Five ways to improve mental health care in your organization

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MHCC and Opening Minds

Opening Minds one of MHCC’s core initiatives

- Evidence-based approach to stigma reduction
- Grass roots, community-development approach
- 4 key target groups: youth, healthcare, media, workplace
- Evaluation and research of existing programs; identification of key ingredients and best practices
- Replication and scaling up
If you want to improve the quality of mental healthcare you have to go after stigma
What we’re going to do

1. Identify the Problem
   • Explore the causes of mental illness-related stigmatization in healthcare and its consequences for patients and staff

2. Learn about strategies and solutions
   • ‘Key ingredients,’ best practices for effective anti-stigma programming
   • Introduction to/demonstration of 4 different evidence-based programs for combatting stigma in healthcare

3. Develop an action plan
   • Develop a strategy, identify specific action items to improve mental health care and reduce stigma in people’s own organizations, departments, practices.
Workshop Objectives

By the end of this workshop you will be able to:

• Explain what mental illness-related stigmatization in healthcare looks like, where it comes from, and what the consequences are for patients and staff.

• Describe a number of evidence-based programs and strategies to reduce stigma, that also increase confidence and comfort treating patients with a mental illness, improve patient care, and improve employee mental health.

• Develop a strategy and action plan for how such tools and programs can be used in your own organization, department or practice to improve the quality of mental health care and promote culture change.
If you want to improve the quality of mental healthcare you have to go after stigma

Why stigma?
1. Identifying the Problem

How does stigma impact quality of care and what are the consequences for patients and staff?

World Café – facilitated by Liz Wigfull
World Café

Qn 1 – 10 minutes

What does mental illness-related stigmatization in healthcare look like and where does it come from?

- examples, scenarios
- distinguish between structural vs interpersonal stigma
- identify causes
World Café

Qn 2 – 10 minutes

How does stigma affect patient care?

- access
- patient-provider interactions
- quality of care (physical care, mental health care)
- patient outcomes
- other
World Café

Qn 3 – 10 minutes

How does stigma impact healthcare providers?

- workplace culture and work environment
- as persons who also have mental health needs and concerns
- other
World Café wrap up

What stood out for you?
A quick survey of the literature

Stigma in healthcare
Stigma in the Workplace

• Barriers and delays to help-seeking for the health care provider

• Devaluation of skills, incompetence, can do the job
  • Consequences for career
  • Discrimination

• Perceptions of dangerousness

• Self-stigma
The Roots of Stigma

Our research found healthcare providers have a number of core learning needs that relate to stigma:

1. Pessimism about recovery / feel like what they do doesn’t matter
2. Lack of skills / confidence
3. Lack of awareness of own prejudices
4. Tendency to see the illness before the person
Research with patients:

• Feel devalued, dismissed, dehumanized by health professionals
  - Treated in demeaning manner
  - Feel punished, patronized, humiliated
  - Being ignored or made to wait excessively long times
  - Seen as a diagnosis not a real person
  - Threats of coercive treatment
  - Excessive paternalism

• Creates barriers to access, negatively affects relationships with healthcare providers, impacts quality of care, creates barriers to recovery

“I’m finding it very difficult to go back to see the same psychiatrist again. On the first visit he had a very condescending attitude”
Barney et al 2009.
Stigma’s Health Impacts

• Barriers and delays to help-seeking
  - 1 year for psychosis; 8+ years for anxiety and depression, longer for vulnerable populations

• Early termination of treatment
  - Patients dropping out; dissatisfaction with care
  - Rejection by health providers; being discharged or turned away
  - Negative consequences include increased risk of suicide

• Poorer mental health care
  - Delivered care often not best practice care;
  - Negative attitudes or beliefs, low provider motivation can impact patient-provider relationships

• Poorer physical care
  - Diagnostic and treatment overshadowing
Working towards a solution

Negative behaviours and attitudes

STIGMA

Patient care and outcomes

Improve quality of care by tackling the roots of stigma in healthcare
2. Evidence-based solutions

Improving quality through stigma reduction
Recap

complete after world café at lunch break

“Mental health systems ... either tolerate or produce unfairness, injustice and inequities.”
Jamie Livingston
If you want to improve the quality of mental healthcare you have to go after stigma

Now that we know why, let’s examine how...
Process model for designing and delivering successful anti-stigma programs for healthcare providers

**Set up for Success (planning & preparation):**
- Have passionate champion as lead, build partnerships & involve people with lived experience from the beginning
- Define program objectives, scope, goals
- Get leadership on board*
- Make maximizing participation a priority*
- Build a sustainability plan

**Target the roots of healthcare provider stigma:**
- Pessimism about recovery / feeling like what they do doesn’t matter
- Seeing the illness ahead of the person
- Lack of skills / confidence
- Lack of awareness of own prejudices

**Build Program using Key Ingredients:**
- Use enthusiastic facilitator to set ‘person-first’ tone & guide messaging
- Include personal testimony
- Include multiple forms/points of social contact
- Emphasize & demonstrate recovery
- Dispel myths
- Teach ‘what to say’ and ‘what to do’

**Work towards Culture Change:**
- Offer booster/refresher sessions*
- Get program embedded
- Integrate anti-stigma messaging throughout organization / department, etc.
- Identify / change system issues

**‘Make the Connection’ (program delivery strategies):**
- Reinforce key messages
- ‘Prime’ audience / put them at ease
- Adapt to context / use relevant examples
- Make it interactive & engaging
- Ensure speakers are trained & supported to tell their story & have equal status to facilitator / audience

*Less applicable for student programs
Stigma Reduction = Improved Quality

Opening Minds, through its research, has identified a number of evidence-based anti-stigma programs for healthcare providers available for sharing and implementation.
Effective Programming Models

• Workplace model
  • Focus is primarily ‘inward-facing’
  • Combat mental illness-related stigma in healthcare as a workplace
  • Improve employee mental health by increasing resiliency with coping skills and other tools and resources
  • Create more supportive culture for all

• Skills based model
  • Especially good fit for physicians and other front line providers
  • Focus is on improving skills, confidence and comfort in working with patients with a mental illness (e.g., communication skills, diagnostic skills, therapeutic skills). Social contact less prominent
  • Typically lower initial pre-post change, but sustained and even improved results over time

• Anti-stigma workshop model
  • Good fit for all practicing healthcare providers
  • Short in duration (1-2 hour)
  • Social contact + educational elements
  • Programs work best with booster/refresher sessions (positive effects diminish over time without boosters)
The Working Mind

Improving the quality of mental healthcare through workplace-based stigma reduction and enhancing employee’s mental health skills and knowledge

Andrew Szeto, PhD
Department of National Defence

R2MR

Program developed by DND as a way to increase the resiliency and mental health of those going to combat

• MHCM has its roots with Lt. Col. Stéphane Grenier and the US Marines
• Big 4 from US Navy
• Strong evidence base

Adapted to various police services and civilian workplace organizations across Canada

• R2MR for first responders
• The Working Mind
R2MR in Other Organizations
TWM in Other Organizations

OPENING MINDS
The Mental Health Continuum Model (MHCM) was developed by the Department of National Defence as part of the Road to Mental Readiness (R2MR) program. Opening Minds, the anti-stigma initiative of the Mental Health Commission of Canada, has adapted the MHCM and R2MR into The Working Mind, a mental health and anti-stigma program for the general workforce.

The MHCM and the coping strategies listed on this card will help you identify signs of good to poor mental health and offer you ways to get back to the healthy phase.

Suit 600
100 Sparks Street
Ottawa, Ontario K1P 5B7
Tel: 613.683.3755
Fax: 613.798.2989

mentalhealthcommission.ca

The Working Mind

Workplace Mental Health and Wellness

MAIN COPING STRATEGIES
- SMART Goal-Setting: set goals that are Specific, Measurable, Attainable, Relevant and Time-bound
- Mental Rehearsal/Visualization: mentally prepare for “what-ifs”
- Self-talk: Focus, Persist, Confident
- Calming/Deep Breathing

OTHER TECHNIQUES
- Join a support group
- Plan time for rest and fun
- Ask for help when necessary
- Set limits and boundaries
- Balance demands and priorities
- Identify unhealthy coping
- Apply problem-solving skills
- Keep lines of communication open
- Make self-care a priority
- Accept that you cannot do it all
- Get help sooner, not later
- Accept offers of help from friends

POTENTIAL SOURCES OF SUPPORT AND HELP
- Family, friends

MENTAL HEALTH CONTINUUM MODEL

HEALTHY
- Normal fluctuations in mood
- Normal sleep patterns
- Physically well, full of energy
- Consistent performance
- Socially active

REACTING
- Nervousness, irritability, sadness
- Trouble sleeping
- Tired, low energy, muscle tension, headaches
- Procrastination
- Decreased social activity

INJURED
- Anxiety, anger, pervasive sadness, hopelessness
- Restless or disturbed sleep
- Fatigue, aches and pains
- Decreased performance, presenteeism
- Social avoidance or withdrawal

ILL
- Excessive anxiety, easily enraged, depressed mood
- Unable to fall or stay asleep
- Exhaustion, physical illness
- Unable to perform duties, absenteeism
- Isolation, avoiding social events

Actions to Take at Each Phase of the Continuum

HEALTHY
- Focus on task at hand
- Break problems into manageable chunks
- Identify and nurture support systems
- Maintain healthy lifestyle

REACTING
- Recognize limits
- Get adequate rest, food, and exercise
- Engage in healthy coping strategies
- Identify and minimize stressors

INJURED
- Identify and understand own signs of distress
- Talk with someone
- Seek help

ILL
- Seek consultation as needed
- Follow health care provider recommendations
- Repair physical and mental health
TWM: Objectives

- Reduce the stigma of mental illness
- Promote mental health in the workplace
- Reconceptualize how one thinks and talks about mental health and mental illness
- Help one identify poor mental health in themselves and others
- Teach coping skills to manage stress and poor mental health, and increase resiliency
- Create a more supportive environment for all
TWM: Main Components

Education-based Prevention program

• Anti-stigma module and evidence-based content
  o Video-based contact, mythbusting, facts, etc.
• “Big 4” skills (SMART goal setting, mental rehearsal, positive self-talk, diaphragmatic breathing)
• AIR (Ad Hoc Incident Review)
• Mental Health Continuum Model
Video
Perceptions of Mental Health and Mental Illness

- **Healthy**
  - Mental health
  - Normal functioning

- **Ill**
  - Diagnosable mental illness
  - Severe and persistent functional impairment
Mental Health Continuum Model

1) Moves from good to poor mental health along a gradient

2) Emphasizes the possibility to back and forth along the continuum

3) Eliminates the need for stigmatizing labels and non-professionals diagnosing

4) Each phase outlines signs and indicators for self-assessment

- **HEALTHY**
  - Mental health
  - Normal functioning
  - Recovery from mental illness

- **REACTING**
  - Common and self-limiting distress

- **INJURED**
  - More severe functional impairment

- **ILL**
  - Diagnosable mental illness
  - Severe and persistent functional impairment
## Mental Health Continuum Model

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Reacting</th>
<th>Injured</th>
<th>Ill</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in Mood</strong></td>
<td><strong>Changes in Thinking and Attitude</strong></td>
<td><strong>Changes in Behaviour and Performance</strong></td>
<td><strong>Physical Changes</strong></td>
</tr>
<tr>
<td>Calm Normal mood fluctuations Taking things in stride</td>
<td>Irritable Impatient Nervous Sadness Overwhelmed</td>
<td>Anger Anxiety Pervasively sad/Hopeless</td>
<td>Angry outbursts Aggression Excessive anxiety Panic attacks Depression Suicidal thoughts</td>
</tr>
<tr>
<td>Good sense of humour Performing well Mental control</td>
<td>Displaced sarcasm Procrastination Forgetfulness</td>
<td>Negative attitude Poor performance or workaholic Poor concentration Bad decisions</td>
<td>Misconduct Can’t perform duties Poor control of behaviour Inability to concentrate</td>
</tr>
<tr>
<td>Normal sleep patterns Few sleep difficulties</td>
<td>Trouble sleeping Intrusive thoughts Bad dreams</td>
<td>Restless, disturbed sleep Overall restlessness Recurrent images Nightmares</td>
<td>Can’t fall asleep or stay asleep Sleeping too much or too little</td>
</tr>
<tr>
<td>Physically well Good energy level</td>
<td>Muscle tension Headaches Low energy</td>
<td>Increased aches and pains Increased fatigue</td>
<td>Physical illness Constant fatigue</td>
</tr>
</tbody>
</table>
Versions of TWM

Employee Workshop (half day)
Supervisor Workshop (full day)
Train-the-Trainer (5 days)
Air module

Master Trainers (3 days)
Preliminary Evaluation Results

Pre-workshop questionnaire → TWM → Post-workshop questionnaire → 3-Month Follow-up questionnaire

Quantitative Results

• Sig. ↓ in stigmatizing attitudes in managers, sig. ↓ in employees (pre to post) (majority of gains retained at 3 month follow-up)
• Significant ↑ in resiliency skills (i.e., perceptions of ability to be resilient) (pre to post)
• Significant ↑ in overall resiliency and mental health and wellbeing (pre to 3 month follow-up)
## Preliminary Evaluation Results

### Qualitative Results for TWM

<table>
<thead>
<tr>
<th>Reduced stigma; more aware &amp; understanding:</th>
<th>Practical skills; more equipped to address MH:</th>
<th>Workshops well received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I liked that the workshop dispelled myths &amp; common misconceptions”</td>
<td>“How to identify continuum in personal life”</td>
<td>• Excellent videos of people with lived experience</td>
</tr>
<tr>
<td>“An eye-opening experience”</td>
<td>“Relevant to real life work and personal situations”</td>
<td>• Interactive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Well presented, interesting, engaging, enjoyable</td>
</tr>
</tbody>
</table>
Other Adaptations in Development

R2MR for Paramedics
R2MR for Fire Departments
R2MR for 911 call centres
R2MR for Corrections

The Inquiring Mind (university students)
The Working Mind for Resident Doctors

*All adaptations contain the core components
What We Are Hearing...

“The Working Mind for Employees has created the biggest shift I've seen in attitudes and awareness in my 30 years of nursing”

Debbie Phillips, a Health Services Manager in Psychiatric Emergency Services with the Addictions and Mental Health Program at Capital Health, is describing the impact of The Working Mind
What We Are Hearing…

“…While I was monitoring the last session, I was contacted by a member while they were in the R2MR session...The member listened to Module 3 and realized some alarming behaviors they have been personally experiencing...I actually got a contact while in class!!...The member was pointed to the proper resources and this truly speaks to the value and power of the material...”

Curtis Hoople, Acting Staff Sargent and R2MR Project Manager, Edmonton Police Service
Adult Mental Health Practice Support Program

Improving the quality of mental healthcare by teaching practitioners ‘what to say’ and ‘what to do’

Scott Patten, MD, PhD
“There is a real lack of knowledge and training among healthcare providers for mental illness. In a lot of cases, they simply don’t know what to do or what to say .... If people feel confident that they can help then this will go a long way to reducing stigma”
Principal Components

Three ½ day workshops with 6-8 weeks action period

Main Tools Taught (3 EB Self Management tools, 1 Assessment tool):

1. Diagnostic Assessment Interview
3. The Antidepressant Skills Workbook
4. Bounceback (CMHA)

Use of Practice Support Coordinator

• provides guidance and support to incorporate tools, skills, and processes in practice workflow

Additional fee codes
Adult Mental Health PSP-Learning Sessions & Action Periods

www.gpscbc.ca/psp-learning/adult-mental-health/tools-resources
Background

• Designed by General Practice Services Committee (GPSC) : joint initiative of the BC Medical Association and the BC Ministry of Health

• Approach developed by Dr. Rivian Weinerman and her team to support primary care providers in the management of mental illness

• Launched in BC with positive evaluation results

  BC Evaluation (MacCarthy et al, 2013):
  - Physicians reported decreased reliance on prescribing antidepressant medications, patients better able to stay/return to work, and improved practice satisfaction and patient care
  - Reductions in stigma continued to improve over time

  CBIS Evaluation (one component of larger program):
  - Reductions in stigma continued to improve over time

• The NS Department of Health and Wellness and the Mental Health Commission of Canada launched a demonstration project in Nova Scotia
  • RCT
  • physician outcomes, patient outcomes, economic analysis
Hypothesis

Enhanced skills, increased comfort & confidence on the part of practitioners lead to diminished social distance and stigmatization.

• People’s beliefs and attitudes toward mental illness
  • set the stage for how they interact with, provide opportunities for, and help support a person with mental illness
  • frame how they experience and express their own emotional problems and psychological distress (disclose, seek care.)

http://www.cdc.gov/hrqol/Mental_Health_Reports/pdf/BRFSS
Research Study

Design: Two-parallel group, double-blind, cluster randomized controlled trial

- Family physicians/nurse practitioners
- MOAs
- Patients

Primary Objectives

- Program leads to lower levels of stigma and comfort among physicians/nurses and MOAs?
- Greater improvement in depressive symptom ratings in depressed patients vs TAU?

Exploratory objectives

- Anti-depressant prescribing
- Physician confidence, comfort
RESULTS
## Physician sample

<table>
<thead>
<tr>
<th>Participant Status</th>
<th>Intervention group</th>
<th>Control group</th>
<th>All participants</th>
</tr>
</thead>
<tbody>
<tr>
<td># recruited</td>
<td>56</td>
<td>55</td>
<td>111</td>
</tr>
<tr>
<td># withdrawn</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Total participants</td>
<td>51</td>
<td>50</td>
<td>101</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Completion status</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>pre-test only</td>
<td>11</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>post-test only</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Both surveys</td>
<td>39*</td>
<td>34</td>
<td>73</td>
</tr>
<tr>
<td>Response Rate</td>
<td>76.5%</td>
<td>68.0%</td>
<td>72.3%</td>
</tr>
</tbody>
</table>
Pre-planned primary OMS-HC analysis: Physicians
Comparison of change between the control and intervention groups non and adjusted for practice size

**Comparison of change between groups non-adjusted**

<table>
<thead>
<tr>
<th>OMS-HC</th>
<th>T-test*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total scale (15 item)</td>
<td>t(70)=-1.48, p=.15</td>
</tr>
<tr>
<td>Attitudes subscale</td>
<td>t(70)=-0.37, p=.71</td>
</tr>
<tr>
<td>Disclosure/help-seeking</td>
<td>t(70)=-0.32, p=.75</td>
</tr>
<tr>
<td>Social distance</td>
<td>t(70)=-1.77, p=.08</td>
</tr>
</tbody>
</table>

**Overall scale: Cohen’s d 0.34**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Total scale (15 item)</td>
<td>t(70)=-1.91, p=.06</td>
</tr>
<tr>
<td>Attitudes subscale</td>
<td>t(70)=-0.68, p=.50</td>
</tr>
<tr>
<td>Disclosure/help-seeking</td>
<td>t(70)=-0.36, p=.72</td>
</tr>
<tr>
<td>Social distance</td>
<td>t(70)=-2.17, p=.03</td>
</tr>
</tbody>
</table>
% of respondents reporting they felt 'very confident' in the overall quality of mental health care they provide to patients (n= )

- **Intervention group**
  - Pre-test: 4.0%
  - Post-test: 20.0%
  - Follow-up: 44.0%

- **Control group**
  - Pre-test: 11.0%
  - Post-test: 3.7%
  - Follow-up: 11.0%
What We Are Hearing…

The program has been great, allowing us to organise our thinking, gain skills, and put them into practice.

A well-executed initiative - the program facilitators/presenters/and supports were great and the first voice advocate was certainly a powerful ingredient, we were inspired by the turn-around effect that can occur.

We have found great success implementing the various tools/skills - people are different types of learners, and this program has enhanced our ability to help them come to the insight that they need to help themselves and to get better.
Patient Sample

Number of participants (n=129)

Allocated to intervention (n=72)

Lost to follow-up (unresponsive to telephone/email, n=7)
  • Completed 1 follow-up (n=14)
  • Completed 2 follow-ups (n=8)
  • Completed 3 follow-ups (n=10)
  • Completed 4 follow-ups (n=33)

Allocated to control (n=57)

Lost to follow-up (unresponsive to telephone/email, n=5; formally withdrew, n=1)
  • Completed 1 follow-up (n=6)
  • Completed 2 follow-ups (n=2)
  • Completed 3 follow-ups (n=14)
  • Completed 4 follow-ups (n=29)

Analysed (n=65)

(excluded from analysis, n=7, due to lost to follow up)

Analysed (n=51)

(excluded from analysis, n=6, due to lost to follow up/withdrawal)

• All participants with any follow-up data were included in the analysis
• n=65 for intervention; n=51 for control
Primary Outcome: Patients

PHQ-9 scores at each follow-up time point: Intervention and control groups
AD Prescribing

Months

Baseline 1 2 3 6

Intervention 26% 45% 55% 58% 60%

Control 49% 68% 80% 74% 76%

Baseline

1 2 3 6

Intervention 60%

Control 76%

### Table

| antidep | Coef.   | Std. Err. | z     | P>|z|    | [95% Conf. Interval] |
|---------|---------|-----------|-------|-------|----------------------|
| grp     | .2115986| .0831337  | 2.55  | 0.011 | .0466596 .3745376    |
| T1      | .0786106| .0419252  | 1.88  | 0.061 | -.0035612 1.1607824  |
| T2      | .0941145| .0419252  | 2.24  | 0.025 | .0119427 .1762863   |
| T3      | .0941145| .0419252  | 2.24  | 0.025 | .0119427 .1762863   |
| T6      | .1406261| .0419252  | 3.35  | 0.001 | .0584544 .2227979   |
| _cons   | .2477967| .0566945  | 4.37  | 0.000 | .1366775 .3589159   |
Anti-Stigma workshops

Short interventions that get healthcare providers thinking about stigma and what they can do differently to improve patient-provider interactions and care
Main Workshop Programs

Online Delivery (MDcme.ca)

• ‘Combating Stigma’ Online accredited CME program for physicians
  [https://www.mdcme.ca/courseinfo.asp?id=143](https://www.mdcme.ca/courseinfo.asp?id=143)

• ‘De-Stigmatizing Practices and Mental Illness’ program for nurses
  [https://www.mdcme.ca/courseinfo.asp?id=167](https://www.mdcme.ca/courseinfo.asp?id=167)

  • Mood Disorders Society of Canada and other partners/sponsors (MHCC, Bell Canada, North Bay Regional Health Centre, AstraZeneca Canada) collaborated with CMA, CPA and Memorial University to develop and launch programs. Original curriculum design by Dr. T Ungar and Dr. R. Weinerman

Face to Face Delivery -- ‘Understanding Stigma’ Program

• Developed by Ontario’s Central LHIN

• 2 and 1 hour versions available; booster modules also available

• Tested in numerous settings with various healthcare audiences with consistently positive results
Program Elements

Educational elements:
• awareness raising/personal reflection
• myth-busting
• skills training
• ‘action plans’

Programs also include multiple social contact, personal testimony components:
• Online programs: delivered via video
• Understanding Stigma: live plus video

Stronger sustained change when implemented with boosters
Leah’s Story
Modules:

- Preparation
- What is Stigma
- Recognizing and Addressing Stigma in Practice
- Strategies for Stigma Reduction
- Social Determinants of Health
- A Way Forward: a Personal Action Plan
Exercise from Module 3
Recognizing and Addressing Stigma in Practice

Consider a patient with a diagnosis of schizophrenia. The following statements represent common stigmatizing myths surrounding the disease. Consider these myths for a moment. Have you heard them before? Once you’ve considered the statements below, experience the educational approach in action by clicking the “Get the Facts” link.

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It’s a moral weakness”</td>
<td>Get the Facts</td>
</tr>
<tr>
<td>“His diagnosis is psychosis”</td>
<td>Get the Facts</td>
</tr>
<tr>
<td>“There’s no hope”</td>
<td>Get the Facts</td>
</tr>
<tr>
<td>“He’s highly dangerous and unpredictable”</td>
<td>Get the Facts</td>
</tr>
</tbody>
</table>

Patient engagement and behavioral strategies cannot improve adherence and therefore outcomes in psychosis since it is all biological.

Get the Facts
<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It’s a moral weakness”</td>
<td>Schizophrenia has strong neurobiologic disorder features².</td>
</tr>
<tr>
<td>“His diagnosis is psychosis”</td>
<td>These are symptoms and may be due to a variety of causes both mental health and physical/medical. Be careful with diagnostic overshadowing and skipping over physical exam and appropriate investigations.</td>
</tr>
<tr>
<td>“There’s no hope”</td>
<td>Symptoms can be controlled. The recovery model denotes the processes by which people with lived experience with mental illness participate, work with lived experience, and live fully within their communities. This can occur in the face of ongoing symptoms of illness, which despite them, the individual can learn to cope or adapt to and thrive. (CPA 2011)</td>
</tr>
<tr>
<td>“He’s highly dangerous and unpredictable”</td>
<td>“Violence is not a product of mental illness. Nor is violence generally the action of ordinary, stable individuals who suddenly “break” and commit crimes of passion. Violent crimes are committed by violent people, those who do not have the skills to manage their anger. Most homicides are committed by people with a history of violence. Murderers are rarely ordinary, law-abiding citizens, and they are also rarely mentally ill. Violence is a product of compromised anger management skills”³. People and media dramatically overestimate the likelihood of violence or unpredictability⁴..... Mental Illness alone does not appear to predict violent behaviour, the combination of substance use in association with mental illness poses the greater risk.</td>
</tr>
<tr>
<td>Patient engagement and behavioral strategies cannot improve adherence and therefore outcomes in psychosis since it is all biological</td>
<td>Patient engagement and behavioural strategies such as CBT are first line treatments that can improve adherence⁶.</td>
</tr>
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Activity: Draft Your Own Personal Action Plan

Purpose of this Activity

- This activity is designed to help you develop a personal action plan focused on self-development and self-awareness leading to de-stigmatizing practices (personal change), while contributing towards an organizational shift, i.e., a change in your workplace.

Activities

- **Self-care**: Reflect and draft a personal action plan for ways that you can ensure emotional and physical health and safety in your workplace. [Download template]

- **Personal change**: Consider what changes you can make to prevent or address stigma in your healthcare relationships, interactions, and routine practices

- **Organizational change**: Consider what changes you can make to contribute towards organizational change towards preventing and/or addressing stigma
‘Understanding Stigma’

- **Famous People PowerPoint** – a looping slideshow featuring famous people who have a mental illness. The PowerPoint plays continuously as participants enter the room and complete the pre-test. It is used to introduce the concept of stigma.

- **Earache Exercise** – a warm-up activity that compares the symptoms and experience of having an earache with that of having depression. It is used to demonstrate the stigma of mental illness by highlighting how the circle of supports shrinks, and the time elapsing before seeking treatment tends to be longer, with mental illness.

- **Stigma Definition** – The term stigma is defined and a short discussion about prejudice and discrimination is facilitated with participants.

- **Myths vs. Facts** – Various statements are shown on the screen and participants are asked to guess whether each one is a myth or a fact. A short explanation is given for each. Many of the statements build on one another and also challenge the participants to think critically about how stigma is embedded in society.

- **Anti-Stigma DVD** – A short (approximately 15 minute) locally made film is shown to allow participants to see the issue of stigma from many different perspectives. The video features perspectives and experiences from a person with lived experience of mental illness, a family member of a person with mental illness, and a healthcare provider.

- **Group Discussion** – Participants are asked to break into small groups of 3-5 people and discuss a set of questions about mental illness stigma as it pertains to their own work environments. Once finished, each group reports back to the larger group and discussion follows.

- **First Voice Presentation** – A personal testimony delivered by a guest speaker who speaks to the group about his/her lived experience with mental illness and/or addiction starting from the first signs and symptoms, to how they live well in the community today. Speakers highlight examples of stigma in healthcare environments as well as positive experiences that led to their recovery. The personal testimony is followed by a question and answer/discussion period.

- **Anti-Stigma Commitment** - Participants are asked to write down an individual commitment to change their practice in a specific way that will contribute to eliminating stigma in their practice and at IWK.

- **Take-Home Resources and Post-test** – At the end of the workshop, participants complete their post-test survey. Participants are also given a brochure on stigma to reinforce the key program messages. A take-home resource giving practical suggestions for language use is also handed out to participants.
‘Understanding Stigma’
‘Understanding Stigma’
Activity from ‘Understanding Stigma’ Program at IWK

Group Activity:

Identify an element of stigma in your workplace

What is its effect on patients/families/staff?

How could we do things differently? (List 3-5 things)
Evaluation Results: Combating Stigma Online CME

One of the best performing programs evaluated by OM to date implement with booster for best results

"It gave me a better understanding of mental health and what people go through. I loved the initial video, really makes you understand."

"It was easy to learn, various teaching aids that kept my interest, relevant to practice in a practical approach... It gave me more confidence with this type of patient."
Evaluation Results: Understanding Stigma

[The program] made such an impact...Hearing someone's personal experiences with mental health and what helped, what didn't, and be reminded how successful someone can be when provided with supports.

It certainly made me think of how we treat people differently .... the ‘myths and facts’ stats were real eye openers.
3. Developing an Action Plan

How will you commit to improving quality through stigma reduction in your practice, department or organization?

Liz Wigfull, MA
Steps to Create and Implement an Action Plan*

• Clearly define your objectives: they must be measurable and achievable.
• Brainstorm to establish all possible courses of action that must be taken in order to achieve the desired objectives.
• Develop an action plan accordingly using a template.
• Review the plan thoroughly to check that it is complete.
• Begin to implement your action plan.
• Track the progress achieved and tick off completed tasks.
• Review and amend the action plan on an on-going basis.

* Taken from the ‘De-stigmatizing Practices and Mental Illness’ online program
Build your Action Plan

1. Identify the change(s) you want to see / Objectives
   - Commit to culture change by identifying both short and longer term objectives
   - Use learning needs as a guide

2. Determine how you will get there
   - Replicate/adapt one of OM’s programs?
   - Develop customized approach informed by key ingredients?
   - Personal changes in healthcare relationships, interactions, routine practice/interactions?
   - Anything else?

3. Identify potential challenges and solutions

4. How will you know if you achieved your objective(s)?
   - Define how you will measure success
   - Set target dates

Unless commitment is made, there are only promises and hopes, but not plans

- Peter Drucker
Thank you

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