Mental Health Commission of Canada

Commission de la santé mentale du Canada

Opening Minds in High School:

Results of a Contact-Based Anti-Stigma Intervention – Partnership Program Saskatoon

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2 OPENING MINDS: CHANGING HOW WE SEE MENTAL ILLNESS

As part of its 10-year mandate, The Mental Health Commission of Canada (MHCC) has embarked on an anti-stigma initiative called Opening Minds (OM) to change the attitudes and behaviours of Canadians towards people with a mental illness. OM is the largest systematic effort undertaken in Canadian history to reduce the stigma and discrimination associated with mental illness. OM is taking a targeted approach, initially reaching out to healthcare providers, youth, the workforce and media. OM's philosophy is to build on the strengths of existing programs from across the county, and to scientifically evaluate their effectiveness. A key component of these program evaluations is contact-based educational sessions, where target audiences hear personal stories from, and interact with, individuals who have recovered or are successfully managing their mental illness. OM's goal is to replicate effective programs nationally, develop new interventions to address gaps in existing programs and add other target groups over time.

For more information, go to: www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx

3 BACKGROUND

Stigma and discrimination have gained the attention of the public health and policy communities as a hidden and costly burden cause by society's prejudicial reaction to people with a mental illness (World Health Organization, 2001), Stigma and discrimination pose major obstacles in virtually every life domain, carrying significant negative social and psychological impacts. Reducing stigma and discrimination have become important policy objectives at both international and national levels (Sartorius & Schulze, 2005). The 2009 launch of the Mental Health Commission's *Opening Minds* anti-stigma/anti-discrimination initiative marked the largest systematic effort to combat mental illness-related stigma in Canadian History.

The *Opening Minds* program has partnered with a number of programs that deliver contact-based education to primary and high school students throughout Canada. Contact-based education involves people who have experienced a mental illness to educate students by telling their personal stories and allowing time for active discussion. In some cases, teacher lesson plans accompany the classroom presentations.

This report is intended to provide programs with an overview of their key evaluation results. A subsequent initiative will examine each program's components in depth in order to highlight the active ingredients that are associated with the largest change.

3.1 Program Overview

The Partnership Program in Saskatoon is a public awareness program provided by Schizophrenia Society of Saskatchewan. The program is aimed at reducing stigma and misconceptions associated with mental illness and includes members of the Society share their knowledge and experiences with numerous audiences. The goal is to promote public awareness of mental illness as a treatable biological disease of the brain, to reduce the stigma and misconceptions associated with mental Illness, and to have people with mental illness who are in recovery speak at presentations to put a positive face on the illness. The target audiences include young people who are most predisposed to the mental illness, students, community agencies, services providers, and the general public. The program described in this report targets high school students.

Presentations are generally one hour in individual classes from grade 9 to grade 12 in the high school system. Teams of two to four people including a person living with schizophrenia or another type of mental illness, a family member, and a mental health professional deliver presentations together. The presenter with the illness describes living with schizophrenia (or other mental illness), the family member outlines the impact of the disease on the family unit, and the mental health professional provides a clinical overview of the mental illness. In many instances, the mental health professional has hands-on experience with people who live with schizophrenia and other psychiatric issues. Each member is an expert in their own right and an equal player in the program. The personal stories usually begin with the person talking about their lives before symptoms, when they were just like everybody else. Then the symptoms began, the individual became ill and the speaker describes the difficulties and stigma they had to face as well as their path to recovery. The stories rap up with the positive things they have in their lives, the successes they have had, and their accomplishments. Speakers are helped by the coordinator to develop and practice their stories and become confident as a public speaker. The program has a handbook for developing the speakers' portion of the presentation and every member receives a copy to keep.

4 EVALUATION METHODS

Students were surveyed before and after the contact-based intervention.

All programs participating in this network initiative used the same pre- and post-test survey questionnaires to collect their data. These surveys were adapted from items used by the six contact-based programs that participated in the instrument development phase of this project. The resulting Stigma Evaluation Survey contained 22 self-report items. Of these:

- 11 items measured **stereotyped attributions**
    - controllability of illness – 4 items,
    - potential for recovery – 2 items, and
    - potential for violence and unpredictability – 5 items
- 11 items measured expressions of **social tolerance**, which include both social distance and social responsibility items
    - desire for social distance – 7 items, and
    - social responsibility for mental health issues – 4 items

All items were scored on a 5-point agreement scale, ranging from strongly agree to strongly disagree. To avoid potential response sets some items were positively worded while others were negatively worded. Items were scored so that higher scores on any item would reflect higher levels of stigma. The scales had good reliability in this pooled sample with a pre-test Cronbach's alpha of 0.82 for the Stereotype Scale and 0.84 for the Social Tolerance Scale. Both are well above the conventional threshold of 0.70 indicating that they are highly reliable. Information on gender, age, grade, and prior contact with someone with a mental illness (close friend or family member) was also collected.

Six hundred and seven pre-tests and 618 post-test surveys were collected (a total of 1225 surveys), but of these, only 443 were able to be matched for analysis. Given the large number of unmatched surveys and the potential for introducing bias by leaving out data from subjects that could not be matched, results presented here are unmatched. This means that the chances of finding statistically significant differences will be reduced. Absolute percentage differences that are in excess of 10% will be used to highlight differences that are potentially noteworthy, even if they don't reach statistical significance.

5 RESULTS

5.1 Sample Characteristics

Six hundred and seven students completed the pre-test survey and 618 completed the post-test. The characteristics of the pre- and post-test groups are presented in Table 1. Sample characteristics are similar between the pre- and post-test groups. A greater proportion of females participated. The majority of students were 16 or 17 years old.

Table 1. Sample Characteristics

	Pre-test % (N=607)	Post-test % (N=618)
Gender		
Male	39.5% (238)	39.6% (239)
Female	60.5% (364)	60.4% (365)
Missing	-- (5)	-- (14)
Age		
11	0.7% (11)	2.3% (14)
12	5.0% (30)	6.2% (37)
13	7.2% (43)	7.0% (42)
14	12.2% (73)	10.8% (65)
15	7.0% (42)	6.0% (36)
16	22.9% (137)	21.0% (126)
17	35.0% (209)	35.8% (215)
18+	8.5% (51)	10.9% (53)
Missing	-- (3)	-- (17)
Grade		
6	0.8% (5)	2.8% (17)
7	7.1% (43)	6.2% (37)
8	6.5% (39)	6.7% (40)
9	14.2% (86)	11.2% (67)
10	7.3% (44)	6.2% (37)
11	31.5% (190)	33.0% (197)
12	32.6% (197)	33.8% (202)
Missing	-- (3)	-- (21)
Contact: Does someone you know have a mental illness (multiple responses accepted)		
No	20.4% (116)	19.1% (112)
Uncertain	19.5% (111)	16.1% (94)
Close friend	9.5% (54)	14.0% (81)
Family member	19.3% (110)	22.7% (133)
Somebody else	21.6% (123)	22.7% (133)
I do	21.1% (120)	21.2% (124)
Missing	-- (35)	-- (17)

5.2 Stereotyped Attributions

Stereotyped attribution items are shown in **Tables 2, 3** and **4**. For ease of presentation, items were recoded into three groups: agree (strongly agree and agree), neutral, and disagree (disagree and strongly disagree). Table 2 shows the majority of respondents held positive (non-stereotypical) attitudes toward people with a mental illness on the controllability items. For example, before the intervention students tended to disagree with the common stereotypes people with a mental illness could snap out of it if they wanted (79% disagree), get what they deserve (79% disagree), tend to bring it on themselves (75% disagree), or that people with mental illnesses often don't try hard enough to get better (74% disagree).

Also reported in **Table 2** is the change score from pre-test to post-test. All four of the Controllability items changed in the expected direction with the largest positive change being for the item "Most people with mental illnesses get what they deserve." At baseline, 79% disagreed with this statement whereas 83% disagreed at post-test (a 5% positive change).

Table 2. Controllability Items

Stereotyped Attributions Items	Pre-test % (N=605)	Post-test % (N=617)	% Change
4. People with a mental illness tend to bring it on themselves			
Strongly disagree/disagree	75.4% (453)	78.6% (481)	3.2
Unsure	19.5% (117)	15.4% (94)	-4.1
Strongly agree/agree	5.2% (31)	6.0% (37)	0.8
Missing	-- (4)	-- (5)	
5. People with mental illnesses often don't try hard enough to get better.			
Strongly disagree/disagree	73.8% (437)	76.8% (466)	3.8
Unsure	19.4% (115)	18.0% (109)	-1.4
Strongly agree/agree	6.8% (40)	5.3% (32)	-1.5
Missing	-- (13)	-- (10)	
6. People with a mental illness could snap out of it if they wanted to.			
Strongly disagree/disagree	79.2% (473)	80.6% (485)	1.4
Unsure	14.4% (84)	13.3% (80)	-0.8
Strongly agree/agree	6.7% (40)	6.1% (37)	-0.6
Missing	-- (8)	-- (15)	
14. Most people with a mental illness get what they deserve.			
Strongly disagree/disagree	78.8% (469)	83.4% (508)	4.6
Unsure	18.8% (112)	14.4% (88)	-4.4
Strongly agree/agree	2.4% (14)	2.1% (13)	-0.3
Missing	-- (10)	-- (11)	

Table 3 shows the stereotyped attributions for the recovery items. Again, prior to the intervention, the majority of respondents held positive (non-stereotypical) attitudes toward people with a mental illness on both items. At post-test, both showed a positive change with the greatest for the item "Most people with a mental illness are too disabled to work" (a 9% positive change). There was a 7% positive change for the item "People with a mental illness need to be locked away."

Table 3. Recovery Items

Stereotyped Attributions Items	Pre-test % (N=605)	Post-test % (N=617)	% Change
3. People with a mental illness are too disabled to work.			
Strongly disagree/disagree	68.2% (215)	77.4% (475)	9.2
Unsure	24.0% (45)	15.6% (96)	-8.4
Strongly agree/agree	7.8% (33)	7.0% (43)	-0.8
Missing	-- (2)	-- (3)	
15. People with serious mental illnesses need to be locked away.			
Strongly disagree/disagree	75.2% (452)	82.2% (502)	7.0
Unsure	19.8% (119)	13.9% (85)	-5.9
Strongly agree/agree	5.0% (30)	3.9% (24)	-1.1
Missing	-- (4)	-- (6)	

Table 4 shows the stereotyped attributions for violence and unpredictability. All five items changed in a positive direction. The largest change was for the item "People with a mental illness are often more dangerous than the average person." On the post-test, 65% of respondents disagreed with the statement, reflecting a 20% improvement; this was the largest positive change realized for any one item. The second highest positive shift was seen for the item "People with a mental illness often become violent if not treated," with a 17% positive shift.

Table 4. Violence/Unpredictability Items

Stereotyped Attributions Items	Pre-test % (N=605)	Post-test % (N=617)	% Change
7. People with a mental illness are often more dangerous than the average person.			
Strongly disagree/disagree	45.3% (270)	64.8% (394)	19.5
Unsure	33.9% (203)	21.4% (130)	-12.5
Strongly agree/agree	20.9% (125)	13.8% (84)	-7.1
Missing	-- (7)	-- (9)	
8. People with a mental illness often become violent if not treated.			
Strongly disagree/disagree	27.3% (164)	44.2% (270)	16.9
Unsure	49.8% (299)	38.5% (235)	-11.3
Strongly agree/agree	23.0% (138)	17.3% (106)	-5.7
Missing	-- (4)	-- (6)	
10. Most violent crimes are committed by people with a mental illness.			
Strongly disagree/disagree	60.9% (363)	73.6% (447)	12.7
Unsure	26.2% (156)	19.4% (118)	-6.8
Strongly agree/agree	12.9% (77)	6.9% (42)	-6.0
Missing	-- (9)	-- (10)	
11. You can't rely on someone with a mental illness.			
Strongly disagree/disagree	58.5% (349)	67.6% (409)	9.1
Unsure	29.6% (177)	26.3% (159)	-3.3
Strongly agree/agree	11.9% (71)	6.1% (164)	-5.8
Missing	-- (8)	-- (12)	
12. You can never know what someone with a mental illness is going to do.			
Strongly disagree/disagree	24.0% (143)	35.5% (215)	11.5
Unsure	35.4% (211)	37.5% (227)	2.1
Strongly agree/agree	40.6% (242)	27.1% (164)	-13.5
Missing	-- (9)	-- (11)	

5.3 Expressions of Social Tolerance

Social tolerance items are shown in **Tables 5** and **6**. **Table 5** presents the items that relate to the expression of social distance. Prior to the intervention, the majority of students showed non-stigmatizing responses for all items but one, with positive responses ranging from 57% to 82%. Just over one quarter (26%) disagreed with the item that involved the most intimate social interaction prior to the intervention, "If I know someone had a mental illness I would not date them."

All of the seven items shifted in a positive direction, showing increased tolerance at the post-test. The largest positive change was seen for the item "I would try to avoid someone with a mental illness." At baseline, 71% disagreed with this item. At the post-test this increased to 81%, indicating an 11% positive shift.

Table 5. Social Distance Items

Stereotyped Attributions Items	Pre-test % (N=605)	Post-test % (N=617)	% Change
18. I would be upset if someone with a mental illness always sat next to me in class.			
Strongly disagree/disagree	69.8% (411)	80.1% (487)	10.3
Unsure	20.4% (120)	14.3% (87)	-6.1
Strongly agree/agree	9.8% (58)	5.6% (34)	-4.2
Missing	-- (16)	-- (9)	
19. I would not be close friends with someone I knew had a mental illness.			
Strongly disagree/disagree	70.5% (416)	76.6% (465)	6.1
Unsure	23.2% (137)	18.6% (113)	-4.6
Strongly agree/agree	6.3% (37)	4.8% (29)	-1.5
Missing	-- (15)	-- (29)	
20. (R) I would visit a classmate in hospital if they had a mental illness.			
Strongly disagree/disagree	72.1% (423)	73.0% (181)	0.9
Unsure	21.0% (123)	20.6% (46)	-0.4
Strongly agree/agree	7.0% (41)	6.5% (30)	-0.5
Missing	-- (18)	-- (14)	
21. I would try to avoid someone with a mental illness.			
Strongly disagree/disagree	71.2% (412)	81.7% (491)	10.5
Unsure	22.3% (129)	15.1% (91)	-7.2
Strongly agree/agree	6.6% (38)	3.2% (19)	-3.4
Missing	-- (26)	-- (16)	
22. (R) I would not mind it if someone with a mental illness lived next door to me.			
Strongly disagree/disagree	77.0% (453)	79.5% (482)	2.5
Unsure	15.0% (88)	12.9% (78)	-2.1
Strongly agree/agree	8.0% (47)	7.6% (46)	-0.4
Missing	-- (17)	-- (11)	
24. If I knew someone had a mental illness I would not date them.			
Strongly disagree/disagree	25.8% (152)	34.6% (208)	8.8
Unsure	48.3% (285)	50.3% (303)	2.0
Strongly agree/agree	25.9% (153)	15.1% (91)	-10.8
Missing	-- (15)	-- (15)	
25. I would not want to be taught by a teacher who had been treated for a mental illness.	58.7% (345)	66.2% (400)	7.5
Strongly disagree/disagree	30.4% (179)	26.2% (158)	-4.2
Unsure	10.9% (64)	7.6% (46)	-3.3
Strongly agree/agree	-- (17)	-- (13)	
Missing			

Note: (R) signifies the item was reverse coded in the scale calculation. Higher scale scores reflect higher levels of stigma.

Social responsibility items are presented in **Table 6**. Before the intervention, students were generally socially responsible when a time commitment was not involved, such as sticking up for someone who had a mental illness if they were being teased (81%) or telling a teacher a student was being bullied (81%). The greatest improvement was seen for the item "I would volunteer my time to work in a program for people with a mental illness," with a 9% positive shift.

Table 6. Social Responsibility Items

Stereotyped Attributions Items	Pre-test % (N=605)	Post-test % (N=617)	% Change
28. (R) I would tell a teacher if a student was being bullied because of their mental illness.			
Strongly disagree/disagree	81.2% (479)	81.6% (492)	0.4
Unsure	13.9% (82)	13.1% (79)	-0.8
Strongly agree/agree	4.9% (29)	5.3% (32)	0.4
Missing	-- (15)	-- (14)	
32. (R) I would stick up for someone who had a mental illness if they were being teased.			
Strongly disagree/disagree	81.4% (478)	85.3% (516)	3.9
Unsure	14.7% (86)	11.7% (71)	-3.0
Strongly agree/agree	3.9% (23)	3.0% (18)	-0.9
Missing	-- (18)	-- (12)	
33. (R) I would tutor a classmate who got behind in their studies because of their mental illness.			
Strongly disagree/disagree	54.9% (322)	60.0% (363)	5.1
Unsure	31.5% (185)	28.1% (170)	-3.4
Strongly agree/agree	13.6% (80)	11.9% (72)	-1.7
Missing	-- (18)	-- (12)	
34. (R) I would volunteer my time to work in a program for people with a mental illness.			
Strongly disagree/disagree			
Unsure	41.5% (244)	50.2% (304)	8.7
Strongly agree/agree	41.2% (242)	35.7% (216)	-5.5
Missing	17.3% (102)	614.0% (85)	-0.3
	-- (17)	-- (12)	

Note: (R) signifies the item was reverse coded in the scale calculation. Higher scale scores reflect higher levels of stigma.

5.5 Program Success

In order to provide an overall measure of the success of the intervention, we chose an a priori cut-off score of 80% correct. Though somewhat arbitrary, we have used this cut-off in previous work to count the number of students who achieve an A grade or higher following an educational session. More specifically, success was measured by comparing the proportion of students who obtained 80% or more correct (non-stigmatizing) answers on the post-test compared to the pre-test.

Figure 1 shows the cumulative percent of the Stereotyped Attribution items reflecting non-stigmatizing responses. Prior to the intervention, 26% of students gave a non-stigmatizing response to at least 9 of the 11 questions (signifying an A grade). At post-test, this was 46% (reflecting a 20% improvement).

Figure 1. Cumulative Percent of Stereotype Scale Items Reflecting Non-Stigmatizing Response

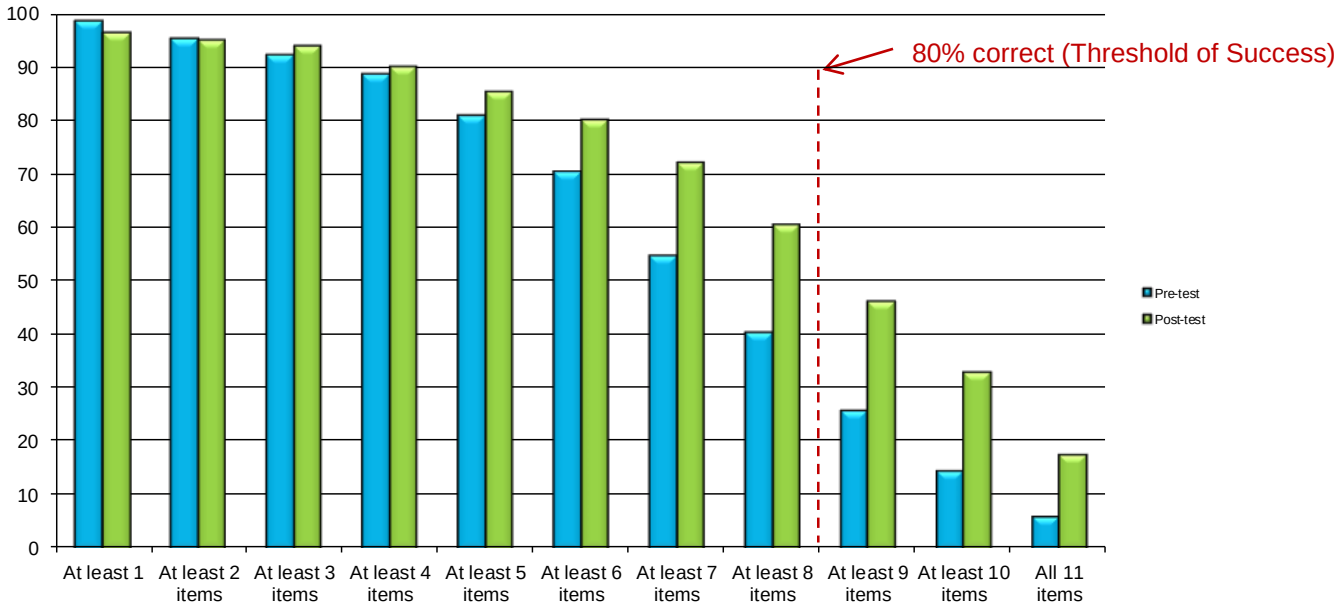
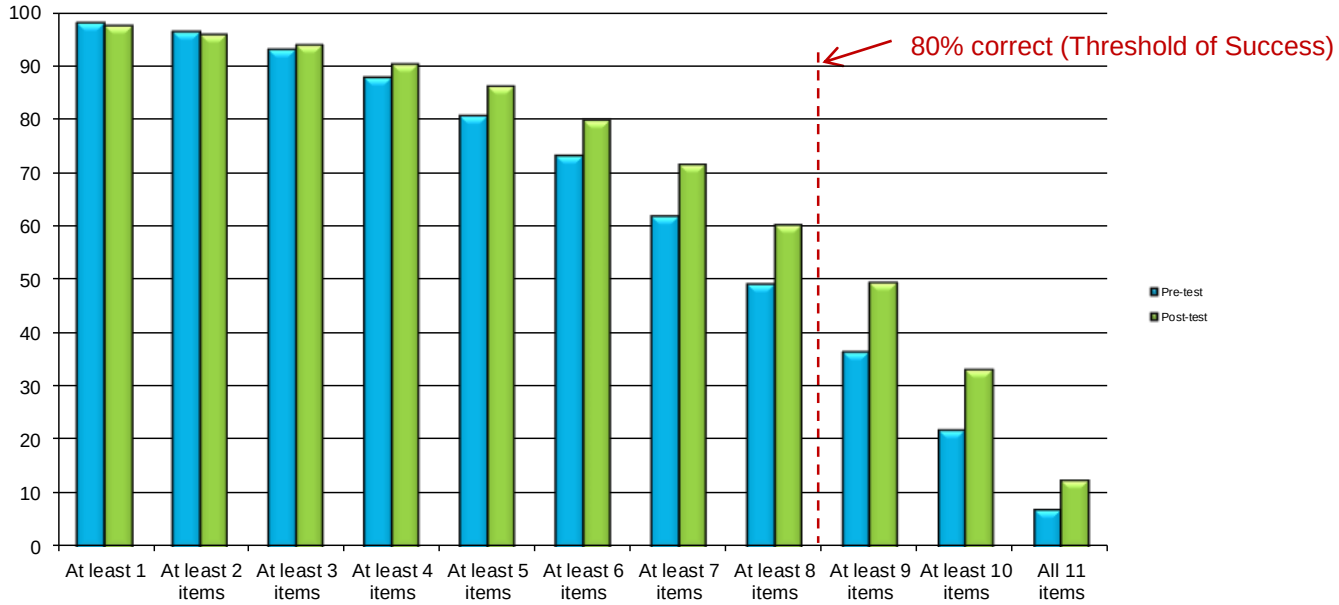


Figure 2 shows the cumulative percent of the Social Tolerance items reflecting non-stigmatizing responses. Prior to the intervention, 37% of students gave a non-stigmatizing response to at least 9 of the 11 questions (signifying an A grade). At post-test, this was almost 50% (reflecting a 13% improvement).

Figure 2. Cumulative Percent of Tolerance Items Reflecting Non-Stigmatizing Response



6 SUMMARY AND CONCLUSIONS

This report describes the results of a contact-based anti-stigma intervention provided to high school students. The results show that this program was successful in improving the proportion of students who got 80% of the answers correct, so received an “A” grade on the tests used to assess social stereotypes and social tolerance. The program achieved greater success in diminishing stereotyped attitudes (21% more students received an “A” grade at post-test) than expressions of social tolerance (13% more students received an “A” grade at post-test).

The positive findings suggest that there are components of the program that work, and program staff consider the speakers’ stories central to their success. Although the program appears to be successful, particularly on the items for social stereotypes dealing with dangerousness and violence, a small number of students continue to hold stigmatizing beliefs despite their participation. In the future it might be beneficial for the speakers to deal more directly with areas related to social tolerance.

Appendix A

Percent Non-Stigmatizing Endorsement of Stereotyped Items

	Pre-test % (n=553)	Post-test % (n=575)
None	1.6% (9)	3.7% (21)
At least 1	98.4% (544)	96.3% (554)
At least 2 items	95.3% (527)	94.8% (545)
At least 3 items	92.2% (509)	93.9% (540)
At least 4 items	88.6% (490)	89.9% (517)
At least 5 items	80.8% (447)	85.2% (490)
At least 6 items	70.5% (390)	80.0% (460)
At least 7 items	54.8% (303)	72.2% (415)
At least 8 items	40.5% (224)	60.5% (348)
At least 9 items	25.7% (142)	46.3% (266)
At least 10 times	14.5% (80)	32.9% (189)
All 11 times	6.0% (33)	17.7% (102)

Percent Non-Stigmatizing Endorsement of Social Tolerance Items

	Pre-test % (n=561)	Post-test % (n=581)
None	2.0% (11)	2.6% (15)
At least 1	98.0% (550)	97.4% (566)
At least 2 items	96.3% (540)	95.7% (556)
At least 3 items	92.9% (521)	93.8% (545)
At least 4 items	87.7% (492)	90.2% (524)
At least 5 items	80.6% (452)	86.2% (501)
At least 6 items	73.1% (410)	79.7% (463)
At least 7 items	62.0% (348)	71.6% (416)
At least 8 items	49.2% (279)	60.2% (350)
At least 9 items	36.5% (205)	49.4% (287)
At least 10 times	22.1% (124)	33.4% (194)
All 11 times	7..0% (39)	12.7% (74)

Challenged, observations and suggestions noted by program staff

These are just some points to ponder if you're doing presentations. The program is rewarding but issues do crop up that are worth preparing for.

- Teachers often reschedule presentations at the last minute after team members have scheduled their time and taken time off work to do the presentation.
- Presentations are sometimes shortened without notice. The Partnership program always request they present when they can have at least one full hour because some schools have shorter days (40 minute classes). The teachers often forget to notify the program if this changes so presenters have to be brief.
- The scheduled teacher may be sick on the day of the presentation so a substitute may be present who has no idea what the program is about. Presenters have to be prepared for that.
- There may be students in an audience experiencing a mental illness who start crying during the presentation and they really need help. Presenters need to be prepared to direct them to the appropriate mental health services.
- Teachers may not have done any prep work with students on mental illness or told them about the program that will be there that day so speakers need to be prepared that this audience knows nothing at all about mental illness.
- Some students are disengaged. They don't ask questions at the end of the presentation. Most are interested but this does happen at times. Speakers need to be prepared to be interactive with the audience and involve them in the presentation. Ask them questions.
- Anyone delivering the program must phone teachers, not just email them to schedule presentations. Program delivery is not a priority for them. Programs could frame a call saying "We would like to present on such and such a date, will that work for you?" Otherwise teachers may not book program at all.
- Occasionally, there are rude audience members who laugh at the people with a mental illness making the presentation. Some teachers have little discipline in their class so speakers might have to ask the student to leave the class or to show some respect. Speakers are encouraged to call them on it in front of everyone. Their attitude often changes quickly.
- Some audience members like to take over. Programs shouldn't let them, and instead remember what the purpose of the presentation is. Presenters should be treated with respect.
- A presenter with a mental illness may show up to present but they may be having major symptoms of psychosis or mania. Other speakers should be prepared to offer to read their story for them. If a presenter is truly psychotic, the presentation should be cancelled and the speaker taken to the hospital, doctor's or counselor's office. If they're simply just having a bad day and can't speak, other speakers can take over. The audience doesn't need to know all of their personal problems.
- Always include a health professional to give a clinical overview of mental illness and provide the facts. They must represent clients with a mental illness in a positive way or not present again.
- Program should have speaking skills meetings with presenters.
- Update presenter's presentations regularly as their circumstances change over time.
- Keep the facts on mental illness current. Some of the stats change every so often.

- Make sure presenters know of all the mental health services they can access in the community. Speakers are a support to them but are not their psychiatrist or psychologist. Always remember that.
- Clients with a mental illness, family members of those with a mental illness, and health professionals are all considered equals in the Schizophrenia Society's Partnership Program. Family members or health professionals can't play God with team members. They are to treat each other with respect and as equal players on the team.
- Presenters with a mental illness are not allowed to use the names of psychiatrists and healthcare workers in their presentation if they've had a negative experience. Presenters cannot slander anyone in their presentations by name.
- Remember language is important. People living with schizophrenia and bipolar disorder are not "schizophrenic or schizos" or "bipolar" – they have schizophrenia, they have bipolar disorder. They are not their illness. We don't call people with cancer "cancerous."