about the location of the program; its reach into local, regional, national, or international audiences; the specific group targeted (youth or health care professionals); the expected outcomes in terms of changes in knowledge, attitudes, behaviours, or practices; where the program was provided (such as in a school, community agency, health agency, or web location); funding sources for the program's activities; whether the program had ever been evaluated; and a comment on the potential national relevance of a program of this nature.

An impartial selection committee composed of national and international experts was convened. In addition to senior Commission staff, the committee included people with a mental illness, family members, researchers, policy makers, mental health advocates, and anti-stigma experts. The Committee developed a set of principles to guide the decision making process. For this phase of the project, programs that received the highest priority for evaluation were those that:

- Use a contact-based interventions that directly involve people with mental health problems to deliver the intervention;
- Had stable funding so would not be in jeopardy of closing during the life of the evaluation; and
- Had the potential to be widely disseminated if demonstrated to be effective.

In addition, programs were deemed to be out of scope if they did not directly address stigma or discrimination, were not yet operational, were requests for research funding, were requests for program funding, or were delivering clinical services without a clear anti-stigma focus.

Results:

Table 1 shows the characteristics of the submissions. The review panel assessed 103 submissions targeting youth and 130 targeting health care providers.

Less than a third of programs targeting each group used direct contact educational approaches. Slightly more youth programs used direct contact. Approximately one in ten of the program

submissions in each group used indirect contact, such as when a video presentation was used to convey consumer experiences. Approximately one in ten programs reported that consumers had been involved in the planning of the program. The bulk of programs in each category, however, reported that they did not include consumers in either the delivery or the planning of their anti-stigma programs.

Programs used a variety of different approaches to achieve their goals. The most common was an educational format. This included both contact-based education (involving direct personal experiences with people who have a mental illness) as well as more traditional didactic education. Programs targeting health care providers were significantly more likely to use an educational approach overall (χ^2 df=1, 8.29, $p = .004$) and to use traditional didactic education rather than contact-based education. Thirty-seven percent of the educational programs targeting youth used traditional didactic methods compared to 63% of those targeting health care providers (data not shown) (χ^2 df=1, 5.6, $p = .01$).

Equal proportions of programs targeted to youth or health care providers used treatment oriented approaches. These included approaches aimed at early identification and help-seeking. Other approaches included promotion/prevention, system level advocacy (for better services or policies), theatre or arts (such as plays, music, or comedy), or programs aimed at engaging and improving awareness. Non-program submissions included ideas for research projects, specific anti-stigma tools (such as books or videos), and offers to become future test sites.

Funding was a challenge for many programs. Just over half of the programs reported that they had stable funding at the time of the submission. A quarter did not have stable funding and the remainder were uncertain, with no differences between target groups.

Less than half of the programs had ever been evaluated, and of those that had been evaluated, and a minority (3-7%) resulted in reports that were published in the peer-reviewed academic literature. A slightly greater proportion of programs targeting health providers were uncertain as to whether their evaluations had resulted in a publication, but these differences were small.

The review panel identified 20 programs targeting youth and 17 programs targeting health care providers to be invited to participate in a larger scale evaluation.

Table 1: Characteristics of Submissions

Program Characteristic	Youth Group % of 103	Health Care Provider Group % of 130
Level of Consumer Involvement*		
• Direct	29% (30)	20% (26)
• Indirect (eg: video)	13% (13)	10% (13)
• Involved in planning	6% (6)	10% (13)
• No consumer involvement	61% (63)	69% (90)
Program Approach*		
• Education	29% (30)	39% (62)
• Treatment oriented	31% (32)	30% (39)
• Promotion/prevention	15% (15)	7% (9)
• Advocacy	2% (2)	8% (10)
• Theatre or Arts	8% (8)	4% (5)
• Engagement	5% (5)	2% (3)
• Other (non-program)	11% (11)	14% (18)
Stable Funding		
• Yes	54% (55)	57% (71)
• No	21% (21)	20% (25)
• Uncertain	26% (26)	23% (28)
Ever Evaluated:		
• Yes	46% (47)	44% (53)
• No	46% (47)	47% (56)
• Uncertain	8% (8)	9% (11)
Evaluation Report Published		
• Academic Journal	7% (7)	3% (4)
• Technical report	6% (6)	4% (5)
• Unpublished	79% (81)	80% (104)
• Uncertain	9% (9)	14% (17)
Invitation Extended – Phase I	19% (20)	13% (17)
* Because programs could have multiple dimensions, percents do not add up to 100 (multiple responses were coded).		

Summary and Next Steps:

The Mental Health Commission of Canada was overwhelmed by the response to its first Request for Interest for anti-stigma programs in Canada to be involved in a systematic evaluation effort. An impartial panel reviewed 103 submissions pertaining to youth and 130 pertaining to health care providers. Though the Commission was aware of a large number of anti-stigma programs in operation across Canada, this level of response could not have been anticipated and it provides even stronger justification for the grass-roots model that has been adopted for the program's first phase of the anti-stigma work.

The review panel used broad criteria to assess each program that combined knowledge of best practices in the field and issues of feasibility. Programs that received the highest priority for evaluation used contact-based approaches that directly involve people with mental health problems who tell students about their illness and recovery (considered to be a best-practice in the field), had stable funding so would not be in jeopardy of closing during the life of the evaluation; and had the potential to be widely disseminated if demonstrated to be effective. Twenty programs targeting youth and 17 targeting health care providers were deemed to meet these criteria. Included in this selection were a number of tools (such as books or videos) that could also benefit from formal evaluation.

Program representatives were invited to attend a planning meeting that was held in Toronto in October 2009 to discuss next steps. Participants considered that it was both feasible and desirable to collaborate to form an evaluation network. Wherever possible and appropriate, network partners with similar programs would adopt similar evaluation strategies with common assessment tools. Evaluation support for study design, data management, analysis, report writing would be provided by the *Opening Minds* Anti-stigma program. In this way the Mental Health Commission of Canada would add value to existing activities by helping programs to demonstrate their effectiveness, by sharing experiences and best practices across the network partners, and by providing expertise needed to report effective practices in the scientific literature where they can become part of best-practice guidelines. The network would also allow for greater breadth and quality of evaluation by enlarging the available sample sizes (by pooling across like programs) and by allowing for testing of variants in program delivery. Finally, we expect that network partners will provide leadership in the dissemination of best –

practices throughout Canada and will be an important resource for new and fledgling anti-stigma programs.

Network partners also identified a number of gaps in existing programming. Noticeably missing from the list of submissions were programs targeting youth or health care providers in aboriginal, multi-cultural and French speaking communities. Special developmental efforts (contemplated as Phase II activities) will be required in these areas.