ENDING STIGMA STARTS WITH YOU

PREVENTING MENTAL ILLNESS & SUBSTANCE USE RELATED STIGMA & PROMOTING RECOVERY ORIENTED PRACTICES IN PRIMARY HEALTH CARE

FINAL REPORT

camh Transformative Global Health

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

Central Toronto Community Health Centres

Unison Health & Community Services

South Riverdale Community Health Centre

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EXECUTIVE SUMMARY

Community Health Centres (CHCs) serve as the first healthcare option for many marginalized and/or immigrant populations within Ontario and are well positioned to address stigma effectively. Due to a dearth of anti-stigma intervention research in Canada, the OTGH and three Toronto-based CHCs agreed to develop an action research study that would lead to the design, implementation and evaluation of a community based anti-stigma initiative. Opening Minds – an initiative of the Mental Health Commission of Canada - provided essential support for this action research project.

The research took place in two phases. Phase I involved extensive information gathering, identification and analysis of the potential components of an anti-stigma and pro-recovery intervention. Specific activities undertaken included a literature review, an environmental scan of each CHC, a mixed method data collection process to gather information on stigma and discrimination among providers and a knowledge synthesis symposium. Phase II focused on the implementation of the anti-stigma intervention, comprised of five evidence-based components: (1) Developing Teams of Leaders, (2) Innovative Contact-based Education (3) Raising Awareness, (4) Recovery-based Arts, (5) Analysis of Internal Policies and Procedures with a focus on mental illness and substance use.

The findings are positive. Results include a 5.9% improvement in stigmatizing attitudes towards people with mental illness and substance use disorders. The intervention fostered a 9.4% improvement in attitudes concerning the potential for recovery and an 8.4% reduction in feelings of social distance toward people affected by substance use issues. Based on these findings, the research has since been scaled up for cluster randomized control trials within two different contexts in Toronto, Ontario and Lima, Peru.

INTRODUCTION

One of the major goals of the Mental Health Commission of Canada is to reduce mental illness related stigma and discrimination. Opening Minds is the Commission's key initiative for fighting stigma and eliminating discrimination, and facilitating improvements in the daily lives of people with mental illness as well as their families. Opening Minds focuses on four main target groups: youth, workforce, media, and healthcare providers. Amongst healthcare providers, the community-based primary health care setting is particularly important because it provides the first point of contact for members of many vulnerable and/or marginalized groups.

These unique front-line opportunities for preventing stigma and promoting recovery are often missed due to lack of preparation, training and/or priority. Indeed, healthcare providers may not consider stigma reduction a high priority due to stigmatizing attitudes that are shared with members of the general public (Schulze, 2007; Corrigan, 2004). Individuals with mental health problems have reported stigmatizing experiences at all levels of the Canadian health care system (CMHA, 2006). Many persons seeking help for mental illness and substance use problems have described experiences of disrespect and/or discrimination by diverse frontline healthcare providers (Mental Health Commission of Canada, 2012). Such experiences have historic foundations.

The term stigma originates from the historic concept of stigmata. It was used by the Ancient Greeks to refer to a physical marking on an individual that exposed a moral flaw in their character (Goffman, 1963). Stigma has also been defined as a social process characterized by exclusion and rejection. This process includes "blam(ing) or devaluation that results from an adverse social judgment about a person or group based on an enduring feature of identity attributable to a health problem" (Weiss & Ramakrishna, 2001, p. 4). The anti-stigma initiative extends Weiss and Ramakrishna's definition of stigma to include behavioural components that result in unequal or unjustifiable treatment.

Reducing stigma and discrimination by primary healthcare providers (hereafter referred to simply as "providers") toward people with mental illness and substance use is the explicit research goal shared by CAMH's Office of Transformative Global Health (OTGH) and the three Toronto-based community health centres (CHCs) involved in this initiative. The three CHCs are South Riverdale Community Health Centre (SRCHC), Central Toronto Community Health Centre (CTCHC), and Unison Health and Community Services (UnisonHCS). In 2010, these institutional partners initiated efforts to develop and implement an anti-stigma/anti-discrimination intervention suitable for frontline healthcare settings.

The collaboration was built on participatory action research principles. Partners fortified efforts to engage all levels of staff and to apply an organizational and systems approach. The latter approach was designed to improve communication between decision-makers and frontline health workers. Such improvements effectively supported coordination of care in a manner that would serve to prevent stigma and discrimination and promote recovery. The initiative should also serve as the foundation for future research into alternative anti-stigma interventions and processes that are relevant for healthcare settings.

This final report marks the successful completion of the five year initiative. It provides an overview of the development and implementation of the project as well as key findings from each component of the intervention. This report is divided into six main sections:

1.0 RATIONALE

Canadians have been engaged in stigma reduction for more than five decades with efforts to raise public awareness about mental illness playing a pivotal role. One of the country's first anti-stigma initiatives took place in Saskatchewan. It involved a wife and husband team conducting a community wide, multi-pronged campaign consisting of public education messages disseminated through group discussions and media outlets (Stuart, 2005). Similar education programs have since been carried out in other provinces. Despite these efforts, Canada has yet to fully engage in developing evidence-based programs that identify key critical factors that perpetuate and sustain mental illness related stigmatizing perceptions and behaviour toward racialized and immigrant populations.

Through capacity building work with PHC systems around the world, the OTGH has identified stigma as a significant help seeking barrier for people with mental illness and substance dependency in many low and middle income countries (Khenti et al, 2011). Stigma has also been found to be a significant challenge for persons of diverse cultural backgrounds (Thirthalli et al, 2012, Leiderman et al, 2011, Peluso et al, 2008). In Ontario for instance, many persons of African, Caribbean and/or Latin American background have indicated reluctance to seek and use mental health services on account of stigma (McKenzie et al, 2011). There is also evidence that the combination of mental illness related stigma and membership in an ethnic minority group can impede treatment and well-being, creating preventable and treatable mortalities and morbidities (Yang et al, 2014).

Numerous studies indicate that ethnic minorities are more inclined to turn to PHC settings for their various health care needs, including mental health problems (Arboleda-Florez & Saraceno, 2001; Khenti et al, 2011; Yang et al, 2014). The literature also shows that PHC is often the first point of entry for individuals, families and communities with health concerns (WHO, 2013). PHC facilities are thus well positioned to facilitate the early detection of mental disorders, provide affordable treatments and follow-up care, and to reduce stigma and discrimination through health promotion and prevention programs.

In Canada, the development of CHCs has enhanced access to PHC for immigrant and marginalized populations by serving as the first option for PHC for many ethnic populations. They are therefore well positioned to facilitate and educate the population about stigma and mental illness. As a result of the identified needs, the OTGH, along with its CHC partners, have thus designed, implemented and tested a community based anti-stigma initiative, with the aim of strengthening PHC.

2.0 PURPOSE AND OBJECTIVES

Purpose

The purpose of this initiative was to design and develop a tailored capacity-building intervention that addressed root causes and mitigated impact of mental health and substance use stigma and discrimination among primary health care providers; and to do so in full partnership with PHC centres.

Overall and Specific Objectives

The overall objective was to develop and implement an anti-stigma/anti-discrimination and pro-recovery intervention targeting providers who serve people with mental illness and substance use problems at CHCs in Ontario. Within this overall aim, are the following specific objectives:

(a) To examine and clarify the phenomenon of stigma and discrimination toward individuals with mental illness and substance use disorders among healthcare providers; with a particular focus on CHC providers serving immigrant populations from Latin America and the Caribbean, Sub-Saharan Africa and South Asia.

(b) To use an action research process for identifying key elements for consideration when designing an effective intervention to reduce stigma and discrimination and increase pro-recovery approaches among PHC providers in Ontario.

(c) To use a consensus process to select key elements, plan and implement a comprehensive anti-stigma/anti-discrimination, pro-recovery intervention for mental illness and substance use programs for CHCs in Ontario.

(d) To develop a knowledge exchange process to share the results of this anti-stigma initiative with other CHCs and community-based agencies in Canada.

3.0 PHASE I: Development of the Intervention

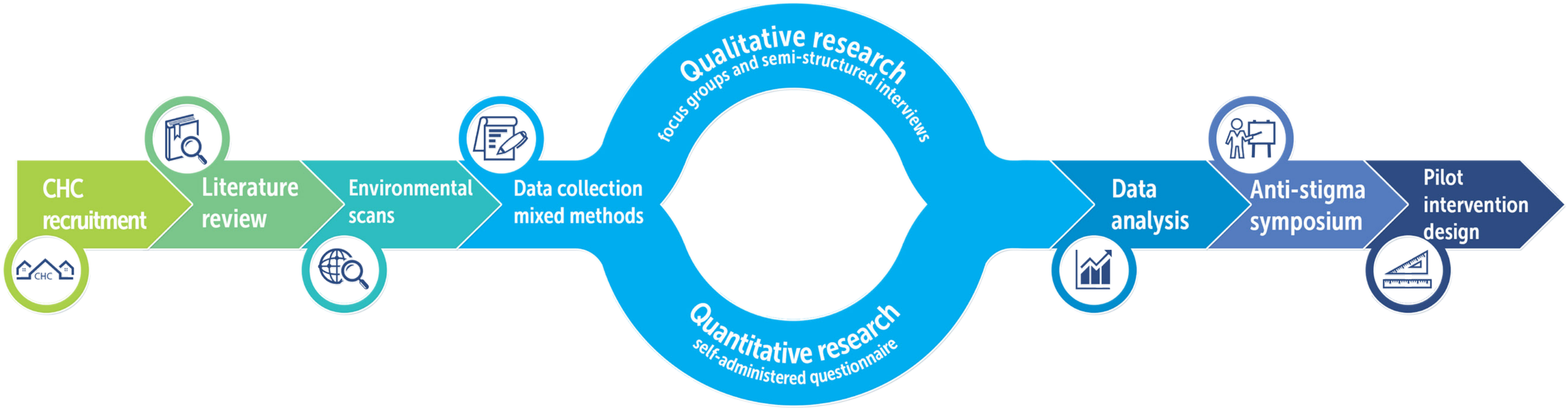


Figure 1: Overall Process of the Development of the Intervention.

Phase I of the anti-stigma initiative took place from April 2010 to March 2012 with funding from the CAMH 2010–2011 Development and Dissemination Grant in Primary Health Care. This phase, entitled “Mental Health and Substance Use Anti Stigma / Discrimination Intervention for Primary Health Care in Ontario” entailed developing an evidence-based intervention to address stigma in PHC settings, with a focus on newcomer populations.

Phase I commenced with a literature review regarding the topic of interest and environmental scans of each CHC in order to clarify their context and the populations served. Following the environmental scans, a mixed-methods action research approach was used to gather information from PHC providers, decision-makers, and service users about the health system structure, the organizational setting, and the magnitude of mental illness and substance use related to stigma, discrimination and associated cultural constructs.

3.1 Literature Review

Below are findings from the literature review which gave impetus to the development of a broad-based, multi-component intervention.

Background

Stigmatization toward persons with mental illness and substance use problems was found to be a historic phenomenon with deep roots in Canadian society (Frank et al, 2005). It is widespread across Canadian society and affects individuals of all ages, cultures, and socio-economic backgrounds (Stuart et al., 2014; Stuart et al, 2012; WHO, 2013). Stigmatization involves attitudes and behaviour that reflect and/or promote "attribute(s) that (are) deeply discrediting" and serve to reduce the bearer "from a whole and usual person to a tainted, discounted one" (Angermeyer et al, 2003). Link and Phelan observe that "stigma exists when elements of labelling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold" (Link and Phelan, 2001, p.382).

Stigmatization Processes

The process of stigmatization is multidimensional and encompasses social-cognitive processes that include stereotypes, prejudice, and discrimination. Stigmatizing persons with mental illness and substance use disorders involves multiple determinants, including ignorance (Augoustinos and Ahrens, 1994) and emotional reactions such as fear, as well as perceived danger (Thornicroft et al, 2007). Certain negative attributions are especially problematic for persons with mental illness and substance use disorders. For instance, the idea that they are dangerous and should be avoided (Corrigan, 2002);they are responsible for their disabilities which result from weak character; that they require authority figures to make decisions for them due to incompetence; and that they require a parental figure to care for them (Corrigan et al, 2003; Brockington et al, 1993).

Discrimination, the behavioural component of stigma, refers to intentional or unintentional actions that adversely affect persons with mental illness and substance use disorders (Taylor, 1981). Persons with mental illness and substance use problems are, or can be, particularly vulnerable to abuse and violations of human rights. Discrimination against these individuals can take many forms; it may appear at an interpersonal level, reflecting a desire for social distance and exclusion and/or may also occur at a structural level when persons with mental illness and substance use disorders are overtly or covertly excluded from public life through a variety of social and institutional means (Michaels et al., 2012; Sayce, 2000).

Stigma can be obvious and direct, such as a negative remark, or subtle, such as an assumption that an individual is violent or dangerous (WHO, 2013). It can result in feelings of anger, frustration, shame, and low self-esteem, as well as discrimination at work, school, and in other areas of life. For someone with mental illness and substance use disorders, the consequences of stigma, especially low self-esteem, can inhibit recovery and promote long-term disability, resulting in devastating effects (Corrigan & Rao, 2012; Stuart, 2005). The effects of stigmatization are particularly troubling because individuals and their families living with mental illness and substance use problems often report that the stigma associated with the diagnosis is more difficult to bear than the actual illness or condition (Phelan et al, 2000). The process of stigmatization and the effects of stigma are complex and also depend on the cultural context (Yang et al., 2013).

A Public Health Problem

Stigma toward persons with mental illness and substance use disorders is recognized globally as a public health issue. This public health issue involves: (1) continuing problems in accessing resources and opportunities, such as employment and housing; (2) social isolation due to exclusion from activities; and (3) low levels of service utilization, including limited access to appropriate health services (Pescosolido et al, 2008). Stigmatization can also increase isolation, which may aggravate mental illness and substance use disorders and social inequalities (van Boetek et al, 2013); for instance, by acting as an obstacle to seeking help or even acknowledging that one is affected with mental illness and substance use disorder (Pescosolido et al, 2008; Room, 2005). Stigma associated with mental illness and substance use disorders also plays a major role in the under-detection of such problems worldwide (Room, 2005; Glazier et al, 2012; Link and Phelan, 2006; Mascayano et al., 2015). It can increase stress, affect life chances, and add to the burden of disease or disability (Cameron et al, 2010; Ivbijaro, 2012).

Health professionals are no less susceptible to stigmatizing beliefs and behaviour than members of the general public (Corrigan et al., 2014a; Fraser, 1993; CMHA, 2013), and evidence of mental illness/substance use stigmatization has been found in diverse healthcare settings (Knaak et al., 2014; Pellegrini, 2014; Shulze, 2007; Corrigan, 2004; Davidson, 2005). Clients of mental health services have reported stigmatizing treatment from both general practitioners and psychiatrists (Augoustinos and Ahrens, 1994). One study found that stigmatization could result in clients being threatened with coercive treatment, being provided with insufficient information, being regarded as lacking the capacity for responsible action, or being patronized and/or humiliated (Stuart et al, 2012).

The Primary Health Care Setting

PHC settings are well-situated to facilitate the early detection of mental illness and substance use disorders and address stigma (Sapag et al., 2012). The continuum of treatment and follow-up services available through PHC is well suited to the holistic treatment needs of clients suffering from mental illness and substance use disorders (Crowley et al., 2015; Glazier et al, 2012). Within primary health settings, community health centres (CHCs) are particularly appropriate for addressing mental illness and substance use disorders and associated stigma.

CHCs offer a diverse range of comprehensive clinical services and health promotion programs in Ontario. The services are specifically designed to “eliminate barriers to accessing healthcare such as poverty, geographic isolation, ethno- and cultural-centrism, racism, sexism, heterosexism, transphobia, language discrimination, ageism, ableism and other forms of social exclusion including issues such as complex mental health (OCHC, 2013, p.1)”. Health promotion and outreach programs at CHCs also address the essential needs - such as housing, harm reduction and food security - that may deter marginalized groups from help-seeking, including those persons with mental illness and substance use disorders (Glazier et al, 2012). CHCs are also well positioned to address stigma because of the ease with which they can adopt recovery-oriented practices, including distinctive inter-personal skills, working collaboratively, and sharing knowledge (Cleary and Dowling, 2009). Such principles and practices are essential for helping individuals with mental health issues find meaning and purpose in life in spite of the devastating setbacks associated with mental illness and/or substance use disorders (Unzicker, 1989). Key ingredients for effective stigma reduction interventions in health care settings have already been identified (Knaak et al., 2014) and there is a critical need for the development of specific strategies in primary health care (Corrigan et al., 2014b).

Stigma Reduction Strategies

Growing evidence attests to the need for stigma reduction approaches to be comprehensive, multifaceted, and able to address various levels of stigma within organizational settings (Goffman, 1963). A historic focus of intervention strategies on individual-level attitudes often failed to account for societal/community level factors and issues related to human rights. Effectiveness was stymied because countering stigma required focusing on deeply held practitioner attitudes and beliefs as well as the structural supports – the policies and practices of the organization - which together served as sources of discrimination (Arboleda-Florez & Sartorius, 2008). The gap has recently been addressed with a research shift toward comprehensiveness when targeting stigmatizing behaviour (Augoustinao and Ahrens, 1994; Corker et al, 2013; Henderson and Thornicroft, 2013). Researchers have proposed capacity building at both professional and organizational levels (Tipper et al, 2006; Knaak et al., 2014).

Growing evidence pointed to the huge potential of capacity building involving practitioners. Such efforts could make a significant difference in the care that clients with mental illness and substance use disorders receive. Many were particularly successful when they involved contact-based education. Contact-based learning involved persons with lived experiences of substance use and/or mental illness sharing their stories and engaging program participants in frank discussion about stigmatization. They described the stigma they encountered, how it continues to affect them as well as alternative scenarios that could have occurred (MHCC, 2011).

Art-based activities were also sources of significant learning. Spandler et al. (2007) suggest that participation in the arts may be an important component of recovery among individuals with mental illness and substance use disorders, especially those feeling hopeless about the future. Art, and the creative process, has been proven to foster feelings of hope, a sense of purpose, coping abilities, and psychological well-being; thereby having a therapeutic effect on people with mental illness and substance use disorders (Heenan, 2006). Utilizing art along with contact based education could therefore prove immensely effective in stigma reduction and recovery promotion.

At the organizational level, the provision of health services for persons with mental illness and substance use disorders was also determined to be an important first step. Specific interventions implemented across entire organizations could ensure the supportive environments needed to encourage anti-stigmatizing practices (Szeto, A.C. & Dobson, 2010). A Swiss study found that fighting burnout to improve practitioners' attitudes toward recovery and contact with service users was key to successful recovery-oriented anti-stigma interventions (Standing Senate Committee, 2006). Other successful efforts to promote stigma-free environments, policies and practices included creating safe spaces for active discussion about stigma and developing creative ways to invite healthcare practitioners to reflect on problems. Creative approaches also included providers and clients sharing insights, jointly addressing issues in individual's recovery as well as defining protocols to identify and address existing or potential stigmatizing situations (Jacobson & Greenley, 2001).

3.2 Environmental Scans

Environmental scans were conducted for each of the three CHCs involved in the initiative. The primary objective of the scans was to inform each organization, up to the board level, about organizational development opportunities related to mental illness and substance use stigma. Although many similar needs, concerns and opportunities emerged among the three CHCs, some aspects varied depending on specific organizational and clientele characteristics.

At the time when the environmental scans were conducted, UnisonHCS and CTCHC had both undergone mergers with other organisations. Both CHCs were also focusing on solidifying and consolidating the merger of their respective health care services, and catchment areas, and wanted to optimize all available resources to make the biggest impact on the community. Managers at both CHCs reported that the anti-stigma initiative fit well with their current amalgamation processes. As a result, UnisonHCS and CTCHC were well positioned to develop and implement strong mental health and substance use stigma-reduction strategies at the organizational level. More generally, staff members at all CHCs expressed optimism that the anti-stigma initiative would assist with developing the best possible responses and strategies to address stigma related issues.

A common challenge across the three CHCs was the multiple vulnerabilities of individuals and communities using their mental health and substance use services. The catchment areas for UnisonHCS and SRCHC had high concentrations of new immigrants, visible minority groups, and people living in poverty, compared to the City of Toronto average. The clientele of CTCHC also included a larger proportion of street involved youth. The additive effect of these stigmatized social positions, with the stigma related to mental illness and substance use disorders, implied greater health burdens for their population.

3.3 Qualitative Research

An action research approach using mixed methods was used to collect information from providers and decision-makers about the magnitude of mental illness and substance use related stigma and discrimination as well as its cultural constructs, the health system structure and organizational setting.

As part of the qualitative research component, focus groups and one-on-one semi-structured interviews were conducted to explore how providers perceive the problem and to identify ideas for developing the anti-stigma/anti-discrimination capacity building intervention. In total, thirteen semi-structured interviews were conducted with individual staff members across the CHCs (except for one interview which involved two interviewees, as per request), focusing on their knowledge of the organization. Three focus groups, one at each CHC, were carried out to gain the perspectives of CHC providers who work directly with clients; approximately ten people attended each group.

Interview and focus group participants were recruited from executive/management teams, community health programs and clinical teams based on the structure, staffing and programming at each site. The interviews and focus groups were held from May to June, 2011. Notably, findings from this qualitative research component generally supported observations made during the environmental scans.

3.3.1. Understandings of the Problem: Qualitative Research Results

a) Contextual Complexities: Social Determinants of Health

Staff members at all three CHCs reported serving client populations that experienced multiple stigmas. One prominent group were clients with concurrent disorders; having both mental illness and substance use disorders. In dealing with persons facing compounded challenges, providers reported a common tendency to focus on immediate issues that caused clients the most distress. Staff also emphasized the significance of the interaction between the experience of stigmas and the social determinants of health (SDH). These SDH include poverty, lack of food security, homelessness or being under-housed, violence, isolation, and intergenerational trauma. The determinants were perceived as playing critical roles in the evolution of client's mental illness and/or substance use disorders. Language proficiency was also identified as an issue. Many clients experienced marginalization due to their lack of proficiency in at least one of Canada's two official languages. In addition, further marginalization was perceived due to attitudes rooted in racism, ethnocentrism, gender bias (especially against transgendered people), and disdain for sex workers.

b) Mental Illness vs. Substance Use

A common perception among staff was that stigmas associated with mental illness and substance use disorders shared many similarities. They also felt that clients with both mental illness and substance use disorders faced more difficulties. A point made often was that stigma recipients in both instances tended to be blamed for their behaviors. Some interviewees and focus group participants did differentiate between the two groups however; highlighting society's perceptions of greater responsibility or intention on the part of people who use substances. Some reiterated the wider societal perception that people who use substances generally chose an unhealthy, dangerous lifestyle as part of an irresponsible but nonetheless rational decision-making process.

c) Cultural Beliefs and Assumptions

Participants also referred to the contextual complexities of stigma, specifically issues involving cultural beliefs. For example, problems had arisen when a client's beliefs or experiences did not coincide with North American medical understandings. As one participant stated, there can be "a lot of other cultural pieces that go with [the health issue] in terms of their belief as to what's impacting them." Healthcare providers may also make incorrect assumptions about a client's culture or place of origin. Participants described ambiguities and difficulties in suggesting outcomes for clients that are marginalized within the context of 'Canadian, White, middle-class culture'. Other participants observed that the healthcare providers' own cultural understandings could cause stigma, depending on their training and experience. Participants also expressed concerns that the language used by health care providers could be stigmatizing. An example that was given involved descriptions of substance users as being 'clean' from drug use. This implied that persons using illicit drugs were 'dirty.' Overall, participants grappled with multiple ambiguities as they attempted to balance medical knowledge and practice with the experiences of their marginalized clients.

d) Overall Structure of Medical System

Some participant also expressed concern that the medical system could be alienating for marginalized populations due to its operational assumption that clients are typically middle class consumers. For instance, clients are expected to have a home with a telephone where they can be contacted; they were also expected to have stable schedules that allowed appointments to be made and kept. When individuals presented without stable addresses, and/or schedules, the discrepancy with dominant expectations could lead to further stigmatizing. In addition, clients may hold beliefs about medical practices or structures based on experiences in their home countries, which may not coincide with those of providers. For example, a few participants highlighted the complexity of involving clients in the decision-making processes regarding their health. Confusion was often the result because of the contrary experiences of medical practice in home countries; which often involved physicians exercise authority and dictating the course of action.

e) Challenges and Crises, Provider Frustration and Burnout

Participants commented that when clients are extremely marginalized, or difficult to work with, the healthcare approach became much more reactive than preventive. Such necessity often led healthcare providers to deep frustration because of a desire for faster curative outcomes. A common result was predictable increases in stigmatizing interactions simply due to repeated frustrations and burn out. Continually facing challenging behavior, especially with insufficient support or training, left many health providers convinced that huge pitfalls were intrinsic to primary care work.

3.3.2. Ideas for an Intervention

a) Training

Overall, participants were quite enthusiastic about receiving training to help clients with mental illness and substance use disorders. The expressed preference was for training that was targeted or adapted for specific roles in the organization. They wanted training made available to all CHC members; including board members, managers, frontline staff and clinicians. There was some disagreement about training focused on dealing with particular groups of clients or sub-populations (i.e., people affected by mental illness and substance use disorders). Some participants felt such training would provide excellent information to providers, while others felt it might further stigmatize these groups. Many participants stressed the importance of integrating training into daily schedules. One time only training with no follow-up seemed less appealing.

b) Community Education

Participants were also enthusiastic about developing community-wide, anti-stigma education campaigns. For one, it would build on existing linkages the CHCs had fostered in their communities. Secondly, it could involve working with “change agents” such as business leaders, clergy, and journalists. There was discussion about differences that might emerge in running a campaign for substance use as well as mental illness. Concern was expressed that celebrities could well feature in media advertisements to lessen the stigma of certain mental health conditions; however, they may not want to participate in efforts to de-stigmatize illicit substance use because of the crime related stigma. Several participants commented that words such as “stigma” and “mental health” might dissuade people in the community from participating in community education. Special care should be taken to choose culturally sensitive language for the various conditions.

3.4 Quantitative Research

As part of the quantitative research component, a self-administered questionnaire was used to assess stigma and discrimination among healthcare professionals already working with persons with mental health and/or substance use problems. The questionnaire focused on three main components: socio-demographic and other relevant variables, stigma and discrimination, and suggestions for interventions.

A total of 137 healthcare workers from units across the three CHCs agreed to participate in the quantitative research component. This component elicited a 47.9% response rate among participants ages 18 to 69 years from a wide range of professions and roles. Their scores for stigma toward individuals with mental health and substance use problems were similar to those among other healthcare providers in Canada and abroad.

Their overall mean scores on the Mental Illness: Clinicans’ Attitudes (MICA) scale of 36.81 (SD = 8.62) is illustrative. This scale measures clinicians’ attitudes towards persons with mental illness and offers a range of scores from 16 to 96; with higher scores indicates a more negative or stigmatizing attitudes. The score of 36.81 falls well within the ranges of reports from other health care studies (Kassam et al, 2010). Stigma scores were also collected using the Opening Minds scale for healthcare providers. This scale was developed by the MHCC with scores ranging from 20 to 100; higher scores indicating a higher level of stigma (Kassamet al, 2012). The overall mean of participant stigma scores here were 46.43 (SD=8.50) which also fell within the average for healthcare providers (41.2 to 49.8).

Participants’ scores for perceived recovery and empowerment tended to be higher for substance use issues than for mental illness. Such scores suggested that healthcare providers perceive one’s recovery from addiction as being more likely than recovery from mental illness. It also implied that they also perceived clients with addiction issues as being more empowered than those with mental illness. Interestingly, participants also placed more social distance between themselves and clients with heroin dependence. By contrast, less social distance was placed with clients having schizophrenia. Providers were also more willing to see clients with schizophrenia than those with heroin dependence. Next in rank for such willingness were persons with cocaine dependence; finally, those with personality disorders were the ones least preferred for consults. Finally, respondents indicated that a tailored intervention for healthcare providers would be most beneficial for addressing stigma. They particularly welcomed anti-oppression training, harm reduction strategies, and psycho-education.

3.5 Knowledge Synthesis and Translation Symposium

On July 14–15, 2011, CAMH's Office of Transformative Global Health organized an interactive two-day symposium to design a comprehensive intervention aimed at reducing stigma and promoting recovery in primary health care. UnisonHCS, SRCHC, and CTCHC liaisons were in attendance, along with an expert advisory panel, which included leading academics and researchers in the field of mental health and substance use stigma. The mix of researchers and health providers considered the results of the joint research and identified key elements of an effective intervention. Effectiveness was derived from successfully reducing stigma and discrimination among CHC providers. Symposium participants identified 13 guiding principles for the development and implementation of Phase I. See Appendix B for the complete list.

The symposium recommended the interviewing of individuals with prior experience in accessing mental health and substance use services. Persons that had been on the receiving end of stigma were expected to provide considerable insight into the phenomenon of stigma. Symposium participants also suggested interviewing peer workers at each CHC in order to address the limitation of exclusively interviewing service providers. Researchers were directed to include a combination of perspectives from both service providers and service users. Participants also proposed that this qualitative research component should build on the research undertaken at the beginning of the project.

Symposium participants identified three critical elements for a potential intervention at CHCs: facilitating contact, organizational planning, and innovative education. Another suggestion was the use of various kinds of media (e.g., posters, billboards, social media) to raise awareness about stigma among CHC providers and clients. It should be noted that participants recognized that there was little evidence to suggest the singular effectiveness of an awareness raising campaign in combating stigma; rather, that media could be one part of a comprehensive program targeting stigma.

Photo 1: Symposium attendees included UnisonHCS, SRCHC, CTCHC liaisons, an expert advisory panel, the project team, CAMH stigma experts and the Mental Health Commission of Canada.

3.6 Action Plan Development

Based on the recommendations from the symposium, each CHC prepared an Action Plan for addressing and preventing stigma at their center. A critical linchpin of this effort would be persons on site with demonstrable commitment to stigma reduction. Such key liaisons, effective ‘champions’, would be tasked with developing a 5-page planning document with concrete ideas. Such plans were intended to help each CHC prepare for further integration of an anti-stigma/discrimination approach into its overall plan. As well, it would lay a foundation for a collaborative partnership with CAMH through the capacity-building process. Specifically, the plans were developed to help each CHC take ownership of the development, implementation, and integration of comprehensive and strategic anti-stigma activities. It would be tailored to their unique needs as each CHC would ground any planned activities within their respective vision, overall goals, action strategy, and evaluation plans.

The action plans proved to be an important component as it facilitated the development and refinement of the intervention. Certain recommendations from the symposium were combined, or discarded, while others were expanded. Five components were subsequently identified as the key elements of a comprehensive anti-stigma intervention: development of teams of leaders; innovative contact-based education; raising awareness; analysis of internal policies and procedures; and recovery-oriented arts. The results from Phase I were helpful for defining, designing, and implementing components of Phase II. It provided a strong foundation for the next steps of a meaningful anti-stigma intervention with the potential to be scaled up provincially, nationally, and globally.

4.0 PHASE II: Implementation

The objective of this phase of the project was to pilot test the anti-stigma/anti-discrimination intervention

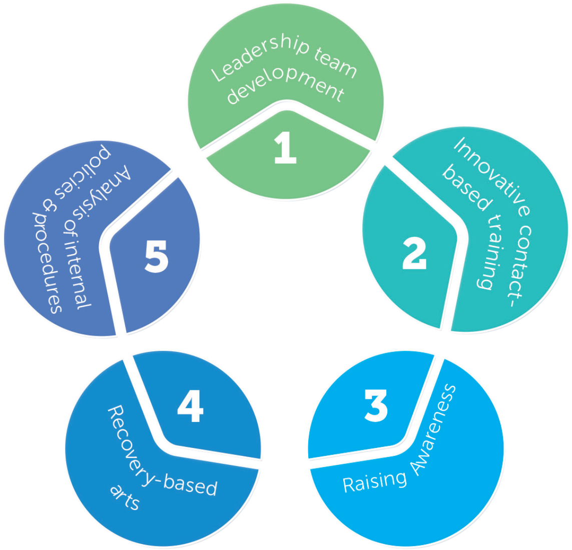


Figure 2: The five component intevention.

4.1 Developing Teams of Leaders

Description

The plan to strengthen anti-stigma leadership at each CHC involved the cultivation of a Team of Local Champions as well as an advisory group of persons with lived experiences and community member. Designated CHC staff was expected to serve as local champion. At one CHC, an existing anti-oppression committee functioned as the team of local champions. The advisory group included individuals with mental health and/or substance use problems that had received services from the CHC. Community members residing within the CHC catchment were also encouraged to participate on the advisory group. Both groups would provide crucial input and leadership for the various components of the intervention.

Photo 2: (Pictured from right to left) Jaime Sapag, Project Scientist, Paulos Gebreyesus, Senior Director at UnisonHCS, Chris Whittaker, Consumer-Survivor, Joe Bortolussi, Former Director at CTCHC and Gordon Singer, a Consumer-Survivor, leading a discussion about the teams of leaders component at the final symposium.

The specific responsibilities of the Team of Local Champions included:

a) Providing input and recommendations during the development of the CHC action plan to reduce stigma and discrimination and promote pro-recovery practices

b) Utilizing the CHC action plans as the basis for planning and implementing anti-stigma and discrimination initiatives and promote recovery

c) Leading the implementation of the action plans in collaboration with the CHC management, staff teams, patient/community advisory group and other stakeholders

d) Monitoring the achievement of each action area within the action plan

e) Serving as champions and advocates for anti-stigma and discrimination and pro-recovery practices in service delivery throughout the organization

Photo 3: Tracy Mead, staff at South Riverdale Community Health Centre and Beverly Smith, member of Health Strength in Action Group (HSAG) were in attendance at the 'Dealing with Difficult Conversations' workshop on February 13, 2015.

The Advisory Group also served as a conduit for community perspective regarding anti-stigma/anti-discrimination initiatives undertaken at each CHC. Members worked extensively with the CHC to plan and implement activities aimed at reducing stigma and discrimination and promoting recovery within both the CHC and wider community.

Development and Implementation

Members of the teams of champions were also provided with relevant leadership training. One training, entitled "Dealing with Difficult Conversations Using a Trauma Informed Approach," proved especially relevant and was implemented at all three CHCs. The facilitators, an advanced practice clinician and an education specialist explored questions with participants regarding such challenges as the effects of trauma on conversation and strategies for changing the conversations.

Photo 4: Dale Kuehl, advanced practice clinician, and Leslie Flores, education specialist, developed and facilitated the workshop on 'Dealing with Difficult Conversations' at UnisonHCS on April 24, 2015.

4.2 Innovative Contact-Based Education

Description

Educational workshops were developed to enhance providers' anti-stigma and recovery-oriented competencies with regard to individuals living with mental illness and/or substance use issues. The training involved learning activities regarding stigma as well as pro-recovery approaches for people with mental health and substance use problems. A key element of the learning involved interactive contact with individuals with lived experiences of mental health and substance use problems; sometimes referred to as consumer-survivors. Such individuals would serve as both facilitators and presenters.

Rationale

The fostering of behavioural changes involves a fundamental re-evaluation of implicit, personal beliefs (stereotypes) and attitudes (prejudices) pertaining to mental health and addiction. Key concerns are stigma within the community - which affects people's likelihood of seeking treatment – as well as within the healthcare system; which poses additional challenges with respect to treatment adherence and recovery rates. PHC providers could thus be effectively trained to better serve as catalyzers to recovery.

Development and Implementation

Practical considerations for the intervention included: maximizing attendance (e.g., minimize disruption to regular duties and responsibilities of PHC workers); fostering audience engagement (e.g., utilize adult learning principles, appeal to multiple learning styles); providing an opportunity for contact-based education by inviting individuals with lived experience to assist with the workshop facilitation and tailoring the content of the intervention to meet the needs of each CHC.

Following consultations with the key liaisons or 'champions', three separate workshops for each CHC were identified as ideal targets. To optimize the potential effectiveness of each workshop, CHC liaisons played integral roles in deciding how to best utilize the workshops. The champions decided to organize the workshops in succession at each CHC so as to build on the content of the previous workshop. Champions also agreed to schedule the workshops as part of regularly scheduled staff meetings. In naming the workshops, careful consideration was given to minimizing negative implicit messaging (e.g., anything suggesting that the intervention is a punitive measure), promoting receptivity to discussing difficult subject matter, and encouraging PHC workers to support the recovery of patients with mental health problems and substance use issues.

4.2.1. Workshop 1: Supporting Recovery 101: Recognizing Stigma & Building on Strengths

Prior to Workshop 1, potential workshop attendees were provided with mental illness and substance use anti-stigma/anti-discrimination reading material, with the goal of engaging the audience in the subject matter. Workshop 1 was designed to accommodate didactic, interactive, and patient contact components; these features were identified based on the results of a literature review on anti-stigma programming and the findings from Phase I.

This workshop had eight objectives:

i. Position workshops as extension of anti-oppression work already being done at CHCs

ii. Link findings from the initial fact-finding process to the goals of the workshop (i.e., where to go from here)

iii. Target mixed feelings PHC providers have about patients with mental health and substance use problems

iv. Promote empathic understanding of patients with mental health and substance use problems

v. Operationalize recovery model (while recognizing limitations)

vi. Sensitize audience to subtle, negative outlook that may affect their attitudes and behaviour toward patients with mental health and substance use problems

vii. Promote effective, non-stigmatizing communication with patients and among CHC staff

viii. Provide opportunity for contact with person with mental health and substance use problems in safe, nonclinical settings

4.2.2. Workshop 2: Supporting Recovery 102: Tools & Strategies

Workshop 2 was developed from the discussion generated and themes identified during and immediately following Workshop 1. Several teaching points were identified as essential considerations for the second workshop: developing specific tools and strategies for challenging mental health and addiction stigma within the CHC; improving communication among CHC staff and with patients to support recovery and challenge stigma; fostering an organizational culture that supports staff but emphasizes accountability; exploring interactions between mental health and addiction stigma and the social determinants of health; and incorporating more interactive learning methods.

The workshop had six objectives:

i. Reflect and empathize with consumer-survivor perceptions of stigma and the social determinants of health; draw connections between perceptions and negative stereotypes that reinforce mental health and substance use stigma

ii. Heighten awareness of individual triggers that may influence service provision negatively and strategies for counter triggers with individual-based de-escalation techniques

iii. Discuss how CHC providers can improve team-based communication and communication with patients to support recovery and challenge mental health and substance use stigma

iv. Explore the difficulties CHC providers face when interactions between mental health and substance use stigma and social determinants of health (e.g., race, poverty, education) affect their ability to coordinate optimal care for mental health and substance use patients

v. Stress the importance of nurturing a culture of support and accountability among CHC providers, an organizational goal that will offer a strong foundation for supporting the recovery of patients

vi. Use active learning methods central to adult education to optimize audience engagement in the above objectives

4.2.3. Workshop 3: Recovery through Empowerment

This educational workshop built on two prior workshops. It sought to position PHC providers as catalysts, rather than barriers, to consumer recovery. The workshop was innovative to the extent in which clients’ lived experiences guided both content and instructional approach. Three to five consumer-survivors served as members of the training teams. This proved to be an important way of engaging PHC providers in discussions and also providing real examples and perspectives from service users.

Four Major Components of Workshop 3:

i. Presentation regarding Recovery Oriented Practice: This presentation provided an overview of recovery-oriented practices; including the skills/knowledge/techniques involved and the various components. Recovery perspectives and environments are assumed to enhance well-being; for example, by reducing the effects of self-stigma for people affected by mental health and substance use problems (Corrigan, 2009). The relationship between concepts of recovery and empathy were also discussed. Practical examples of recovery-oriented practice were elaborated along with the idea of recovery through empowerment.

ii. Small Group Work - Leveling the Playing Field: Participants were asked to reflect on one of two scenarios illustrating stigma, discrimination, or exclusion within a PHC setting. They were then divided into small break-out groups to: (i) define the terms of 'stigma,' 'discrimination,' and 'recovery;' and (ii) identify ways to introduce the topic of stigma with clients using safe, non-threatening language. Following brief discussions, one person from each group shared their definitions and the key points of discussions with the larger audience. This activity aimed to develop two main competencies: first, greater self-awareness of stigmatizing behaviour through personal reflection, introspection and by adopting the service users' point of view; second, to reflect respect for the expertise and unique knowledge gained as a result of having experienced mental health.

Photo 5: Michelle Joseph (second from right), Executive Director at Unison Health and Community Services, engaging in small group work as part of the contact-based education component in April 2014.

Photo 6: Chris Whittaker (third from right), Personal Experience Speaker, facilitating a discussion with a small group of staff at Unison Health and Community Services in April 2014.

iii. Role Play - Fostering Recovery, Building Humility, Empathy and Understanding: Building on the earlier activity, a consumer/survivor and one volunteer staff participant engaged in a role-playing exercise based on a real-life experience of a consumer/survivor. The staff participant took on the role of the consumer/survivor and the consumer/survivor assumed the role of the PHC worker. Workshop participants were asked to think about the feelings experienced by the client and the causes, triggers, processes, and threatening language involved in stigmatizing encounters within PHC settings. Large group discussions explored how empathy can be fostered and incorporated into daily client interactions.

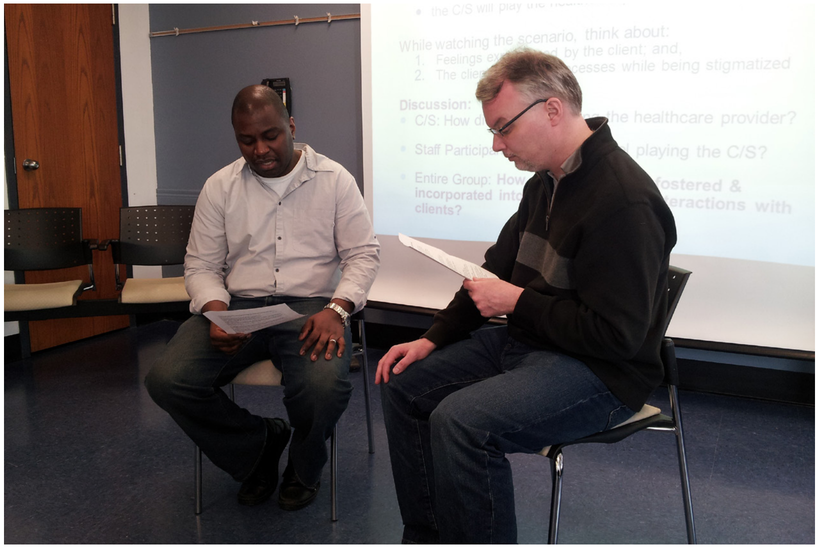


Photo 7: Chris Whittaker (right), Personal Experience Speaker, and a staff participant from Unison Health and Community Services switch roles and engage in exercises, illustrating a scenario in front of the larger group in April 2014.

iv. Panel Discussion - Recovery in Practice: This panel was composed of three to four PHC workers and one to two consumer/survivors. It was moderated by a workshop facilitator. The facilitator presented an experience related to client stigmatization within the context of community-based PHC. The panel informally discussed the key triggers to the stigmatizing behavior in the scenario. They considered how the situation could have been handled differently. The panel also discussed the types of proactive behavior PHC workers could use to foster recovery-oriented care. During the panel, the moderator presented points to be discussed and recorded the best practices suggested by panel members.

Photo 8: Wayne Duhaney, Kate Freeman, Gordon Singer, and Chris Whittaker participating in a panel discussion at Unison Health and Community Services in April 2014.

4.3 Raising Awareness

Description

A logo, tagline and posters for the project were developed in order to raise awareness among health-care providers and the general population about stigma and discrimination toward persons with mental health and substance use problems.

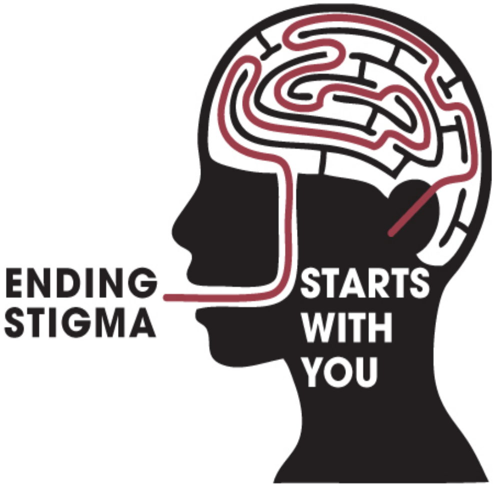
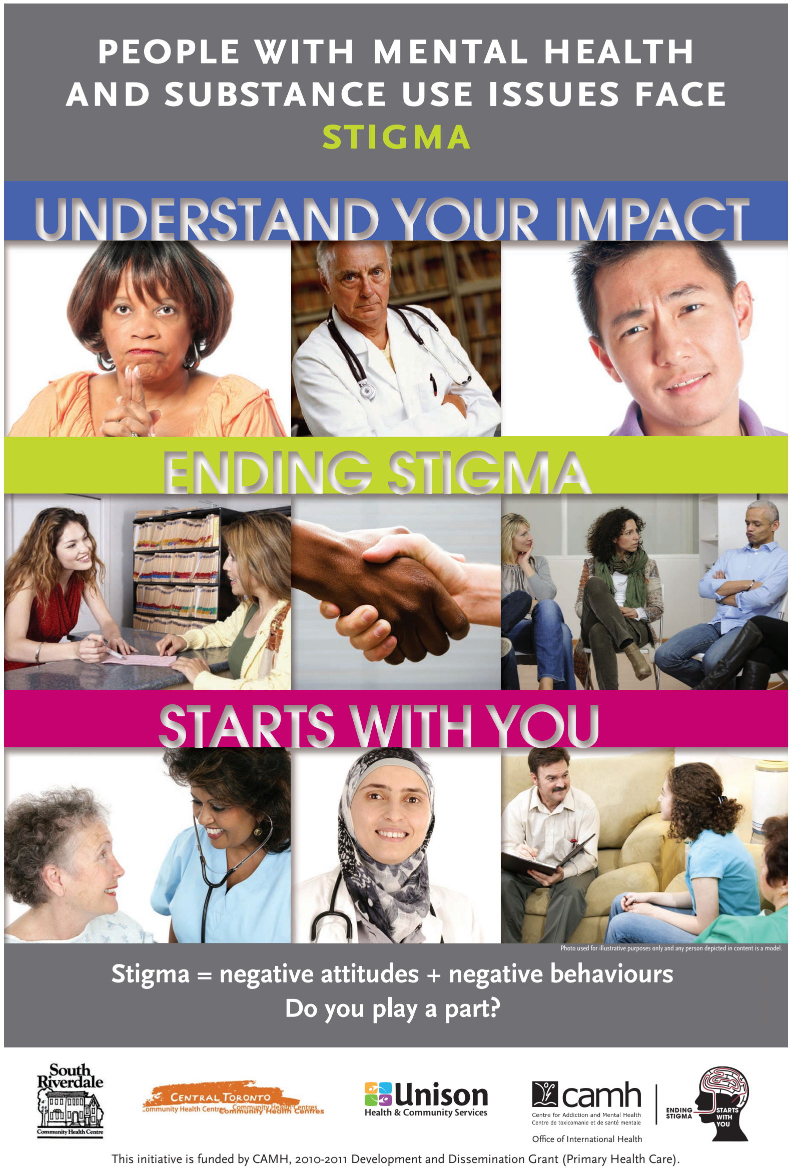


Figure 3: Project Logo.

Development and Implementation

The OTGH project team and CHC champions, with the support of CAMH's Creative Services Department, developed the logo and tagline. These were considered essential tools for 'branding' the initiative. The poster was initially developed to focus primarily on PHC providers. During the process of development however, it became apparent that clients would also see the posters hanging on CHC walls. It was thus reframed for wider use and translated into the seven widely spoken languages at the CHCs: French Spanish, Cantonese, Mandarin, Portuguese, Italian, and Somali. Materials were disseminated to a wider audience through other types of media, including CHC websites and CHC newsletters. The CHCs also identified community partners where posters were placed and disseminated.



This initiative is funded by CAMH, 2010-2011 Development and Dissemination Grant (Primary Health Care).

Figure 4: The anti-stigma project poster developed by the project team in collaboration with creative services at CAMH.

4.4 Recovery-based Arts

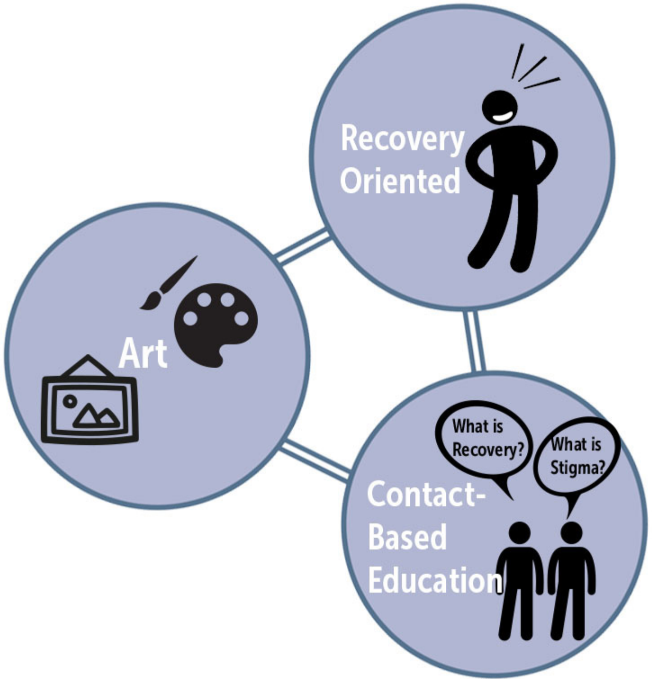


Figure 5: The three core elements of the recovery-based arts component are: contact-based education, art and a recovery-oriented perspective.

Description

Arts-based methods are known to have positive effects on both internal and group perspectives. Building on this knowledge, a 10 week arts-based workshop series was developed to show how important it is for clients to take an active role in their own recovery process. The series aimed to promote and/or strengthen awareness of how clients were contributing in a positive way to their own lives and/or a greater social cause. The workshops allowed clients to partner in creating services that uphold the principles of anti-stigma and anti-discrimination for themselves and for others. Learning how to best apply recovery-based arts called for focused contact-based education. Such education afforded participants many opportunities to practice confronting stigma as well as gain the necessary insights for strengthening their own anti-stigma, pro-recovery approach. The arts-based workshop also emphasized the importance for wellbeing of clients taking an active role in their own recovery process. Through this learning, clients would also gained renewed perspective that they were contributing in a positive way to their own lives and/or the greater public good. Persons with lived experiences could collaborate in creating services that upheld principles of anti-stigma and anti-discrimination knowing that arts-based methods have fueled positive internal and social shifts. Through this arts-based research component with PHC staff and persons with lived experiences, a recovery-based framework was put into action.

The objectives were as follows:

i. To provide PHC providers with an opportunity to learn from consumer-survivors, in a non-clinical relationship, about their perspectives on recovery, including facilitators and challenges.

ii. To utilize arts-based methods to learn from consumers and community members about their personal experiences with stigma and discrimination, especially those affecting their recovery process at the PHC level.

iii. To apply the arts using contact-based education to reveal nuances of recovery from various consumer survivor perspectives, so that PHC providers can learn how best to facilitate the recovery process.

iv. To give priority to suggestions/needs of consumers and community members to improve existing primary care and community services, and to implement innovative anti-stigma/discrimination, pro-recovery interventions.

v. To support and contribute to the objectives of the larger project.

Development and Implementation

The series included 8–10 sessions, each lasting approximately 1.5–3 hours. The total number of participants per session ranged from 5–12, including 1–3 PHC providers. Ten clients reflecting the diversity of the community served by each CHC were recruited to participate in the workshop series and final group exhibition. Clients were recruited through a mix of staff referrals and direct recruitment. CHC workshop facilitators met with staff members to discuss referrals and then met with clients privately to screen them, explain the project, answer questions, identify individual needs, and obtain signed consent.

Participant inclusion criteria:

- a) Clients currently accessing PHC services at one of the CHCs and having experienced stigma due to their drug use and/or mental health issues.
- b) Being relatively stable, not in crisis or easily triggered, and able to make a 10-week commitment.
- c) Preferably living in the catchment area covered by the CHC.
- d) Being at a stage of life where they can reflect on their experience, are willing to share experiences, and discuss issues concerning stigma and acceptance.
- e) Having personal boundaries re: self-disclosure.
- f) Being able to listen to others and adhere to the policy about respect.
- g) Refraining from being judgmental toward people who use drugs and/or have a mental health condition.
- h) Interested in making art (previous art experience not required).

Photo 9: Lorraine Barnaby, a health promoter at Central Toronto Community Health Centre, along with CTCHC staff and consumer-survivor participants creating art in April 2015.

Photo 10 & 11: Participants from South Riverdale Community Health Centre silk-screening and upcycling fabric to create pieces.

Photo 12: Darlene King said "[the workshops] showed me that I can be an artist and do not need to use my mouth to say things, but I can use my hands." She is expressing her gratitude for the workshops at the Unison Health and Community Services final Art Show on February 26, 2015.

Photo 13: Group Artwork from Central Toronto Community Health Centre displayed at the final symposium in July 2015.

Photo 14: The group artwork of the positive counterpart of stigma, created in the workshop at Unison Health and Community Services at the Keele-Rogers site. Jesus 'Jesse' Robles, a consumer-survivor, described this work as "Coming up and out of negativity to an enlightened positive part. Where you are expressing your reality of life surrounding success and acceptance."

Photo 15: The group artwork of the negative counterpart of stigma, created in the workshop at Unison Health and Community Services at the Keele-Rogers site. Jesse described this work as "the stigma battlefield."

4.5 Analysis of Internal Policies and Procedures

Description

Policies are statements that articulate an organization's guiding principles and perspectives on any particular matter; more particularly, mental health policies define the vision, values, principles, objectives as well as broad framework for action to achieve related goals (WHO, 2007). According to Paul et al., policy analysis is "the task of analyzing and evaluating public policy options in the context of given goals for choice by policymakers or other relevant actors" (1989, p.1). This component of the project follows from the system perspective upon which the intervention is based.

Following the determination of decision makers to reduce stigma and enhance recovery in the primary care setting, project staff and CHC champions examine policy areas for strengths, gaps and any opportunities to enhancing service delivery for those with mental illness and substance use disorders. Their analysis considers whether the right mix of policies and procedures are in place to address any contextual factors at a systems level; minimizing negative effects and implications while promoting recovery-based procedures. The entire process aims to connect the analysis with the development of concrete and context specific recommendations that address all key concerns.

Specific Objectives

i. To assess CHC policies and procedures that affect mental health and substance use problems and determine how these policies contribute to stigma and discrimination

ii. To create recommendations for strengthening CHC policies and procedures with the goal of reducing mental health and substance use stigma and discrimination and promote recovery.

4.5.1. Development of the Policy Analysis Tool

A systematic literature review was undertaken to find policy analyses conducted at the PHC level as part of anti-stigma/anti-discrimination interventions. The search included articles focusing on the methodology of conducting a policy analysis as well as articles that described experiences involving policy analysis at a PHC level. No relevant policy analysis tool, appropriate for analyzing stigmatizing and discriminatory practices within primary health care settings, were found; so a tool was developed specifically for this intervention based on existing frameworks.

After reviewing the articles and documents identified by the search, six documents were selected to inform and guide this policy analysis tool. The tool incorporated a variety of questions to help clarify whether policies supported an anti-stigma/anti-discrimination environment. These questions were developed based on the following documents:

i. A Framework for Analyzing Public Policies-The National Collaborating Centre for Healthy Public Policy (2012)
ii. CIHI: Recognizing and Exploring Positive Mental Health. A Policy Dialogue (2011)
iii. Health Equity Impact Assessment-Ontario Ministry of Health and Long-Term Care (2012)
iv. The BIAS Free Framework (2006)
v. The Toolkit- Institutional Treatment, Human Rights and Care Assessment (2010)
vi. WHO Quality Rights Tool Kit (2012)

iv. The BIAS Free Framework (2006)
v. The Toolkit- Institutional Treatment, Human Rights and Care Assessment (2010)
vi. WHO Quality Rights Tool Kit (2012)

4.5.2. Analysis of Internal Policies and Procedures

The policy analysis was guided by an external professional conversant with stigma and discrimination related issues as well as local Champions. Notably, two of the three CHCs were not able to participate in this component due to challenges related to one CHC's recent reviews of all policies and procedures for accreditation purposes and circumstances associated with another's change in leadership. The participating team selected the following policies and procedures for consideration: (1) Managing Disruptive Behaviour/Threatening; (2) Violent and Aggressive Behaviour Protocol; (3) Primary Care Client Intake Protocol; (4) Non Insured Intake Protocol Acute Mental Disturbance Protocol; (5) No Show Protocol; and (6) Terminating Client Relationship Protocol.

Each item was analyzed using the tool (see Appendix B). Some questions could be answered with a simple "Yes" or "No" while others required more information. Once the analysis was complete, "Yes" and "No" responses were tallied to gain some initial ideas as to how well policies were designed to address stigma and discrimination. Following this step, a more thorough thematic analysis was conducted to identify policy gaps.

4.5.3. Policy Analysis Results

a) Terminology

Overall, the policies clearly communicated organizational purpose. All policies provided very clear and detailed instructions on how each should be implemented. Most provided scripts and forms for staff members to fill out when reporting an issue: discussions and complaints were formal processes, documenting all details and clearly identifying the contact person.

b) Policy Orientation / Updates for Staff

From an operations perspective, although policy implementation was documented in detail in the form of scripts and incident forms, it was not clear how policies were conveyed to staff. No record indicated whether there had been training or orientation in the use of policies and protocols. It was also not clear whether measures were in place to ensure policies were applied successfully, where such measures could be found, and whether they were accessible to clients.

c) Complaints and Resolution Processes

Another issue that appeared in three of the six policies related to the complaints and resolution processes. One document clearly indicated that following a disturbance, clients could discuss and provide feedback to staff on how the situation could have been handled better. This process placed the ownership in the hands of both the provider and the client. One of the documents also clearly laid out a resolution process and ways to ensure the entire complaint and resolution process was confidential. By contrast, two other documents clearly laid out a resolution process but did not specify whether the complaints process was confidential. Complaints processes are necessarily confidential in order to ensure that clients are not discriminated against. Another documents outlined how clients could file a complaint; stating that front desk staff would assess the reason for the complaint and contact the provider to assess the urgency. If there is still a need, this individual would then direct the client to the site manager. The process implied lack of timeliness in the period within which a client would speak to the site manager.

d) Policy Review Frequency

According to the review, four of six policies would be re-examined every two years; while two other policies were to be reviewed every three years. The reasons for these differences in review periods were not provided. It would be beneficial for CHC staff to undergo a full policy review every two years to ensure that all documents were updated and all staff members aware of the policies. The remaining topics fell under three themes: access to care and inclusion; equity and respect; and supportive environments.

i. Access to Care and Inclusion

Access to Care and Inclusion were recognized as priority concerns for anyone working with mental health clients; especially given the evidence that recovery depends on persons with mental illness and/or addictions having easily access care and feeling welcomed and included within a health setting. Notably however, only two of the six policy documents used the word "inclusion." Three documents mentioned that anyone who lived, worked, or attended school in the catchment area was included in the population served by the CHC. This included children under the age of 12 as well as the uninsured population. Four documents did not state who could use the facilities.

The issue of "access to care" was discussed in all of the policies except for one. A client's status became 'inactive' if services were not accessed for three consecutive years, or if a reorientation session has not been attended in the following two years. Unfortunately, the prospect of re-entry (including new data gathering) could prevent some clients from accessing healthcare. None of the policies took into account transportation barriers or barriers in accessing healthcare, except for the uninsured population. As a result, some policies may have unintended consequences that could lead to reduced access to care.

Two documents clearly stated that those outside of the catchment area would have to access services at another CHC. If individuals had three "no-shows," or were "deactivated," they would have to repeat orientation. These policies may need to be more sensitive to barriers that individuals face in accessing care; some may not be able to attend orientation again due to the time commitment.

ii. Equity and Respect

None of the documents discussed the concepts of cultural appropriateness of communication and healthcare delivery, stigma, anti-oppression, human rights, dignity, fairness, equity, or client rights. It was not explicitly stated that clients would not be subjected to verbal, mental, physical, and sexual abuse; no document included stigma or discrimination as a reason for complaint. In addition, none of the policies explicitly stated that staff members would interact with clients in a respectful way and treat them with dignity, humanity, and respect. One document stated that the CHC aimed to "provide a safe environment for clients, staff, students, visitors and volunteers that are free from harassment, abuse, discrimination and violence". Two documents recognized the uninsured as a priority population; however, none of the documents identified vulnerable/marginalized populations.

iii. Supportive Environments

None of the documents reviewed considered concepts of recovery, harm reduction, client-centered care and/or self-determination. One document recognized the CHC's responsibility to 'create an environment that fosters accountability, respect, safety, cooperation and continuous improvement'. Another document indicated that a common purpose of the CHC is to 'maintain a safe environment for staff, volunteers and clients' and 'to assist those clients reestablish control.'

With regard to building supportive/positive relationships, one document noted the CHC aim of fostering trusting relationships with staff as a means for clients to achieve improved health. Another document emphasized the CHC's commitment to developing and maintaining effective relationships with its clients by building upon their strengths and supporting them to manage their health or personal concerns.

With regard to quality of care provided by healthcare providers, one document stated that the CHC focuses on providing consistent and appropriate approaches. Another stated that 'we understand that service providers are bound by their colleges, and the policies and protocols of (the organization), as well as being guided by the organization's vision, mission and values.' Four documents did not mention quality of care or care.

4.5.4. Policy Analysis Recommendations

The policy analysis yielded nine recommendations to the CHC:

i. A statement at the beginning of each policy should indicate that the CHC strives to work in an environment that supports and promotes supportive and positive relationship-building, outstanding quality of care, discrimination/stigma-free care, and respect for all.

ii. The CHC should promote an anti-stigma/anti-discrimination environment. The beginning of each policy should state that no person will be denied access to facilities or treatment on the basis of economic factors, race, color, sex, language, religion, political opinion, nationality, ethnicity, Indigenous heritage, social origin, property, disability, birth, gender identity, age, or status; and that no clients will be subjected to verbal, mental, physical, or sexual abuse.

iii. Policies should incorporate concepts such as cultural appropriateness of communication and healthcare delivery, quality of care, supportive environments, supportive/positive relationship building, inclusion, stigma, discrimination, anti-oppression, human rights, dignity, respect, fair/fairness, recovery, harm reduction, client-centered care, self-determination, equity, and client rights.

iv. Concepts such as equity, dignity, and respect should be embedded within the decision-making process.

v. A document defining all concepts discussed in the policies should be included.

vi. All policies should be reviewed biannually by board and staff to ensure contemporary relevance.

vii. Policies (especially those related to terminating client relationships) should incorporate determinants of health inequities, barriers to accessing health care, and other issues pertaining to vulnerable/marginalized populations.

viii. Include a document that states how policies are conveyed to staff, clarifies whether there is training or orientation for the use of policies and protocols, what measures are in place to ensure the policy is utilized and is successful, where the policies are located, and whether they are accessible to clients.

ix. Include stigma/discrimination as a reason for complaint, as one way of promoting an anti-stigma/anti-discrimination environment in a CHC setting.

CHC leaders were provided with the results of this assessment. In turn, decision makers indicated that strategies would be developed to apply the relevant findings towards systemic strengthening of policies and procedures.

5.0 PHASE III: Findings

5.1 Quantitative Findings: Pre and Post Intervention Assessment Results

The following findings are based on a comparison of baseline and final datasets. Data are divided into several themes with a brief explanation and interpretation below each table. All data are correlational and cannot be used to infer a causal link between any one component of the intervention and changes in the various scales. Additionally, the lack of experimental control and the high rate of turnover (about half of the final sample indicated that they had been at their CHC less than five years) makes it difficult to assess the direct results of the overall intervention. However, many improvements were observed in the attitudes and knowledge among staff members concerning patients with mental illness and substance use during and after the intervention.

5.1.1. Sample Description

Table 1 (below) compares the baseline and final data samples. At baseline, 137 participants answered the survey. At final collection, this number had decreased to 110 participants' responding to the survey. A 19.7% decline in participants has been estimated for the study period based on an estimated 15% increase in staffing numbers. The two samples were compared to ensure they did not vary significantly from each other in terms of characteristics of the participants. Table 1compares the baseline and final data on gender, age, marital status and whether or not the participant was born in Canada. No significant differences were observed across these categories in baseline and final data sets, indicating that the samples taken at the beginning and end of the intervention were roughly equivalent in terms of statistical comparisons. Approximately two-thirds of the sample identified as female, and very few respondents indicated a gender other than male or female. Age distribution was fairly even, with the age group 30–39 most represented in both samples. About half of participants reported being either married or in a common-law relationship. Nearly half of the sample reported being born in Canada. CHC staff members were highly educated, with more than 80% reporting an education level of higher than high school. It is worth noting that a large amount of data was missing from each of the demographic questions. Staff members were assured that their responses would remain confidential, but they may have been worried about being identified by their demographic characteristics.

Table 1: Sample Description

Survey item	Categories	Baseline		Final	
		Count	Column (%)	Count	Column (%)
What is your gender?	Man	25	18.2	14	12.7
	Woman	95	69.3	73	66.4
	Other (Transgendered, Genderqueer, Prefer not to answer)	3	2.1	5	4.5
	Missing	14	10.2	18	16.4
What is your Age?	(1) 18-29 years	21	15.3	12	10.9
	(2) 30 -39 years	37	27.0	25	22.7
	(3) 40-49 years	31	22.6	23	20.9
	(4) 50 – 59 years	25	18.2	21	19.1
	(5) 60 – 69 years	5	3.6	8	7.3
	Missing	18	13.1	21	19.1
Are you currently married, living as married, widowed, divorced, separated, or have you never been married?	Married	45	32.8	43	39.1
	Common-Law	25	18.2	11	10.0
	Widowed/Separated/Divorced	23	16.8	14	12.7
	Single/Never married	28	20.4	21	19.1
	Missing	16	11.7	21	19.1
Were you born in Canada?	Yes	64	46.7	52	47.3
	No	59	43.1	39	35.5
	Missing	14	10.2	19	17.3
What is the highest level of education that you have completed?	High School	1	0.7	0	0.0
	Some College/Special Training	20	14.6	14	12.7
	Bachelor's Degree	44	32.1	41	37.3
	Graduate or Professional Training	54	39.4	37	33.6
	Missing	18	13.1	18	16.4

5.1.2 CHC Role Description

Table 2 (adjacent) presents some information about professional characteristics of staff members who filled out the survey at the beginning and end of the project. As with demographic information, in most cases the data did not differ statistically as indicated by a Chi-square test. A statistical difference was observed between the baseline and final survey results in terms of the number of staff who had received additional training, with more staff reporting having received additional training at the end of the project. It is unclear whether they were referring to the training that was provided over the course of the intervention.

Table 2: Roles within the CHC

		Baseline		Final	
Survey item	**Categories**	**Count**	**Column (%)**	**Count**	**Column (%)**
Which primary health care area do you work for (in your CHC)?	Clinical team	44	32.1	34	30.9
	Community health team	37	27.0	22	20.0
	Administrative	9	6.6	17	15.5
	Other	27	19.7	16	14.5
	Missing	20	14.6	21	19.1
How long have you been working at this CHC? Please circle the response that best represents your situation.	< 6 months	8	5.8	9	8.2
	6 to < 12 months	13	9.5	4	3.6
	1 to < 2 years	19	13.9	5	4.5
	2 to < 5 years	26	19.0	23	20.9
	5 to < 10 years	28	20.4	24	21.8
	10 years or more	26	19.0	26	23.6
	Missing	17	12.4	19	17.3
Overall, how long have you been working in primary health care? Please circle the response that best represents your situation.	< 6 months	5	3.6	7	6.4
	6 to < 12 months	9	6.6	2	1.8
	1 to < 2 years	10	7.3	2	1.8
	2 to < 5 years	23	16.8	13	11.8
	5 to < 10 years	23	16.8	22	20.0
	10 years or more	41	29.9	39	35.5
	Missing	26	19.0	25	22.7
What is the highest level of education that you have completed?	Yes	34	24.8	45	40.9 *
	No	77	56.2	46	41.8
	Missing	26	19.0	19	17.3

🟩 * Lime Green Highlight, $p < 0.05$

5.1.3. Comparison of Scales

Table 3 (below) shows some significant improvements in scores over the course of the pilot study. First, there was a significant improvement in the Opening Minds Scale for Healthcare Providers (OMS-HC) which is designed to measure stigmatizing attitudes that healthcare providers have about clients with mental health and substance use problems. Scores on this scale were lowered by 5.9%, and this difference was shown to be statistically significant by independent samples T-test.

The Bogardus Scale for Social Distance: Heroin Dependence showed a significant improvement, with a reduction in scores of 8.4%. This indicates that staff members had significantly less desire for separation from those with heroin dependence after the intervention, compared with baseline. Improvement was also noted in the Bogardus scale for Social Distance: Schizophrenia over the course of the project. However, this change was less substantial and significant at the $p<0.10$ level.

Similarly, the Recovery Assessment Scale for Addiction showed a significant improvement in scores, with a reduction of 9.4% compared to baseline. This indicates that attitudes surrounding the recovery potential of those with addictions problems were significantly better at the end of the intervention. However, a significant improvement was not observed in attitudes concerning the recovery potential of those with mental illness as measured by Recovery Assessment Scale for Mental Illness.

Interestingly, the scores for the CCHS Stigma Module focusing on depression were lower (indicating worse attitudes) while those for cocaine dependence improved. Interpreting this variable is difficult. This tool asks respondents how they think other people see each condition, so after the intervention they might have realized that some conditions are less stigmatized than they initially thought, whereas others are more stigmatized than they initially thought.

Similar reductions were observed in the CCHS Stigma Module scores for personality disorder and alcohol dependence, but these were less consistent, and were only being significant at the $p<0.10$ level.

Table 3: Scale Comparisons Between Baseline and Final

	Baseline			Final			Difference
Measurement Scale	Mean	N	Std. Dev.	Mean	N	Std. Dev.	
Opening Minds Survey	45.2	136	8.4	42.5	109	8.4	5.9% *
Mental Illness: Clinicians' Attitudes	36.9	134	8.6	35.0	103	9.7	5.0%
Bogardus: Schizophrenia	11.9	125	3.2	11.1	94	3.0	6.7% +
Bogardus: Heroin	13.6	124	3.9	12.5	94	3.7	8.4% *
Recovery Assessment Scale: Mental Illness	51.3	120	13.9	49.6	96	14.2	3.3%
Recovery Assessment Scale: Addictions	53.9	121	14.7	48.8	92	15.2	9.4% *
Willingness Scale	20.1	128	4.4	20.6	103	4.3	-2.6%
Attribution Questionnaire	83.1	128	26.3	81.2	102	25.6	2.3%
Empowerment: Mental Illness	6.1	125	3.9	5.9	94	4.5	2.8%
Empowerment: Addictions	7.1	125	4.7	6.5	92	4.5	8.2%
Stigma: Depression	22.6	118	4.4	17.9	88	3.8	21.0% *
Stigma: Schizophrenia	17.1	118	4.7	17.6	88	3.9	-2.9%
Stigma: Personality Disorder	16.4	119	4.7	17.6	88	3.9	-6.9% +
Stigma: Alcohol Dependence	16.5	118	4.8	17.6	88	3.9	-6.3% +
Stigma: Cocaine Dependence	14.1	117	5.0	17.4	88	4.0	-24.1% *

*	Lime Green Highlight, $p < 0.05$
+	Green Highlight, $p < 0.10$

Opening Minds Survey

As noted earlier, the Opening Minds Scale for Healthcare Providers (OMS-HC) revealed significant changes during the course of this pilot study. This is an important finding, because this scale is specifically designed to measure stigmatizing attitudes among healthcare providers. Table 4 (below) shows the subscales of the OMS-HC in more detail. The most consistent improvement was in the subscale measuring attitudes about the disclosure of mental illness or addiction. A significant improvement was also observed in the social distance subscale, at the $p<0.10$ level, mirroring the improvements in the Bogardus social distance scores (Link et al., 1987).

Table 4: Opening Minds Survey

	Baseline			Final			Difference
OMS Subscale	**Mean**	**N**	**Std. Dev.**	**Mean**	**N**	**Std. Dev.**	
Attitudes	14.1	136	3.9	13.4	109	3.7	5.0%
Disclosure	14.2	136	2.9	13.3	110	3.2	6.6% *
Social Distance	9.9	136	3.1	9.1	109	2.9	7.1% $^{+}$

*	Lime Green Highlight, $p < 0.05$
+	Green Highlight, $p < 0.10$

5.1.4. Differences by Gender

Table 5 (see below) compares the scores on each of the scales by gender. At the end of the study period, scores were very similar between men and women. Independent samples T-tests revealed no significant differences in any of the scales. Data from those identifying as a gender other than male or female are not reported, to maintain anonymity.

Table 5: Comparing Final Scores by Gender

		Final			
Survey item	**Gender**	**N**	**Mean**	**Std. Dev.**	**Std. Error Mean**
Opening Minds Survey	Male	14	43.0	9.2	2.4
	Female	73	42.4	8.2	1.0
Mental Illness: Clinicians' Attitudes	Male	14	36.3	7.9	2.1
	Female	73	34.9	9.7	1.1
Bogardus: Schizophrenia	Male	14	11.7	3.3	0.9
	Female	73	12.6	3.8	0.4
Bogardus: Heroin	Male	14	11.2	4.1	1.1
	Female	73	11.1	2.9	0.3
Recovery Assessment Scale: Mental Illness	Male	14	45.5	15.0	4.0
	Female	73	50.2	13.3	1.6
Recovery Assessment Scale: Addictions	Male	14	46.1	11.2	3.0
	Female	72	48.9	15.8	1.9
Willingness to treat	Male	14	19.4	5.1	1.4
	Female	73	20.7	4.1	0.5
Attribution	Male	14	88.6	29.5	7.9
	Female	73	78.4	23.6	2.8
Empowerment: Mental Illness	Male	14	5.9	2.8	0.8
	Female	73	6.1	4.9	0.6
Empowerment Scale: Addictions	Male	14	6.2	2.5	0.7
	Female	73	6.8	4.9	0.6

5.1.5. Mental Illness vs Addictions

The baseline data indicates that participants had more negative attitudes towards persons with addictions, compared to those with mental illness, at the beginning of the pilot study, Table 6 (below) reveals differences between paired addiction scales at baseline and at final collection. The percent difference column shows that the gap in attitudes between addictions and mental illness decreased over the course of the intervention. These differences were particularly substantial when comparing the particular substances in the CCHS stigma module. RAS scores were also lower for addiction than for mental illness, indicating a reversal in attitudes about the two types of conditions, between baseline and final datasets. Table 3 also indicated significant changes being observed in the Bogardus Scale for Heroin Dependence and the RAS-Addictions (RASA); but not in the corresponding mental illness scales. This latter observation suggests that greater improvements were made in attitudes towards persons with addictions, compared to those with mental illness, over the course of the training, This could mean that there was more room for improvement in attitudes about substance use in the first place; which may also explain why the final scores for addictions and mental health were so similar.

Table 6: Differences between addictions and mental illness scales

	Baseline					Final				
Measurement Scale	Mean	N	Std. Dev.	Std. Error	Difference	Mean	N	Std. Dev.	Std. Error	Difference
Bogardus: Schizophrenia	11.9	124	3.2	0.3	14.8%	11.1	94	3.0	0.3	12.7%
Bogardus: Heroin	13.6	124	3.9	0.3		12.5	94	3.7	0.4	
Recovery Assessment Scale: Mental Illness	51.2	119	13.9	1.3	4.9%	49.4	92	13.7	1.4	1.1%
Recovery Assessment Scale: Addictions	53.7	119	14.7	1.3		48.8	92	15.2	1.6	
Stigma: Schizophrenia	17.1	117	4.6	0.4	17.5%	17.6	88	3.9	0.4	1.0%
Stigma: Cocaine Dependence	14.1	117	5.0	0.5		17.4	88	4.0	0.4	
Stigma: Depression	22.6	118	4.4	0.4	26.8%	17.9	88	3.8	0.4	1.5%
Stigma: Alcohol Dependence	16.5	118	4.8	0.4		17.6	88	3.9	0.4	

5.1.6. Exposure to Full Intervention

A considerable proportion of participants were not at their CHC for all components of the intervention due to its five year duration. Table 7 compares the scores of those who have been at their CHC longer than five years (and thus could have been exposed to all components) with the scores of those on hand less than five years. The comparison reveals that staff members who have been at their CHC for more than five years scored significantly higher on the OMS-HC, the Schizophrenia version of the Bogardus Social Distance Scale, and the Willingness scale. This indicates that those who have been at their CHC for the entire length of the intervention had attained significantly more positive attitudes towards clients with addictions or mental health issues.

One possibility for these differences is different attitudes among long-term versus short-term employees: those who have been working longer might be more sensitive to the needs of clients with these kinds of troubles and thus should be expected to have fewer stigmatizing attitudes towards clients. To explore this possibility, Table 7 compares those who had been working at their CHC for longer than five years with those who had not, at the baseline collection point. The table reveals no statistically significant differences between these groups on any of the scales used in the survey. This finding suggests that length of employment is insufficient to explain the differences shown in Table 7.

Table 7: Comparing staff, that have been/and not been, at CHC for 5 or more years

		Baseline					Final				
Measurement Scale	**Time At CHC**	N	Mean	Std. Dev.	Std. Error	Difference	N	Mean	Std. Dev.	Std. Error	Difference
Opening Minds Survey	< 5 Years	66	45.7	8.3	1.0	3.8%	41	44.8	8.1	1.3	10.9% *
	> 5 Years	53	43.9	8.1	1.1		50	39.9	7.8	1.1	
Mental Illness: Clinicians' Attitudes	< 5 Years	66	37.1	7.9	1.0	3.7%	41	35.4	9.8	1.5	5.0%
	> 5 Years	54	35.8	8.6	1.2		50	33.6	8.8	1.2	
Bogardus: Schizophrenia	< 5 Years	66	12.3	3.5	0.4	6.0%	41	11.8	2.8	0.4	10.7% *
	> 5 Years	52	11.6	2.7	0.4		50	10.5	3.0	0.4	
Bogardus: Heroin	< 5 Years	65	14.2	4.3	0.5	7.9%	41	13.2	3.2	0.5	10.7%
	> 5 Years	52	13.1	3.1	0.4		50	11.8	3.8	0.5	
Recovery Assessment Scale: Mental Illness	< 5 Years	60	49.2	13.3	1.7	-6.9%	41	51.1	12.6	2.0	6.6%
	> 5 Years	52	52.6	14.4	2.0		50	47.7	14.4	2.0	
Recovery Assessment Scale: Addictions	< 5 Years	61	52.6	14.3	1.8	-5.9%	40	50.5	14.3	2.3	7.4%
	> 5 Years	53	55.7	15.5	2.1		50	46.7	15.3	2.2	
Willingness Scale	< 5 Years	61	19.5	4.5	0.6	-7.5%	41	19.4	4.5	0.7	-11.8% *
	> 5 Years	54	20.9	3.6	0.5		50	21.7	3.9	0.6	
Attribution	< 5 Years	63	82.0	27.1	3.4	0.7%	41	84.8	26.9	4.2	10.1%
	> 5 Years	53	81.4	19.9	2.7		50	76.2	24.0	3.4	
Empowerment Scale: Mental Illness	< 5 Years	66	5.9	4.4	0.5	-8.5%	41	5.8	4.3	0.7	0.2%
	> 5 Years	53	6.4	3.3	0.5		50	5.8	4.4	0.6	
Empowerment Scale: Addictions	< 5 Years	66	7.2	5.4	0.7	3.1%	40	6.4	4.4	0.7	-0.4%
	> 5 Years	53	7.0	3.9	0.5		49	6.4	4.4	0.6	

🟩* Lime Green Highlight, $p < 0.05$

5.1.7. Previous training

At both time points, staff members were asked if they had received additional training in dealing with clients with mental illnesses or addiction. Tables 8a and 8b (see adjacent and below) compare baseline and final scores for those who indicated receiving such training as well as those that reported no additional training. The tables reveal more significant differences between staff who reported no additional training compared to those reporting additional training. It is important to note that there is no way of knowing whether the participants in Table 8a were the same at both time points because we could not track individual participants. vThe tables indicate that at the final data collection, a larger proportion of staff reported receiving additional training, which could partly explain the differences observed in the data. One interpretation of the differences between Tables 8a and 8b is that those who had not received additional training improved the most over the course of the pilot study. This may indicate that those with no additional training are likely to receive the most benefit from stigma trainings programs.

Table 8A: Comparison of baseline and final for staff with at least some additional training

	Additional Training: YES						
	Baseline			Final			Difference
Measurement Scale	N	Mean	Std. Dev.	N	Mean	Std. Dev.	
Opening Minds Survey	34	42.0	7.8	45	39.8	7.8	5.2%
Mental Illness: Clinicians' Attitudes	34	35.1	7.8	45	32.6	9.0	7.2%
Bogardus: Schizophrenia	34	11.4	3.0	45	10.8	2.7	5.5%
Bogardus: Heroin	34	12.5	3.2	45	12.1	3.7	3.3%
Recovery Assessment Scale: Mental Illness	32	52.7	10.4	45	51.6	13.8	2.2%
Recovery Assessment Scale: Addictions	33	58.2	12.7	45	51.3	15.5	11.8% *
Willingness Scale	33	22.2	3.0	45	22.0	4.0	0.9%
Attribution Questionnaire	34	71.9	22.6	45	77.5	23.6	-7.7%
Empowerment: Mental Illness	34	5.8	3.3	45	5.7	4.6	1.3%
Empowerment: Addictions	34	6.1	4.0	44	6.2	4.6	-1.0%
Stigma: Depression	32	23.5	3.7	43	17.7	4.0	24.5% *
Stigma: Schizophrenia	32	17.4	4.7	43	17.5	4.0	-0.4%
Stigma: Personality Disorder	32	17.3	5.1	43	17.4	4.1	-0.3%
Stigma: Alcohol Dependence	32	17.9	4.8	43	17.4	4.1	2.9%
Stigma: Cocaine Dependence	32	15.6	4.9	17.4	43	17.2	-10.8%

🟩 * Lime Green Highlight, $p < 0.05$

Table 8B: Comparison of baseline and final for staff with no additional training

	Additional Training: NO						
	Baseline			Final			Difference
Measurement Scale	N	av	Std. Dev.	N	Mean	Std. Dev.	
Opening Minds Survey	76	46.3	8.2	46	44.4	8.3	-4.2%
Mental Illness: Clinicians' Attitudes	77	37.3	8.5	46	36.7	9.7	-1.5%
Bogardus: Schizophrenia	76	12.3	3.2	46	11.5	3.3	-6.9%
Bogardus: Heroin	75	14.5	4.0	46	12.8	3.6	-11.1% *
Recovery Assessment Scale: Mental Illness	73	50.8	15.3	46	47.2	13.6	-7.1%
Recovery Assessment Scale: Addictions	74	52.6	15.5	45	46.1	15.0	-12.3% *
Willingness Scale	75	19.0	4.3	46	19.4	4.1	2.0%
Attribution Questionnaire	76	85.7	23.4	46	82.7	27.4	-3.4%
Empowerment: Mental Illness	76	6.5	4.3	46	6.2	4.6	-3.8%
Empowerment: Addictions	76	7.8	5.1	45	6.9	4.5	-11.4%
Stigma: Depression	73	22.5	4.6	73	22.5	4.6	-20.0% *
Stigma: Schizophrenia	73	16.5	4.5	44	17.8	3.9	7.9%
Stigma: Personality Disorder	74	15.5	4.3	44	17.8	3.9	14.4% *
Stigma: Alcohol Dependence	73	15.7	4.7	44	17.8	3.9	13.5% *
Stigma: Cocaine Dependence	73	13.1	4.8	44	17.7	3.9	35.0% *

* Lime Green Highlight, $p < 0.05$

5.1.8. Born in Canada

Important differences were observed between staff members who were born in Canada and those born elsewhere. Table 9a indicates that there were many improvements between the baseline and final scores among staff members born in Canada. Most of the changes were significant. By contrast, Table 9b shows far fewer improvements among staff born outside Canada.

One explanation may be that elements of the intervention reflected the cultural experiences of Canadians more so than for those born outside the country; thus resulting in more measurable improvements among those better able to relate to the learning. Future inventions may need to consider a wider range of cultural illustrations of addictions and mental illness to ensure better outcomes among staff members born elsewhere.

Table 9A: Born in Canada: YES

Born in Canada: YES

	Baseline				Final				Difference
Measurement Scale	N	Mean	Std. Dev.	Std. Err.	N	Mean	Std. Dev.	Std. Err.	
Opening Minds Survey	64	43.8	7.7	1.0	52	41.2	8.5	1.2	2.7% $^{+}$
Mental Illness: Clinicians' Attitudes	64	35.7	8.9	1.1	52	32.3	8.5	1.2	3.4% *
Bogardus: Schizophrenia	62	13.7	4.0	0.5	52	12.6	3.5	0.5	3.6%
Bogardus: Heroin	63	11.9	2.7	0.3	52	11.0	2.5	0.3	2.5% $^{+}$
Recovery Assessment Scale: Mental Illness	60	52.5	12.7	1.6	52	51.6	13.2	1.8	3.4%
Recovery Assessment Scale: Addictions	60	55.5	14.4	1.9	51	50.7	14.9	2.1	3.8% $^{+}$
Willingness Scale	60	20.8	4.2	0.5	52	21.2	4.1	0.6	2.9%
Attribution Questionnaire	62	77.4	19.6	2.5	52	75.0	23.0	3.2	4.1%
Empowerment: Mental Illness	63	6.0	3.9	0.5	52	5.4	4.7	0.7	11.7%
Empowerment: Addictions	63	6.9	4.7	0.6	51	6.1	5.0	0.7	10.1%
Stigma: Depression	60	23.5	3.9	0.5	49	18.3	3.7	0.5	2.1% *
Stigma: Schizophrenia	60	17.1	4.9	0.6	49	18.0	3.8	0.5	2.9%
Stigma: Personality Disorder	60	16.1	5.0	0.6	49	17.9	3.9	0.6	3.7% *
Stigma: Alcohol Dependence	60	16.4	5.1	0.7	49	18.0	3.9	0.6	3.7% $^{+}$

* Lime Green Highlight, $p < 0.05$

\+ Green Highlight, $p < 0.10$

Table 9B: Born in Canada: NO

	Born in Canada: NO								
	Baseline				Final				Difference
Measurement Scale	N	Mean	Std. Dev.	Std. Err.	N	Mean	Std. Dev.	Std. Err.	
Opening Minds Survey	58	46.1	8.4	1.1	39	43.7	8.3	1.3	5.2%
Mental Illness: Clinicians' Attitudes	59	37.5	7.1	0.9	39	37.6	10.0	1.6	-0.3%
Bogardus: Schizophrenia	58	13.6	3.7	0.5	39	12.3	3.9	0.6	9.6%
Bogardus: Heroin	58	11.9	3.6	0.5	39	11.3	3.7	0.6	5.0%
Recovery Assessment Scale: Mental Illness	55	49.4	15.0	2.0	39	46.4	14.2	2.3	6.1%
Recovery Assessment Scale: Addictions	57	52.6	15.0	2.0	39	46.1	15.8	2.5	12.4% *
Willingness Scale	58	19.4	4.1	0.5	39	19.8	4.4	0.7	-2.1%
Attribution Questionnaire	57	86.0	27.5	3.6	39	87.4	27.3	4.4	-1.6%
Empowerment: Mental Illness	59	6.2	4.0	0.5	39	6.6	4.2	0.7	-6.5%
Empowerment: Addictions	59	7.3	4.7	0.6	38	7.1	3.9	0.6	2.7%
Stigma: Depression	56	21.8	4.7	0.6	38	17.4	4.0	0.6	20.2% *
Stigma: Schizophrenia	56	16.9	4.4	0.6	38	17.2	4.1	0.7	-1.8%
Stigma: Personality Disorder	57	16.6	4.3	0.6	57	16.6	4.3	0.6	0.0%
Stigma: Alcohol Dependence	56	16.5	4.6	0.6	38	17.2	4.0	0.6	-4.2%
Stigma: Cocaine Dependence	56	14.1	4.8	0.6	38	17.1	4.0	0.7	-21.3% *

🟩 * Lime Green Highlight, $p < 0.05$

5.2 Overall Qualitative Findings

Using a SWOT (Strength-Weakness-Opportunity-Threats) analysis, five structured interviews (1–2 hours each) were conducted with senior managers at all three CHCs to explore their perspectives on the process used to develop the intervention, as well as the intervention itself. Several common themes emerged across the three CHCs.

5.2.1 Time Restrictions

Time restrictions were considered a major drawback for staff engagement and participation in various components of the intervention. Several managers said that many of the intended subjects – especially physicians – were not able to attend some of the educational workshops, be a part of the team of local 'champions,' and/or participate in the art workshops due to resource limitations. Some of the reasons are explicated in the managers' following remarks:

> So the obstacles that I think we faced … in engaging staff is that the staff involvement required time; because you wanted staff participating from all levels of the organization – both from the clinical, from health promotion as examples … I'll speak specifically to clinical – every time you pull a staff from their clinical service role is that's an access issue so it's one less appointment for a client. So having physicians, for example, participate was not – we weren't able to make that happen because physicians' concern was "I'm coming to group – I need to be seeing clients," so there was this competition for time and I think the priority that this group faced was really they prioritize seeing the clients versus participating in some of the activities.

> I think the obstacles are really, for us anyways, is it's always challenging within in our organization for people to take time away from frontline work … it's easier if you're a health promoter … than if you're physician because you have more flexibility in your schedule than somebody who is seeing one-to-one clients every half hour.

> Primarily it's a sense that there's such restrictions on time on staff time. Given the funding environment … provider time is highly scrutinized … and initiatives such as this one … are not resourced … and are often perceived to be in competition with direct services for clients and so that … has plagued this process throughout its 5 years and is sometimes misconstrued as resistance to change. So it's a tough balance to think about the immediate demands on time versus the commitment to improve quality of service to ensure that we are fulfilling our mission, vision, and values to be an inclusive and welcoming organization for people with a history of mental health and substance use.

5.2.2. Tailoring of Various Components

Managers also discussed the need to further tailor the different components of the intervention so that it would better address the specific needs of their CHC. Some recommended including the team of local champions, in reviewing or consulting, prior to the educational workshops and training. The following comments are instructive:

> Making sure that the trainings actually fit the audience you're working and understanding that audience before doing it is critical…each CHC has different audience, difference pool of people, or strategies or interventions but understanding that and then looking at your workshop and trying to manipulate the information in the workshop to meet those needs is needed. I think you need to avoid a one size fits all but rather customize a presentation given the particular variables of that group.

> I think what could be improved is tailoring the educational workshop to fit the environment; so it might've been good to have a planning conversation with the education team and staff from our organization to plan, to identify what their training needs would be rather than have a set training module that you then bring to the organization.

5.2.3. Overall Analysis

Overall, all senior managers reported that the multi-component intervention affected knowledge, attitudes, and behavior. They said that the intervention revealed stigma (intentional or not) within the CHC, which created barriers for clients. They consistently noted that addressing stigmatization barriers and challenges led to improvements in access to care, quality of care, and responsiveness to clients at all three levels (organization, team, and individual). They also indicated benefits for established cultures of reflective practice and/or continuous quality improvement. Lastly, exploring multiple modes of making art was identified as an essential resource with future utility for other types of planning and programming.

The senior managers also indicated some benefits of the intervention for pre-existing anti-oppression work. Specifically, they were aware that some clients were not disclosing and that the intervention was perceived as helping to foster a social environment that made disclosing that much easier. Managers said they planned to continue certain components post-intervention: the team of 'champions,' art workshops, and periodic reviewing of internal policies. There was ambivalence expressed with respect to the benefits of additional training; although one manager did intend to continue with the training and educational workshops when possible.

Many of the senior managers said that there were advantages in using this kind of multi-component intervention to address mental health and substance use-related stigma. They indicated that the mixed-methods approach provided an effective way of engaging a diverse team of staff and gauging knowledge and attitudes; this was especially pronounced with the initial baseline survey. All of them said that the intervention was helpful in improving staff members' knowledge, attitudes, and behavior related to stigma/discrimination toward people with mental health and substance use problems.

The intervention reportedly helped clarify the discourse around recovery, stigma, and discrimination. It allowed staff members to recognize that mental health and substance use was not only a struggle faced by clients – it may also have affected their own personal lives. It also led to increased levels of knowledge, with new language and concepts being introduced into their CHCs. One manager commented that the intervention allowed staff members "to look through the lens of the client and therefore gain a different, more knowledgeable and better awareness of the client's experience around stigma." Another said that the intervention helped improve the attitudes of frontline staff members, who are often the first point of contact. This was important as the reception area is usually a client's starting place, and can involve challenges related to discrimination and stigma. Some managers said that the intervention yielded a better appreciation between the twinning of mental health and substance use, and strengthened the existent harm reduction work being conducted. One person stated that there were many opportunities for implementing this kind of intervention because the CHC is still “on a steep learning curve in terms of mental health and substance use-related stigma.” They referred specifically to how knowledge gathered from the intervention could be used to inform a CHC strategic directions and the language used when working with clients who have mental illness and substance use disorders.

A few senior managers referred to components of the intervention that they thought should be removed or changed due to time constraints. One of these was the training workshops which proved onerous to schedule. Another was the survey tool that was used to capture staff members’ knowledge; some managers considered the tools as taking too much time to complete. Managers also recommended a dedicated program manager/coordinator to each CHC to be more responsive to staff members throughout the intervention. Another recommendation was for additional honorariums for clients’ time and significant increases in the budgeted amounts for participating CHCs. Lastly, they identified the need for a more condensed, shorter intervention.

Staff perspectives

Staff rated the intervention positively whilst indicating some key areas for improvement. One key area was some of the specific questions that were asked in the surveys. A few persons indicated that that they actually felt stigmatized by the questions that were being asked and that some questions could be better worded. Some wondered about the focus on CHCs rather than other healthcare settings such as hospitals. Other staff said that the survey was very long and difficult to complete. A few staff noted that the wording of survey items was at time confusing and that they were unsure how to answer them. A few persons also expressed the view that some questions were not applicable to all experiences or lifestyles and as such were not likely to measure the intended concepts or constructs. Several providers observed that staff turnover accounted for many persons not being exposed to the whole intervention by the final collection point. This observation is confirmed by the final collection rate of 29.0% among participating staff that had been at their current CHC for less than 5 years. Some noted that the training on stigma should be an ongoing exercise and that future programs should address the differences in participation rates when offering such training.

Limitations

There are several limitations that should be considered when interpreting the implications of the above results. These limitations make it difficult to determine the exact extent to which the intervention is the cause of the improvements noted in staff scores. First, there has been a large amount of staff turnover due to the fact that the intervention was conducted over the course of 5 years. A substantial proportion of staff members have not been at their respective CHCs for the entire intervention period. This factor makes it difficult to determine how many staff members were positively affected by the intervention. The lack of consistent exposure to the intervention should be considered in interpreting the findings.

Several tables also reveal missing data for many survey items. As tables 1 and 2 show, missing cases for demographic and CHC role information tended make up between 10% and 19% of the sample. For the measurement scales we also see that there is a pattern of receiving fewer responses the later the question shows up in the survey. For example, for the OMS-HC we see a response rate of 99.3% at baseline and 99.1% at final. For the final measurement scale, the CCHS stigma module for cocaine dependence, there was a response rate of 85.4% at baseline and 80.0% at final. Another limitation of the study is the inability to pair the responses of those staff members who filled out the baseline and final surveys. This was also not possible due to the length of the project and high turnover rates of staff.

6.0 Scaling up and Knowledge Translation

Knowledge Translation and Future Intervention Settings

The power of the ideas contained in the report is evidenced in the significant support that CAMH has subsequently received for further research. Two cluster randomized control trials are currently underway which build on the Opening Minds results. One, a CIHR funded 3-year RCT is taking place in Toronto involving 6 CHCs. Another involving 12 CHCs over two years is underway in Lima, Peru. The latter is funded by Grand Challenges Canada. The investment by Opening Minds in the pilot has thus borne significant local and global fruit.

Such positive developments should not detract from the critical need to pursue further action-research into alternative mechanisms for sustaining attitudinal and behavior changes within organizational settings. Researchers need to examine the efficacy of alternative types of ongoing and self-sustaining primary health care cycles, such as periodic orientations and mandatory staff development programs, for promoting recovery perspectives, and preventing stigma/discrimination. The need for policy incentives at a system level (at the level of LHINs or provincially) to effectively promote organizational focus on the topics will also be essential for sustaining the efforts to date.

The logical next steps are to expand the application to other CHCs, as well other types of primary care (such as Family Health Teams), across the province of Ontario and further afield. Other community health settings are also well suited to the intervention and should be included in dissemination strategies. Hospitals in Ontario and across the country may well be the next research frontier for testing the application. CAMH and Opening Minds may want to consider testing the intervention in specific hospital departments such as emergency rooms as a starting point for this level of research. The results should also be shared with students in varying disciplines. Being informed early of the types of implicit bias that routinely diminish practice should strengthen receptiveness to pro-recovery and destigmatizing lessons and policies. Undergraduates in various health and allied fields, including medical students, stand to benefit from solid preparation at the earliest stage in their professional development. The knowledge that has been garnered should also inform continuing education approaches for health providers already working in the field.

Photo 16: Primary investigators of the anti-stigma initiative, (from left to right) Jaime Sapag, Inés Bustamante, Sireesha Bobbili and Akwatu Khenti visiting a community health centre in Peru.

Photo 17: Sireesha Bobbili (third from right), Special Advisor, Emily Lentinello (standing), Research Coordinator, and champions from the CHCs engaging in the RCT selection process for the CIHR funded anti-stigma initiative.

APPENDIX A: SCALES USED

1. Opening Minds, Mental Health Commission of Canada. Assessing Stigma Towards Mental Illness for Health Care Providers. Opening Minds Survey for Health Care Providers. Used with permission from Opening Minds, Mental Health Commission of Canada.

2. Mental Illness: Clinician's Attitudes Scale (MICA). The MICA scale was developed at the Health Services and Population Research Department, Institute of Psychiatry, King's College London. Kassam A., Glozier N., Leese M., Henderson C., Thornicroft G. (2010) Development and responsiveness of a scale to measure clinicians' attitudes to people with mental illness (medical student version). Acta Psychiatrica Scandinavica 122(2), 153-161. Used with permission from Dr. Graham Thornicroft.

3. Modified Borgadus Social Distance Scale. Used also in: Link, B. G., Cullen, F. T., Frank, J. & Wozniak, J. F. (1987). The social rejection of former mental patients: understanding why labels matter. American Journal of Sociology 92, 1461-1500. Abiodun O. Adewuya a; Roger O. A. Makanjuola . Social distance towards people with mental illness in southwestern Nigeria. 2008 Journal of Psychiatrynt of Australian and New Zealand.

4. From the Carter Center battery of measures. Used with permission from Dr. Patrick Corrigan

5. Willingness Scale: developed by OTGH team in July 2009 but not yet validated.

6. Attribution Questionnaire: The 27-item verison (AQ-27. Corrigan, P.W., Edwards.A., Green, A., Diwan, S.E., & Penn, D.L. (2001) Prejudice, social distance, and familiarity with mental illness. Schizophrenia Bulletin, 27, 219-226. Used with permission from Dr. Patrick Corrigan

7. Based on a new Statistics Canada Stigma Module that has been developed with the Mental Health Commission and Statistics Canada for use in the 2012 Canadian Community Health Survey (CCHS). Used with permission from Dr. Heather Stuart.

APPENDIX B: GUIDING PRINCIPLES

The 13 principles listed below, are the guiding principles created for the development and implementation of the anti-stigma/discrimination and pro recovery intervention for healthcare providers at CHCs.

1. Reducing mental health and substance use stigma/discrimination is a shared responsibility – everybody can make a difference.
2. Changing attitudes about mental health and substance use stigma/discrimination is not enough – it is necessary to focus on reducing discriminatory behaviours.
3. The focus should be on mental health promotion, human rights protection, recovery and wellness, to build a sense of promise and hope.
4. Prevention of stigma/discrimination is essential.
5. Anti-stigma and anti-discrimination initiatives must be part of a comprehensive long- term process.
6. Interventions should include inter-departmental and interdisciplinary measures and responses.
7. Strong organizational commitment and leadership is necessary in terms of developing anti-stigma/discriminatory policies and procedures.
8. Mental health consumers/survivors must play a critical role in planning, design, implementation, and evaluation of anti-stigma efforts.
9. Cultural appropriateness and relevance is necessary to have an impact. All efforts should be made to address this challenge.
10. Anti-stigma anti-discrimination strategy as a component of an overall strategy to strengthen/integrate mental health/addictions within primary health care.
11. Special attention should be paid to burnout/mental health problems of staff.
12. The intervention should be simple and feasible.
13. Continuous evaluation and research should be incorporated into the intervention.

APPENDIX C: POLICY ANALYSIS TOOL

Policy Content and Language Do the policies include or discuss the following word/concepts? If yes, how?	**Policies**					
	Policy 1	**Policy 2**	**Policy 3**	**Policy 4**	**Policy 5**	**Policy 6**
Mental Health Clients						
Supportive Environment						
Supportive/Positive Relationship Building						
Cultural Appropriateness of Communication and Health Care Delivery						
Quality of Care						
Inclusion						
Substance Users						
Stigma						
Discrimination						
Anti-oppression						
Human Rights						
Dignity						
Respect						
Fair/ Fairness						
Recovery						
Harm reduction						
Client-centered care						

Self determination						
Access to Care (e.g. How does policy describe or affect access to care? Will some clients have differential access? Different impact?)						
Equity						
Client Rights						
Does the policy identify vulnerable/marginalized populations?						
Does the policy identify the determinants of health inequities for this population?						
Are the facilities available to anyone who requires treatment?						
Does the policy state that “no person is denied access to facilities or treatment on the basis of economic factors, race, colour, sex, language, religion, political opinion, nationality, ethnic, indigenous, social origin, property, disability, birth, age or status”?						
Does the policy state that staff will interact with service users in a respectful way and treat service users with dignity, humanity and respect?						
Does the policy state that “no services users will be subjected to verbal, mental, physical and sexual abuse”						
Does the policy identify populations that may experience transportation barriers?						
Does the policy identify barriers in accessing care (physical disabilities, low SES, geographically isolated)?						
Does the policy classify MHSUPs as persons with disability?						
How frequently will the policy be reviewed?						
Date of last policy update? (dd/mm/yyyy)						
What method is used to convey each policy to staff?						

What measures are in place to ensure the policy is utilized?						
What measures are in place to ensure the policy is successful?						
Is there staff training and orientation for each policy (Yes/No)						
Where are the policies located/ housed? e.g. public folder						
Are any of the policies readily accessible to clients (Yes/No/ N/A)						
Does the policy outline how it will be implemented? (Yes/No)						
What are the unintended effects of this policy? (e.g. health, specific effects to a certain group)						
Does the policy include stigma and discrimination as a reason for complaints (Yes/No/ N/A)						
Do the policies outline how the clients can file a complaint?						
Is the complaints process formal or informal?						
Does the complaint process include confidentiality? (Yes/No/N/A)						
What types of behaviours require disciplinary actions?						
Who is identified as the contact person for filing complaints?						
Does the policy include a resolution process(Yes/No/ N/A)						

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