



Mental Health  
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du Canada

# That's Just Crazy Talk Evaluation Report

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[www.mentalhealthcommission.ca](http://www.mentalhealthcommission.ca)

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## **1 OPENING MINDS: CHANGING HOW WE SEE MENTAL ILLNESS**

Stigma is a significant concern for those living with a mental illness. Stigma is a primary vehicle for the entrenchment of discriminatory behaviours, and has been identified as a major barrier to timely and accessible care, recovery, and quality of life for persons living with mental illnesses (1-2). As such, reducing the stigma and discrimination associated with mental illness is becoming an increasingly important focus. One particular area of focus is that of the healthcare sector.

As part of its 10-year mandate, The Mental Health Commission of Canada (MHCC) has embarked on an anti-stigma initiative called Opening Minds (OM) to change the attitudes and behaviours of Canadians towards people with a mental illness. OM is the largest systematic effort undertaken in Canadian history to reduce the stigma and discrimination associated with mental illness. OM is taking a targeted approach, with healthcare providers being one of its main target groups. OM's philosophy is not to reinvent the wheel, but rather to build on the strengths of existing programs from across the country. As such, OM is conducting evaluations of various programs to determine their success at reducing stigma. OM's goal is to replicate effective programs nationally. (3)

A key component of these program evaluations is contact-based educational sessions, where target audiences hear personal stories from, and interact with, individuals who have recovered or are successfully managing their mental illness. The success of contact-based anti-stigma interventions is generally supported by international studies as a promising practice to reduce stigma. OM is partnering with programs in Canada who are reaching out to its initial target groups: youth, healthcare providers, the workforce and news media. Over time, OM will add other target groups.

For more information, go to: [www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx](http://www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx)

## **2 BACKGROUND**

*That's Just Crazy Talk* is a one-hour stage play designed to address stigma toward mental illness by illustrating how internalized and public stigma manifest. The play is performed by Victoria Maxwell, a recognized educator and speaker on the lived experience of mental illness and recovery. The stage play has now been video-recorded and is available on DVD. Previous research has demonstrated that the live stage play is effective at reducing stigma, and that the recorded version may also be effective as an anti-stigma tool. (4-5)

Opening Minds was interested in learning whether the DVD performance was also effective at reducing stigma among one target group in particular – healthcare providers. To this end, Opening Minds partnered with Dr. Sagar V. Parikh, Deputy Psychiatrist-in-Chief, University Health Network (UHN), and Professor of Psychiatry, University of Toronto, and postdoctoral researcher Lisa D. Hawke, PhD, who were undertaking a larger study on the impact of *That's Just Crazy Talk - A Filmed Contact-Based Intervention* on stigma in various population groups.

*That's Just Crazy Talk - A Filmed Contact-Based Intervention* program has three main components: introduction and distribution of information/educational pamphlet about bipolar disorder, the screening of the *That's Just Crazy Talk* play, and an interactive post-viewing group discussion.

The program was delivered to two main healthcare provider groups – practicing healthcare providers, and students in healthcare. *That's Just Crazy Talk - A Filmed Contact-Based Intervention* was delivered in group format to approximately 58 healthcare providers and students in various Ontario locations between the months of September 2012 and March 2013, and its impact on stigma measured.

### 3 EVALUATION METHODS

In order to assess stigma toward mental illness, practicing healthcare providers and healthcare students were provided a questionnaire package at three different time points. The first survey was completed before their participation in *That's Just Crazy Talk - A Filmed Contact-Based Intervention* (pre-test survey). The second questionnaire was provided to participants immediately following the program (post-test survey). The final survey was administered one month following participants' attendance at their *That's Just Crazy Talk - A Filmed Contact-Based Intervention* session (follow-up survey).

All surveys contained the 12-item Opening Minds Scale for Health Care Providers (OMS-HC-short) so that changes over time could be assessed. The OMS-HC-short is a 12-item scale that measures healthcare providers' attitudes and behavioural intentions toward people with a mental illness. (6) A copy of this scale is provided in **Appendix A**.

To complete the scale, participants are asked the extent to which they agree or disagree with each item. Items are rated on a 5-point scale: *strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree*. To create a total score for the scale, all 12 items are summed for each participant. Total scores can range from 12 to 60, with lower scores indicating less stigma.

For this particular evaluation, Cronbach's alphas for the scale were .49 for the pre-test, .76 for the post-test, and .78 for the follow-up survey. These results suggest an acceptable level of internal consistency for the scale at post-test and follow-up. It is uncertain why the Cronbach's alpha at pre-test was lower, although it was observed that the Cronbach's alphas for the scale at pre-test were particularly low among the practicing healthcare provider group as compared to the student group (practicing healthcare providers, pre-test alpha=.42; students, pre-test alpha =.67).

Paired t-tests were used to analyze total score changes on the scale at the three time points. The direction and magnitude of change from pre to post intervention was also examined. Further, by grouping certain questions from the scale together, the OMS-HC was used to examine two main dimensions of stigma: attitudes toward people with mental illness; and healthcare professionals' attitudes about disclosure of a

mental illness. (6) A threshold was also created to measure success, defined as the proportion of respondents who obtained 80% or more correct (non-stigmatizing) answers on the scale. Lastly, differences by participant type (i.e., practicing healthcare providers and students) were examined.

In all, 58 participants completed one or more surveys. A total of 56 participants completed both the pre-test and the post-test. Forty-two participants completed all three surveys – the pre-test, the post-test and the follow-up survey. The examination of score changes from baseline to post intervention was based on paired analyses of the 56 participants who completed both the pre-test and the post-test surveys. The examination of follow-up scores was based on a paired analysis of 42 participants who completed all three surveys.

## 4 RESULTS

### 4.1 Participant Demographics

**Table 1** highlights the breakdown of participants by age, gender, target group, and occupation. As shown in the table, just over half of participants were practicing healthcare providers (53.4%), while just under half were students in a healthcare discipline (46.6%).

Among the practicing healthcare providers, just over half identified their occupation as nursing (27.6% of the full sample, 51.6% of practicing healthcare providers). Similarly, among the student participants, most were students in nursing (29.3% of the full sample, 63.0% of students). Most participants were female (89.7%). The mean age of participants was 35.8 years.

**Table 1.** Demographic Characteristics of Participants

	n (=58)	%
Group		
Practicing healthcare provider	31	53.4%
Student in healthcare	27	46.6%
Occupation		
Nurse	16	27.6%
Social worker/OT/physiotherapist/dietician	8	13.8%
Psychologist	3	5.2%
Physician	1	1.7%
Community support worker	3	5.2%
Student – nursing	17	29.3%
Student - psychology	10	17.2%
Gender		
Female	52	89.7%
Male	6	10.3%
Age (mean age=35.8)		
20 and under	15	25.9%
21-30	14	24.1%
31-40	4	6.9%
41-50	10	17.2%
51-60	11	19.0%
Over 60	4	6.9%

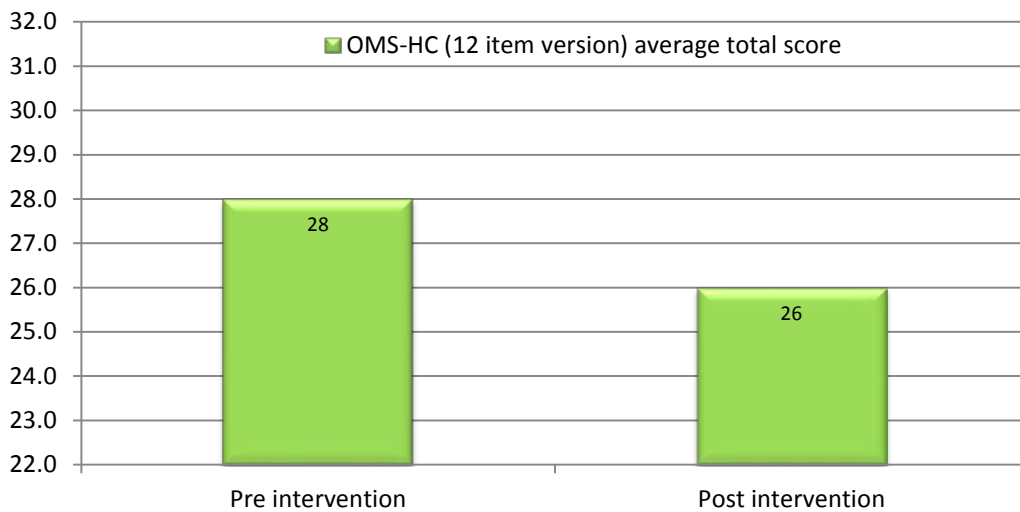
#### 4.2 OMS-HC Total Score Change from Pre to Post Intervention

To create scale scores for the OMS-HC, items were summed across all surveys having complete data from pre intervention to post intervention. With the 12-item version of the scale, total scores can range from 12 to 60, with lower scores indicating less stigma.

For the pre-test, total scores ranged from 20 to 38, with an average of 28.02 (SD = 4.63). For the post-test, total scores ranged from 16 to 39, with an average of 26.00 (SD = 5.43). This represents a 7.2% improvement in score from pre to post intervention, and a standardized mean difference (SMD) of .44, which may be considered a moderate effect.

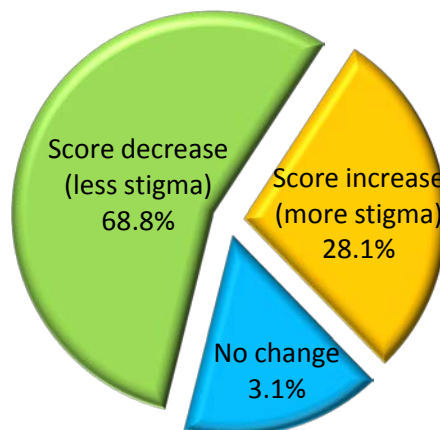
Results of a paired t-test show that the mean score change from pre to post intervention is statistically significant [ $t(55)=3.67, p=.001$ ].

**Figure 1.** Average Total Scores: Pre-test and Post-test (matched analysis, n=56)



**Figure 2** shows the percentage of participants who had a total score increase (i.e., more stigma), total score decrease (i.e., less stigma) or a score that had no change. As highlighted in the figure, just over half of participants had scores that improved from pre to post program (55.4%). Just under three in ten had an increase in score from pre to post program (28.6%), while 16.1% had no change in score from pre to post program.

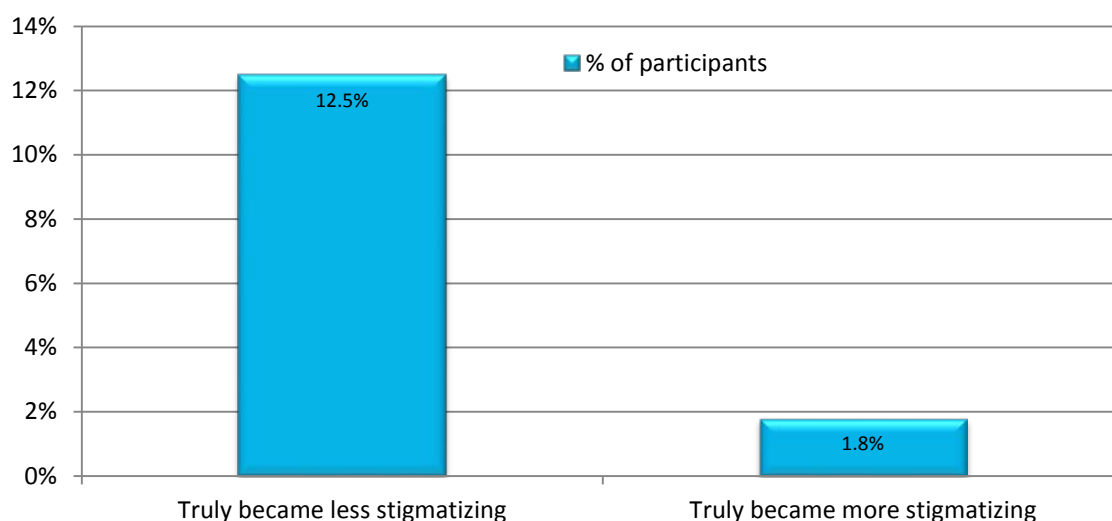
**Figure 2.** Direction of Change from Pre to Post Program (n=56)



The minimum detectable change (MDC) statistic is another method for examining program impact. The calculated MDC for the OMS-HC scale is 6.51.<sup>1</sup> This suggests that a score increase or decrease of 6.5 points or more on the OMS-HC scale reflects a true change in attitude – one that cannot be attributed to measurement error.

As highlighted in **Figure 3**, when the MDC is applied to participants' score changes from pre to post program, the number of participants who actually became more stigmatizing is minimal, at one participant (1.8%). On a similar note, when the MDC is applied to the scores that improved, the percent of participants that truly became less stigmatizing as a result of the *That's Just Crazy Talk - A Filmed Contact-Based Intervention* is 12.5%.

**Figure 3.** Pre to Post Score Change using the MDC Statistic (n=56)



#### 4.3 Stigma Content Areas

Original scale testing suggested two main subscales within the OMS-HC - attitudes toward mental illness, and inclinations toward disclosure of a mental illness and help-seeking. (5) Although subsequent analyses have identified three subscales (paper in progress), the use of the 12-item version of the scale for this project allowed only the ability to conduct analysis on the two original subscales.

The first subscale or dimension is healthcare providers' inclinations toward disclosure of a mental illness. This dimension can be used to provide an indication of the stigma healthcare providers believe exists due to having a mental illness and how this might impact help-seeking. The second dimension is that of attitudes toward people with mental illness.

<sup>1</sup> The MDC for the OMS-HC scale was calculated based on a standard error of measurement (SEM) of 2.80 [from test-retest results on the full scale, see(6)] and a z score of 1.65 (90% confidence level). The formula for calculating this statistic is as follows:  $MDC = SEM \times \sqrt{2} \times z$  score associated with confidence level of interest. For the current analysis, the MDC should be considered approximate, as OM does not yet have test-retest results for the 12-item version of the scale.

Scores were created by calculating the mean for all items in that content area. A summary of mean score changes for the two content areas is provided in **Table 2**.

As shown in the table, the dimension of attitudes toward mental illness showed a statistically significant improvement from pre to post program [ $t(54)=4.89, p<.001$ ]. The content area pertaining to likelihood of disclosure and help-seeking did not show any significant improvement from pre to post intervention [ $t(54)=0.47, p=.581$ ].

**Table 2.** Stigma Content Areas: Changes in Respondent Mean Scores from Pre to Post (n=56)

Content Area	Pre-test mean (95%CI)	Post-test mean (95%CI)	Mean Change (95%CI)	Paired t-test
Attitude towards people with mental illness	1.87 (1.81-1.93)	1.61 (1.55-1.67)	0.26 (0.15-0.37)	$t(54)=4.89 p<.001$
Disclosure/help-seeking	2.99 (2.91-3.08)	2.95 (2.86-3.04)	0.04 (-0.10-0.18)	$t(54)=0.58 p=.581$

#### 4.4 Individual Item Analysis

Again using paired data, individual item changes on the scale were measured from pre to post intervention. Five of the 12 items on the scale showed a statistically significant improvement from pre to post program. Those statements are as follows:

- *I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.*
- *If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain, headache), I would likely attribute this to their mental illness.*
- *If I had a mental illness I would tell my friends.*
- *Despite my professional beliefs, I have negative reactions towards people who have a mental illness.*
- *More than half of people with a mental illness don't try hard enough to get better.*

There was one statement that showed a statistically significant increase in stigma from pre to post-test:

- *If I were under treatment for a mental illness, I would not disclose this to any of my colleagues.*

Individual item scores are provided in the data tables in **Appendix B**.

#### 4.5 Threshold of Success

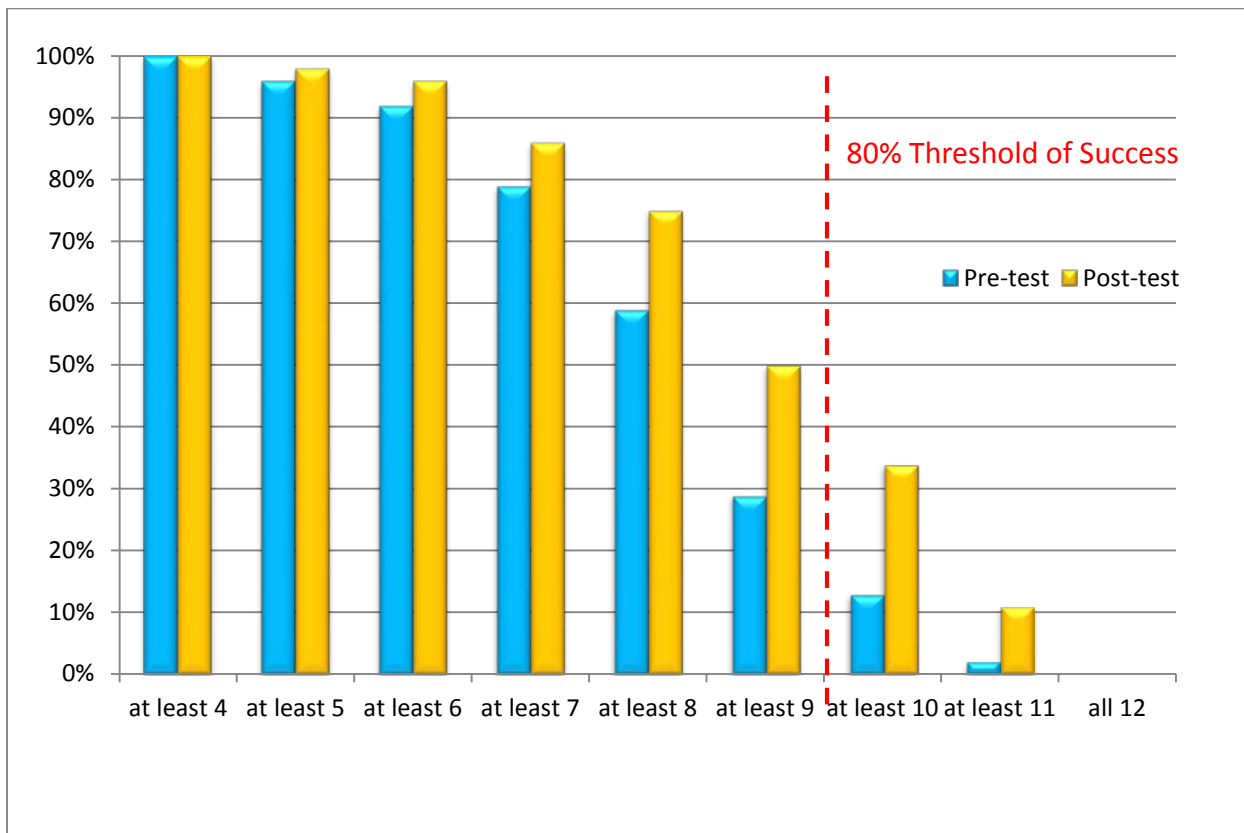
Another way to examine the impact of *That's Just Crazy Talk - A Filmed Contact-Based Intervention* on mental illness stigma is to examine how many participants reached a "threshold of success" on the OMS-HC scale; in other words, how many participants responded to a certain number of items on the OMS-HC in a non-stigmatizing way.

The threshold of success measure is derived by recoding each participant’s response on the OMS-HC scale to represent either a stigmatizing or a non-stigmatizing response. For example, “Most people with mental illness could snap out of it if they wanted to” was recoded as non-stigmatizing if the respondent selected *strongly disagree* or *disagree*, and recoded as stigmatizing if the respondent chose *neutral*, *agree*, or *strongly agree*.

**Figure 4** shows the cumulative percentages of participants who had non-stigmatizing responses for each possible score out of 12 at pre-test and again at post-test. A threshold of 80% (or at least 10 out of 12 “correct” - i.e. non-stigmatizing – answers) was used as an indication of success on the OMS-HC.

As highlighted in the figure, prior to participating in the *That’s Just Crazy Talk - A Filmed Contact-Based Intervention*, 12.5% of participants were across the threshold of success on the scale. At the completion of the program, the percentage who were across the threshold level of success had increased to 33.9% of participants.

**Figure 4.** Cumulative Percent of Non-stigmatizing Responses on OMS-HC for Pre-test and Post-test



#### 4.6 Differences by Participant Type

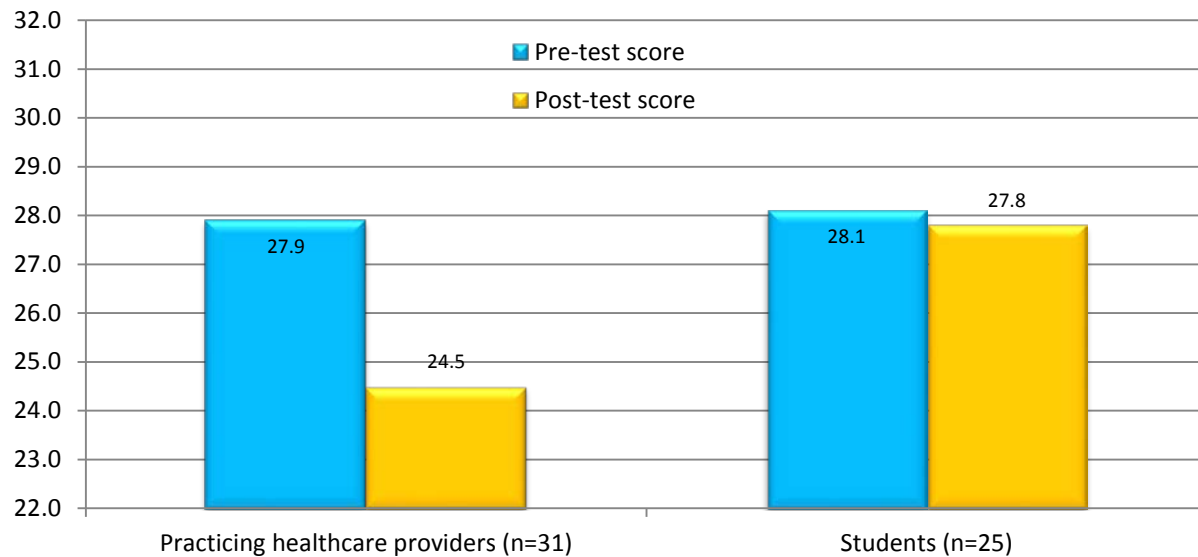
As noted above, program participants were either students in healthcare (46.6%), or healthcare professionals already in practice (53.4%). OMS-HC scores were examined according to ‘student’ versus ‘practicing healthcare provider’ status. As highlighted in **Figure 5**, baseline scores for the two groups were



similar (student average total pre-test score, 28.1; practicing healthcare provider average total pre-test score, 27.9).

As further highlighted, practicing healthcare providers' scores improved more from pre to post intervention than did the students' scores. Practicing healthcare providers' scores changed an average of 12.2% (3.4 points on the scale, SMD = .75) from pre to post program, while students' scores changed an average of only 1.1% (0.4 points on the scale, SMD = .08).

**Figure 5.** Pre-test and Post-test Scores by Participant Group: Students and Practicing Healthcare Providers



T-test results show the difference in score change between practicing healthcare providers and students to be statistically significant [ $t(54)=-2.87, p=.006$ ].

Further, results of paired t-tests indicate the change in score from pre to post intervention for practicing healthcare providers was statistically significant [ $t(30)=4.26, p<.001$ ]. The change in score from pre to post intervention for students was not [ $t(24)=.58, p=.565$ ].

#### 4.7 Follow-up Survey Results

As noted above, the 12-item OMS-HC scale (OMS-HC-short) was again distributed to program participants one month following their participation in *That's Just Crazy Talk - A Filmed Contact-Based Intervention*. Examining scale scores a period of time after the completion of the intervention allows us to examine the extent to which program impacts may have been sustained over time.

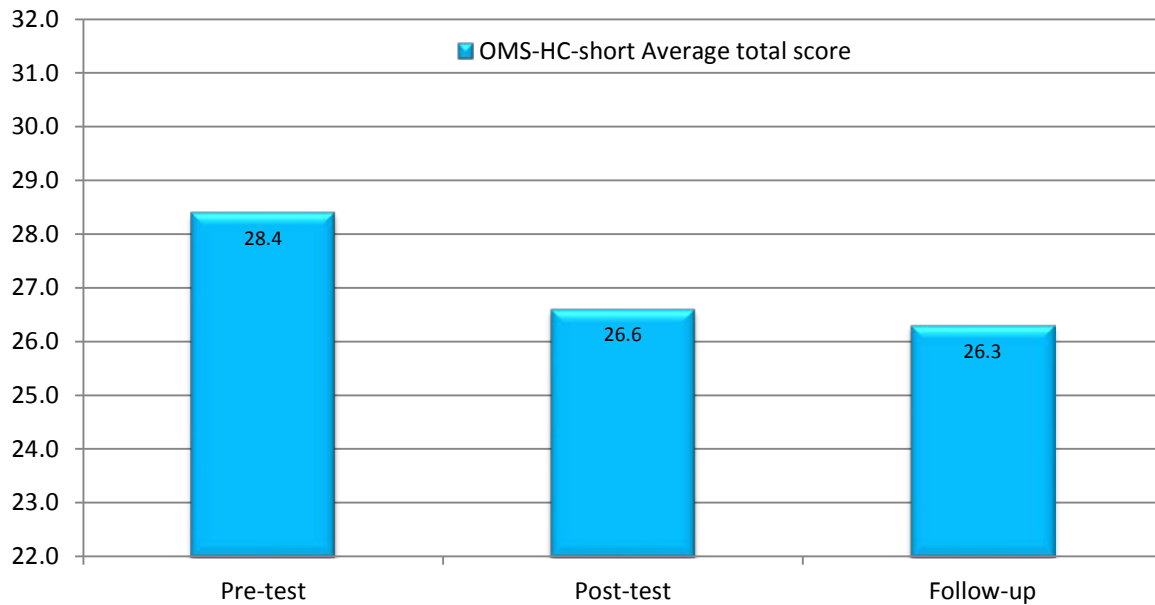
In all, 42 of the 56 participants completed a follow-up survey in addition to the pre and post-test surveys. The results highlighted below are based on a matched analysis of these 42 participants' responses over the three time points.

**Figure 6** shows the average total score across time for those participants who completed a survey at all three time points. As highlighted in the figure, the positive score improvement realized from pre to post

program was sustained to the time of the follow-up survey (pre-test score, 28.4; post-test score, 26.6; follow-up score, 26.3).

Results of a paired t-test showed the score improvement from baseline to one month follow-up to be statistically significant [ $t(74)=3.03, p=.004$ ].

**Figure 6.** OMS-HC score for participants at three time points: pre intervention, post intervention and one-month follow-up (n=42)



Further, an examination of follow-up scores by participant type (i.e., students versus practicing healthcare professionals) was conducted. **Table 3** shows results based on a matched analysis of responses from participants who completed a survey at all three time points (practicing healthcare providers, n=22; students, n=20).

**Table 3.** OMS-HC Scores across all Three Time Points by Participant Type: Practicing Healthcare Providers and Students

	Pre-test score (95%CI)	Post-test score (95%CI)	Follow-up score (95%CI)	t-test (mean change from baseline to follow-up)
Practicing healthcare providers (n=22)	28.8 (27.9-29.7)	25.7 (24.6-26.8)	24.7 (23.4-26.0)	$t(21)=3.81 p=.001$
Students (n=20)	27.9 (26.9-29.0)	27.6 (26.6-28.6)	28.0 (26.7-29.3)	$t(19)=0.07 p=.943$

As shown, the positive score change observed among the practicing healthcare providers from pre to post *That's Just Crazy Talk - A Filmed Contact-Based Intervention* was sustained at follow-up [mean change from baseline to follow-up=4.1 scale points,  $t(21)=3.31, p=.001$ ].

## 5 SUMMARY AND CONCLUSIONS

The evaluation of *That's Just Crazy Talk - A Filmed Contact-Based Intervention* was overall favourable.

- Results indicate that the program was effective at improving attitudes and behavioural intentions among healthcare providers toward mental illness. This is demonstrated by: 1) statistically significant lower scores on the stigma scale at post-test as compared to baseline; and 2) a notable increase in the percentage of respondents who gave non-stigmatizing responses to at least 80% of the questions at post-test as compared to baseline.
- In breaking down the OMS-HC into two major dimensions of stigma – attitudes toward people with a mental illness and attitudes toward disclosure/help seeking, paired analysis showed a statistically significant improvement in scores for the content area of attitudes toward people with a mental illness.
- At the time of the one-month follow-up survey, improvements realized from pre- to post intervention had been maintained. While this result is indeed encouraging, further research to measure participant outcomes at three and six month follow-up would provide more clarity on how long the positive benefits of the intervention can be expected to last.
- Analysis of results by participant type suggests that the program is effective for practicing healthcare providers, but not necessarily for students. This is demonstrated by statistically significant lower scores on the stigma scale at post-test and follow-up as compared to baseline for the 'practicing healthcare provider' group. No notable change in score was observed for the student group at any of the three survey time points. Further research would be required to understand more clearly why the intervention worked well for practicing healthcare providers but not for students in healthcare.

In all, the evaluation results suggest that the *That's Just Crazy Talk - A Filmed Contact-Based Intervention* program is effective at reducing mental illness-related stigma among practicing healthcare providers. For a short intervention (i.e., one-hour, single session program) these results are encouraging, and are comparable to other successful short (i.e., one-two hour, single session) contact-based interventions previously evaluated by OM.(e.g., 7-8)

The results are particularly encouraging as this is a video-based contact-based intervention and, as such, does not require the coordination of in-person (i.e., live) speakers. This makes the *That's Just Crazy Talk - A Filmed Contact-Based Intervention* program a potentially more easy-to-access and easy-to-implement anti-stigma tool for busy healthcare settings faced by such ongoing constraints as time, resources and competing priorities. This program could be adopted, replicated and/or used as an effective tool for anti-stigma programming for practicing healthcare providers, although evaluation is always required to examine outcomes in new jurisdictions or settings.

## References

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## Appendix A

### OMS-HC Scale for Healthcare Providers (short version)

	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I would see myself as weak if I had a mental illness and could not fix it myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I would be reluctant to seek help if I had a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If I had a mental illness, I would tell my friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Despite my professional beliefs, I have negative reactions towards people who have mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. There is little I can do to help people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. More than half of people with mental illness don't try hard enough to get better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Healthcare providers do not need to be advocates for people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I struggle to feel compassion for a person with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix B

### Data Tables

**Table B1.** OMS-HC Frequency Distributions for Pre-test, Post-test, and Follow-up (*all respondents*)

Item	Pre intervention (n=58)			Post intervention (n=56)			Follow-up (n=44)		
	Disagree/ Strongly Disagree	Neither Agree nor Disagree	Agree / Strongly Agree	Disagree/ Strongly Disagree	Neither Agree nor Disagree	Agree / Strongly Agree	Disagree/ Strongly Disagree	Neither Agree nor Disagree	Agree / Strongly Agree
I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	39.7% (25)	31.0% (18)	29.3% (17)	60.7% (34)	17.9% (10)	21.4% (12)	47.7% (21)	15.9% (7)	36.3% (16)
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.	81.0% (47)	3.4% (2)	15.5% (9)	98.2% (55)	1.8% (1)	0.0% (0)	95.5% (42)	4.5% (2)	0.0% (0)
If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	41.4% (24)	24.1% (14)	34.5% (20)	21.4% (12)	21.4% (12)	57.1% (32)	29.5% (13)	18.2% (8)	52.2% (23)
I would be more inclined to seek help for a mental illness if my treating healthcare provider was <u>not</u> associated with my workplace.	10.3% (6)	13.8% (8)	75.9% (44)	7.1% (4)	14.3% (8)	78.5% (44)	13.6% (6)	11.4% (5)	75.0% (33)
I would see myself as weak if I had a mental illness and could <u>not</u> fix it myself.	60.3% (35)	17.2% (10)	22.4% (13)	69.6% (39)	14.3% (8)	16.1% (9)	65.9% (29)	15.9% (7)	18.2% (8)
I would be reluctant to seek help if I had a mental illness.	69.0% (40)	12.1% (7)	18.9% (11)	69.6% (39)	14.3% (8)	16.1% (9)	70.5% (31)	9.1% (4)	20.4% (9)
If I had a mental illness, I would tell my friends. (reverse)	32.8% (19)	24.1% (14)	43.1% (25)	48.2% (27)	23.2% (13)	28.5% (16)	56.8% (25)	15.9% (7)	27.3% (12)
Despite my professional beliefs, I have negative reactions towards people who have mental illness	81.0% (47)	13.8% (8)	5.2% (3)	92.9% (52)	3.6% (2)	3.6% (2)	77.3% (34)	11.4% (5)	11.4% (5)

Item	Pre intervention (n=58)			Post intervention (n=56)			Follow-up (n=44)		
	Disagree/ Strongly Disagree	Neither Agree nor Disagree	Agree / Strongly Agree	Disagree/ Strongly Disagree	Neither Agree nor Disagree	Agree / Strongly Agree	Disagree/ Strongly Disagree	Neither Agree nor Disagree	Agree / Strongly Agree
There is little I can do to help people with mental illness	81.0% (47)	12.1% (7)	6.9% (4)	89.3% (50)	10.7% (6)	0.0% (0)	93.2% (41)	4.5% (2)	2.3% (1)
More than half of people with mental illness don't try hard enough to get better.	72.4% (42)	17.2% (10)	10.3% (6)	98.2% (55)	1.8% (1)	0.0% (0)	93.2% (41)	6.8% (3)	0.0% (0)
Healthcare providers do <u>not</u> need to be advocates for people with mental illness.	96.6% (58)	3.4% (2)	0.0% (0)	98.2% (55)	0.0% (0)	1.8% (1)	97.7 (43)	2.3% (1)	0.0% (0)
I struggle to feel compassion for a person with a mental illness.	94.8% (55)	3.4% (2)	1.7% (1)	92.9% (52)	5.4% (3)	1.8% (1)	93.2% (41)	2.3% (1)	4.6% (2)

**Table B2.** OMS-HC: Mean Scores from Pre-test to Post-test with Content Areas Indicated (*paired surveys*)

Dimension	Item	Mean score		Pair Samples T-Test (n=56)	
		Pre test	Post-test	T-value	P-value
<b>Attitude</b>	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	2.73	2.39	2.60	.012
<b>Attitude</b>	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.	2.00	1.50	3.06	.003
<b>Disclosure</b>	If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	2.86	3.39	-3.29	.002
<b>Disclosure</b>	I would be more inclined to seek help for a mental illness if my treating healthcare provider was <u>not</u> associated with my workplace.	3.98	3.91	0.70	.484
<b>Disclosure</b>	I would see myself as weak if I had a mental illness and could <u>not</u> fix it myself.	2.54	2.36	1.32	.192
<b>Disclosure</b>	I would be reluctant to seek help if I had a mental illness.	2.29	2.20	0.90	.374
<b>Disclosure</b>	If I had a mental illness, I would tell my friends.	3.27	2.88	2.48	.016
<b>Attitude</b>	Despite my professional beliefs, I have negative reactions towards people who have mental illness.	1.89	1.66	2.28	.027
<b>Attitude</b>	There is little I can do to help people with mental illness.	1.82	1.68	1.27	.209
<b>Attitude</b>	More than half of people with mental illness don't try hard enough to get better.	2.04	1.43	4.30	>.001
<b>Attitude</b>	Healthcare providers do <u>not</u> need to be advocates for people with mental illness.	1.20	1.23	-0.41	.687
<b>Attitude</b>	I struggle to feel compassion for a person with a mental illness.	1.41	1.38	0.33	.742