Mental Health
Commission
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la santé mentale
du Canada

Building and Delivering Successful Anti-stigma Programs for Healthcare Providers

Results of a Qualitative Study

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1 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. Target groups were selected based on feedback received in the 2006 national consultation undertaken by the Senate Committee on Social Affairs, Science and Technology and other expert opinion (Pietrus, 2013). OM's philosophy is not to reinvent the wheel, but rather to build on the strengths of existing programs from across the country. As a result, OM has actively sought out such programs, few of which have been scientifically evaluated for their effectiveness.

Now partnering with more than 100 organizations, OM is conducting evaluations of the programs to determine their success at reducing stigma. OM's goal is to replicate effective programs nationally.

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

For more information, go to: http://www.mentalhealthcommission.ca/English/initiatives-and-projects/opening-minds

2 BACKGROUND

Opening Minds coordinated and funded a series of evaluation projects of anti-stigma programs for healthcare providers, one of OM's key target groups, with the purpose of determining program outcomes (Pietrus, 2013). While OM's partner programs in general have shown overall evidence of positive change, there has been considerable variation among the programs in terms of their effectiveness. As well, among the programs that have had the strongest results, they were not uniform with respect to their target audience, program content, program length, type of social contact provided or program setting (see Knaak, Modgill & Patten, 2014; Pietrus, 2013).

As such, a qualitative investigation was undertaken to examine programs in greater depth and detail. The purpose of the qualitative research was to identify best practices and strategies among OM's partner programs, to identify key program ingredients for effective stigma reduction, to better understand why some programs were more successful than others and to gain further theoretical insight to the process of building successful anti-stigma programs for healthcare providers.

3 METHODOLOGY

The purpose of the research was to explicate the process for designing and delivering successful anti-stigma programs for healthcare providers. This included identifying critical components related to program design (i.e., content ingredients necessary for stigma reduction), critical components related to program delivery and other key ingredients, strategies, practices or processes integral to a program's success. A qualitative approach was decided as the most suitable as we were seeking to understand programs in greater depth and detail, and were also interested in learning about the whats, hows and whys of anti-stigma programming for healthcare providers from the perspectives and experiences of program stakeholders themselves. The specific methodology chosen for the research was that of grounded theory, as it is a good methodological fit for questions of process and where inductive theory-building is a main research goal (Charmaz, 2006; Strauss & Corbin, 1988).

The primary source of data was in-depth interviews with stakeholders from OM's partner programs (see **Appendix A** for details about partner programs included in this research). A total of 23 such interviews were conducted -- 17 with program leads and 6 with persons with lived experience of a mental illness involved in program delivery. The purpose of these interviews was to gather information about the program, solicit opinions about best practices, key ingredients, as well as challenges and successes in program implementation. Interviews were tape recorded with respondents' informed consent and transcribed by the researcher. All interviews were conducted with a promise of confidentiality and anonymity in any reporting of results.

In addition to in-depth interviews with program stakeholders, the following supplementary data sources were used:

- direct program observation (n=8; 4 programs were observed in person via site visits; 4 programs were observed via video);

- document inventory and review (n=48) including facilitator’s manuals, PowerPoint presentations, speaker recruitment/training packages, course syllabi, handouts, videos/links to videos, partner-produced reports, marketing materials, and other program materials;
- analysis of qualitative feedback (i.e., open ended questions on evaluation surveys) from program participants across the various programs (n=1812);
- supplementary follow-up/clarification interviews to glean additional program details or information needed for saturation of emerging categories and themes (n=12).

Data collection activities took place between January 2013 and November 2013. Data analysis proceeded via grounded theory’s constant comparison method, which is characterized by a specific procedure for coding. Open (line-by-line) coding was first undertaken to identify themes and key ideas in the data. Axial coding was then employed to specify the thematic categories and to describe each theme to the point of theoretical saturation. Then, selective and theoretical coding was used to identify the relations among the categories/themes. A single coder was used. The analysis led to the generation of a model articulating the process for building and delivering successful anti-stigma programs for healthcare providers. This process, along with its accompanying steps, strategies and imbedded best practices, is described below.

4 RESULTS

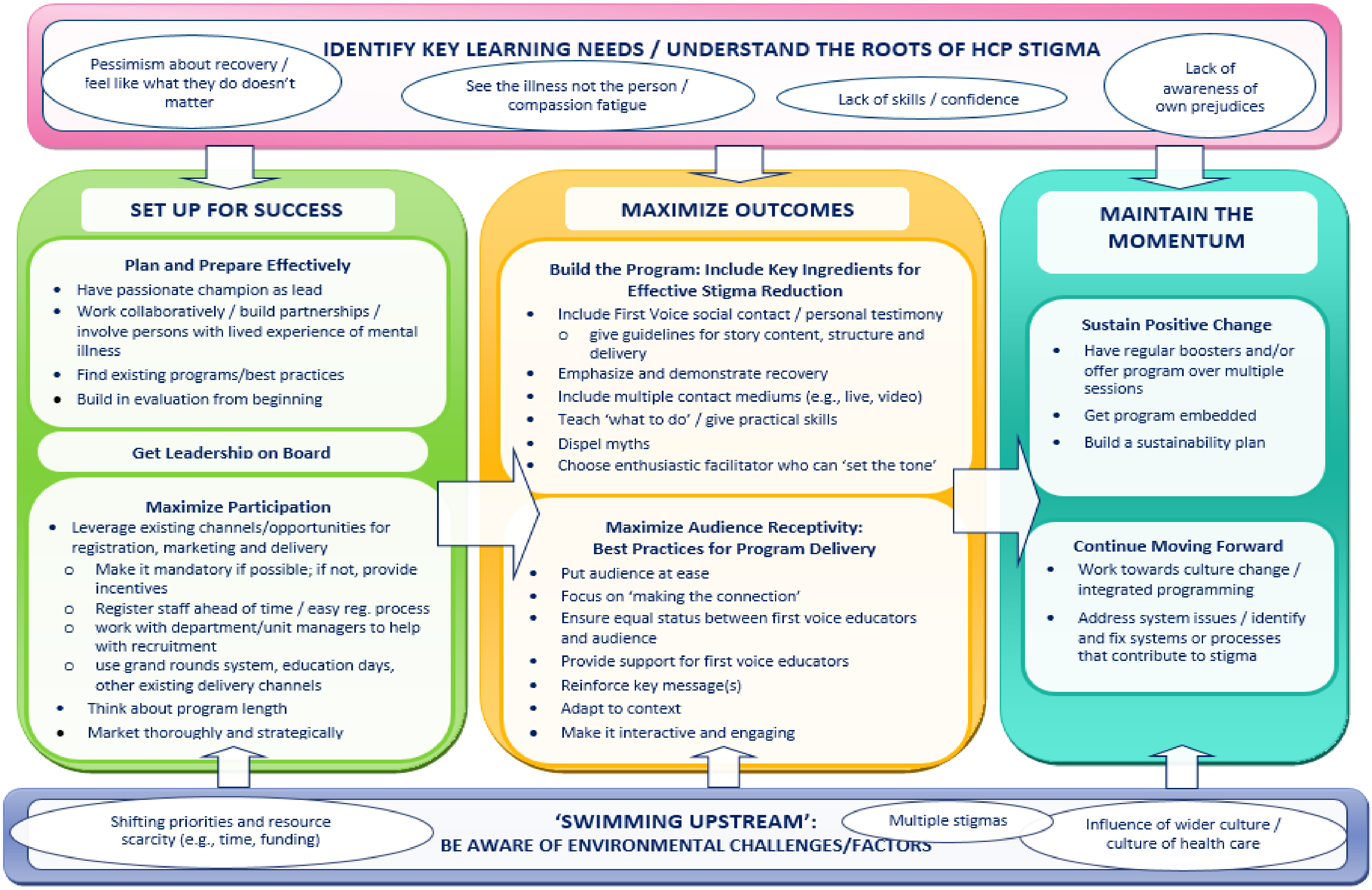
The findings from this research led to the generation of a theoretical model articulating the process of designing and delivering successful anti-stigma programming to healthcare providers. This includes both practicing healthcare providers as well as healthcare providers-in-training (i.e., students). As some differences emerged between student and practicing healthcare provider programs with respect to key practices and strategies for successful programming, two versions of the process model were generated – one for designing and delivering successful anti-stigma programs for practicing healthcare providers **(Figure 1)** and one for designing and delivering successful anti-stigma programs for student healthcare providers **(Figure 2)**.

As the key elements for both models are highly similar and overlapping, findings are discussed together, with differences noted where applicable. As highlighted in the model(s), the process for designing and delivering successful anti-stigma programming for healthcare providers can be described through the following main themes or ‘stages’:

- identifying key learning needs;
- preparing and planning effectively;
- getting leadership on board (practicing healthcare provider programs only);
- maximizing participation (practicing healthcare provider programs only);
- building the program using key ingredients for effective stigma reduction;
- delivering the program in a way that maximizes audience receptivity;
- maintaining the momentum using best practices and strategies for program sustainability; and
- being aware of/attending to external factors and ongoing challenges.

Each of the key themes or stages have a number of embedded best practices, strategies and/or activities that were identified by respondents as being important for program success. These are highlighted in the models themselves (see Figures 1 and 2), and are also described in more detail below.

Figure 1. Process Model for Successful Anti-Stigma Programming for Practicing Healthcare Providers



IDENTIFY KEY LEARNING NEEDS / UNDERSTAND THE ROOTS OF HCP STIGMA

- Pessimism about recovery / feel like what they do doesn't matter
- See the illness not the person / compassion fatigue
- Lack of skills / confidence
- Lack of awareness of own prejudices

SET UP FOR SUCCESS

Plan and Prepare Effectively

- Have passionate champion as lead
- Work collaboratively / build partnerships / involve persons with lived experience of mental illness
- Find existing programs/best practices
- Build in evaluation from beginning

Get Leadership on Board

Maximize Participation

- Leverage existing channels/opportunities for registration, marketing and delivery
    - Make it mandatory if possible; if not, provide incentives
    - Register staff ahead of time / easy reg. process
    - work with department/unit managers to help with recruitment
    - use grand rounds system, education days, other existing delivery channels
- Think about program length
- Market thoroughly and strategically

MAXIMIZE OUTCOMES

Build the Program: Include Key Ingredients for Effective Stigma Reduction

- Include First Voice social contact / personal testimony
    - give guidelines for story content, structure and delivery
- Emphasize and demonstrate recovery
- Include multiple contact mediums (e.g., live, video)
- Teach 'what to do' / give practical skills
- Dispel myths
- Choose enthusiastic facilitator who can 'set the tone'

Maximize Audience Receptivity: Best Practices for Program Delivery

- Put audience at ease
- Focus on 'making the connection'
- Ensure equal status between first voice educators and audience
- Provide support for first voice educators
- Reinforce key message(s)
- Adapt to context
- Make it interactive and engaging

MAINTAIN THE MOMENTUM

Sustain Positive Change

- Have regular boosters and/or offer program over multiple sessions
- Get program embedded
- Build a sustainability plan

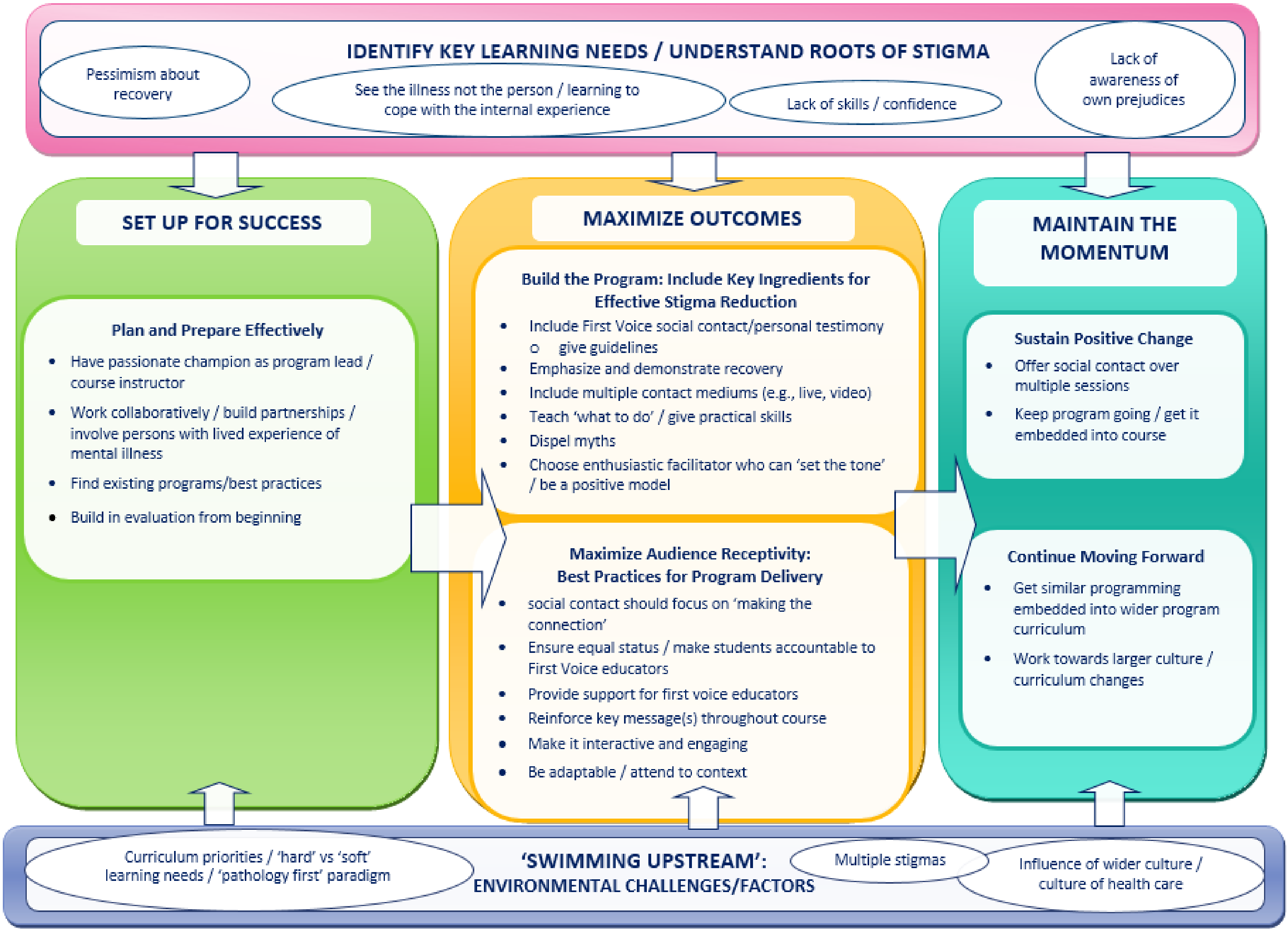
Continue Moving Forward

- Work towards culture change / integrated programming
- Address system issues / identify and fix systems or processes that contribute to stigma

'SWIMMING UPSTREAM': BE AWARE OF ENVIRONMENTAL CHALLENGES/FACTORS

- Shifting priorities and resource scarcity (e.g., time, funding)
- Multiple stigmas
- Influence of wider culture / culture of health care

Figure 2. Process Model for Successful Anti-Stigma Programming for Students in Healthcare


IDENTIFY KEY LEARNING NEEDS / UNDERSTAND ROOTS OF STIGMA

SET UP FOR SUCCESS

Plan and Prepare Effectively

- Have passionate champion as program lead / course instructor
- Work collaboratively / build partnerships / involve persons with lived experience of mental illness
- Find existing programs/best practices
- Build in evaluation from beginning

MAXIMIZE OUTCOMES

Build the Program: Include Key Ingredients for Effective Stigma Reduction

- Include First Voice social contact/personal testimony
    - give guidelines
- Emphasize and demonstrate recovery
- Include multiple contact mediums (e.g., live, video)
- Teach 'what to do' / give practical skills
- Dispel myths
- Choose enthusiastic facilitator who can 'set the tone' / be a positive model

Maximize Audience Receptivity: Best Practices for Program Delivery

- social contact should focus on 'making the connection'
- Ensure equal status / make students accountable to First Voice educators
- Provide support for first voice educators
- Reinforce key message(s) throughout course
- Make it interactive and engaging
- Be adaptable / attend to context

MAINTAIN THE MOMENTUM

Sustain Positive Change

- Offer social contact over multiple sessions
- Keep program going / get it embedded into course

Continue Moving Forward

- Get similar programming embedded into wider program curriculum
- Work towards larger culture / curriculum changes

'SWIMMING UPSTREAM': ENVIRONMENTAL CHALLENGES/FACTORS

4.1 Specify Key Learning Needs/Understand the Roots of Healthcare Provider Stigma

Among the first activities respondents identified as being of key importance when planning an anti-stigma program was to clarify the key learning needs of one's target group. Identifying key learning needs helps for setting program goals and objectives and directing the program content. Respondents opined that understanding the 'roots of healthcare provider stigma' was key to identifying the target audience's key learning needs. They described a number of core issues they believed contributed to the manifestation of stigmatizing attitudes or behaviours among healthcare providers. These are described below (highlighted also in Figures 1 and 2 as the model's top band).

4.1.1 Lack of Skills/Confidence

One of the key issues respondents described was a **sense of helplessness and hopelessness** about mental illness. Two main concerns were mentioned. The first was a lack of adequate training and skills for working with clients with a mental illness. This was particularly the case for healthcare providers not specialized in mental health, such as emergency department staff and primary care practitioners, for example. Respondents mentioned that healthcare providers often do not know what to do or what to say to help. This, respondents opined, contributed to stigma in that it leads to feelings of anxiety and a desire for avoidance or social/clinical distance. As the following comments illustrate:

> *If people feel confident that they can help people with a mental illness and feel like they can cope with the feelings that arise, then this will go a long way to reducing stigma and helping people. We need to get them feeling empowered, feeling confident about how they can help.... there is a real lack of knowledge and training among healthcare providers for mental illness. In a lot of cases, they simply don't know what to do or what to say.*
>
> *In the ER nobody really knows what to do or what to say or how to deal with it. Everyone just tries to pawn the person off as quickly as possible because they don't know how to address it.*

It was in this context that respondents emphasized the value of providing skills training – with a special emphasis on communication skills – as an important programming ingredient (see Section 4.2).

4.1.2 Pessimism about Recovery

Another commonly mentioned issue was that many healthcare providers hold **pessimistic views about the reality and likelihood of recovery**. This contributes to stigma in that it leads healthcare providers to feel that 'what they do doesn't matter.' As one respondent commented:

> *[Healthcare providers] need to see what recovery looks like. It's very important to get them to make that shift. Many don't really see recovery as possible, they don't know what it looks like. Because they see people at the height of distress. They don't see people when they are recovered. A lot of stigma comes from frustration in feeling that whatever they are doing doesn't mean anything.*

It was in this context that respondents emphasized a key learning need among healthcare providers is to help them understand and believe in the realness of recovery, and that what they do does make a difference. Social contact with a person with lived experience of a mental illness, who is living in recovery and can share their personal story, was identified as a particularly powerful and effective means to demonstrate the realness of recovery from a mental illness to healthcare providers (see Section 4.2 below).

4.1.3 See the Illness, not the Person

Another key issue identified by respondents was the need for healthcare providers to better **'see the person before the illness.'** Many respondents felt that healthcare providers often see the diagnosis more so than the human person:

> *With healthcare provider stigma … the big take-home message they need to get is that there is a real person that has all the complexities as each one of us. They are more than just a diagnosis.*

This was emphasized as a key learning need for both student and practicing healthcare provider populations. In the case of student healthcare providers, respondents articulated that students' training was often lacking in emphasis on the importance of **understanding the human experience**. As the following comments illustrate:

> *Much medical/healthcare education comes predominantly from a pathology perspective instead of a person perspective….We need to help students see the people they will be working with as people, not just diagnoses.*
>
> *Healthcare providers are book-learned. I always felt like I wasn't an individual with an illness but an illness...If you have a chance to train students to see people before the illness – get them pre-degree and give them the opportunity to interact with us and have discussions – then they would see things in a much more realistic and rich way.*

For practicing healthcare providers, the issue of **compassion fatigue** was raised as a concern in this context, and a key reason why programming aimed at getting healthcare providers to 'see the person before the illness' was important:

> *A lot of it is compassion fatigue. You don't go into these professions if you don't care about people. But when you see the most acute cases – when you are around it all the time -- you can get a bit of burnout. [Healthcare providers] cope by using foul language or by making stigmatizing comments towards the population they are working with and that's part of how they cope.*

In a similar vein, another respondent talked about this learning need in terms of learning how to positively cope with the **internal experience**, the feelings and emotions that can be brought up in healthcare providers when working with patients**:**

> *In medicine I think this is a big part of where stigma comes from. It's the feelings that can be brought up inside the practitioner … because they often have to cope with hard situations, helping people in acute situations. The feelings can be very powerful and even scary. One way people cope is to say 'I don't want to deal with this.' I just want to avoid the situation.*

4.1.4 Lack of Awareness of own Prejudices

The final key learning need mentioned by respondents was that of **lack of awareness** about stigma. Respondents felt that many healthcare providers are simply unaware of their own prejudices and stigmatizing behaviours. As the following comments show:

> *I hated to admit it but I saw myself in some of the stories the consumer shared [in our program]. We forget our words. We do have a powerful impact.*
>
> *For [participants in the program] many acknowledged … how they realized they held many prejudices about people with mental illnesses they didn't even realize they had.*
>
> *Many healthcare providers are unaware that certain terms are considered offensive or stigmatizing.*

Respondents emphasized how these 'key learning needs' help to determine a program's specific goals and objectives. Examples of common program goals and objectives mentioned are provided in the box below.

Respondents also emphasized that working in consultation with learners (i.e., the target audience), as well as persons with lived experience of a mental illness, as a helpful strategy for specifying the key learning needs and setting program goals and objectives. The following comment illustrates:

> *We wanted to focus on the ER first. We conducted focus groups with clients and families to solicit their experiences in the ER. It confirmed what exists in the literature about their experiences of feeling labelled and of medical needs not being attended to once staff realize there was a mental illness diagnosis. This also reaffirmed the need to get into the ER. Then, we designed a needs assessment survey for ER staff about their experiences and level of knowledge about mental illness. These two things together really helped us to zero in on what we needed the program to accomplish.*

Examples of Key Program Objectives

- To provide tools that increase healthcare providers' confidence and skills in working with patients with a mental illness
- Improved language usage
- To change the way healthcare providers practice
- To increase awareness about stigma and mental illness / to help healthcare providers become aware of prejudices they don't know they have
- To dispel myths
- To instill hope and belief in recovery
- To increase empathy and perspective-taking
- To help healthcare providers see the person behind the illness / to humanize mental illness
- To get healthcare providers to see that 'what they do matters' and that 'small things do make a difference'
- To help healthcare providers cope positively with the internal experience

4.2 Build the Program: Include Key Ingredients for Effective Stigma Reduction

Building the program to ensure it meets its learning objectives (see Section 4.1 above) was one of the most salient themes that emerged from the research. Respondents spoke at length about what they believed to be the most important program elements to include for effective stigma reduction. Six key ingredients were identified:

1. Programs should include social contact from a trained speaker who has lived experience of a mental illness. Preferably, the social contact should be in the form of a personal testimony and it should be live, if possible.

2. Programs should employ multiple forms or points of social contact (e.g., live plus video, multiple first-voice speakers, multiple points of social contact between program participants and persons with lived experience of a mental illness).
3. Programs should focus on behaviour change by teaching skills that help healthcare providers know 'what to say' and 'what to do.'
4. Programs should engage in myth-busting.
5. Programs should emphasize and demonstrate recovery as a key part of its messaging.
6. Programs should use an enthusiastic facilitator/instructor who models a person-centred approach (i.e., a 'person-first' perspective as opposed to a 'pathology-first' perspective) to set the tone and guide program messaging.

Each of these ingredients is described in more detail below and is also highlighted in Figures 1 and 2 (middle vertical band of the model).

4.2.1 Include Social Contact, preferably in the form of a Personal Testimony or Life Narrative from a Person with Lived Experience of a Mental Illness

Respondents strongly emphasized the importance of including a '**first-voice' (i.e., social contact)** component in an anti-stigma program. Respondents felt that the most effective form of social contact was that of a **personal narrative/testimony**, where persons with lived experience of a mental illness shared their story of illness and recovery. As the following comments illustrate:

> *You absolutely have to have the speaker. Healthcare providers are all over it. They love the speakers and the feedback I get most is, 'we want to hear more personal stories.' They see it as a reminder. The aspect they get from it is a reminder that these are real people. They see people at their worst and they need a reminder that there is a person's life all around it, around the illness. It's like a refresher to something they knew already so they welcome it.*
>
> *Why does it work? Because it gives the back story. Without the real person providing their story up to now, you don't see the whole person. You only see an ill person, you don't see 'I have a family. I used to be a kid. I used to have all the things you guys have. Then I got sick, then I got better. Then I got sick again,' and so forth. It demonstrates that there is complete person there who has an issue, as opposed to the issue being the complete person.*
>
> *The consumer presentation is very powerful. I had never experienced listening to a consumer that way. I saw myself in some of the stories she shared.*
>
> *The personal story works because it is a subtle, gentle way to reduce stigma. It's not didactic or forced learning.*

As suggested in the excerpts above, there were a number of reasons why respondents felt having a personal testimony component was effective for reducing stigma. First of all, respondents said that hearing someone's personal story helps to create empathy and understanding, allowing healthcare providers to 'see the person behind the illness.'

Personal Testimony Tips

- The overall tone of the story should be a hopeful and inspiring message. Blaming or negativity should be minimized
- The story should be told as a narrative and be authentic to the speaker's own personal experiences
- Stories should be helpful to the audience in that they communicate messages about what healthcare providers did well and also what they could do better
- Stories should have the following essential components:
  - the story should include a bit about their background and where they came from (e.g., childhood, family, interests, etc.)
  - the story should talk about their journey through illness and recovery
  - the story should include a pivot point or key moment in their recovery – what or who made a difference; what stuck with them and gave them hope
  - the story should talk about their experiences with the healthcare system. Negative experiences should be shared, but it is also important to emphasize what healthcare providers did right
  - the story should include a bit about stigma and their experiences with stigma
  - the story should end on a positive and inspiring note that emphasizes their accomplishments, their strengths, and talks about where they are now and what they are doing in their life now
- Stories should be interactive, with the ability for participants to ask questions and engage in discussion

Respondents also felt that including a personal testimony component provided a powerful and effective way for participants to understand how stigma operates in the lives of people with lived experience of a mental illness. Furthermore, personal testimonies instill hope, allowing healthcare providers to see the reality of recovery and evidence that their contribution as healthcare providers can and does make a difference. Respondents had a number of recommendations for the personal testimony component itself, particularly in terms of its content and structure. The box above highlights the main points of what respondents believe ‘good’ personal testimony stories should include.

While respondents felt both live and filmed forms of social contact could be effective, they generally felt that **a live speaker** was preferred, if possible. As one respondent commented:

> *The reaction tends to be stronger when it is live. There’s more of a ‘wow’ factor. Is stigma reduction actually different? I don’t know if we can actually say that…but there is certainly less of a wow factor without the live person there.*

Respondents also emphasized the importance of providing support and training for first-voice speakers, including giving guidelines for story development, presentation training, and support during the delivery of the personal testimony. Some programs developed speaker recruitment and training packages to support the personal testimony component of their program. Other programs used already-trained first-voice speakers from agencies such as the Schizophrenia Society.

It is also important to note that while many respondents emphasized the value of a personal testimony presentation, this was not always the format used by programs. In some cases, first-voice narratives involved program participants meeting with persons with lived experience of a mental illness (sometimes at multiple time points), with the purpose of learning that person’s life story. This was a format commonly used by some student programs (e.g., see Knaak et al., 2013; Luong et al, 2012). In other cases, the first-voice component was dramatized, structured as a play or as a stand-up comedy routine (e.g., see Knaak, Hawke & Patten, 2013).

4.2.2 Include Multiple Forms of Social Contact

Another program ingredient believed to be important for maximal program effectiveness is the inclusion of **multiple forms, modes, or points of personal contact** in the program. In other words, respondents said that having multiple first-voice speakers is better than having a single speaker. As well, showing a video featuring persons with lived experience of a mental illness and having a live personal testimony/first-voice component is better than having only one of these two elements.

The inclusion of more than one social contact element or points of contact meant that program participants would be exposed to different social contact experiences during the course of the program. The main rationale for why this program element was important was the idea that ‘different people learn in different ways, and different stories will resonate differently with different people.’ As the following comments illustrate:

> *The key is having multiple social contact components – all these different ways of sharing stories and humanizing mental illness may not work as well on their own. But all together the components work together to add up to a successful program. Different people learn in different ways and different things get their attention and connect to them. That’s why doing a combination of approaches is so important.*

> *Having the varied content is valuable. It allows the audience to see the impact of stigma in multiple ways in the real world...The point at which the connection is made with the audience usually happens with the video or the first-voice. Not everybody is at the same threshold of learning, so seeing things*

> *from different angles and lenses is helpful. It's the sum of the different components working together that makes the program effective.*

The theme of having multiple social contact elements was also supported through participant feedback. For example, for programs with multiple points of social contact (e.g., videos as well as a live personal testimony), participant responses to the question, 'which part of the program most affected your perceptions of mental illness' were varied, with certain social contact elements resonating more strongly with some participants, and other social contact elements resonating more strongly with others (e.g., see Knaak & Patten 2013, 2014).

Participant feedback from one of OM's partner programs that included three different forms of social contact – the screening of a PhotoVOICE documentary, a live first-voice/personal testimony, and a music video from a person with lived experience of a mental illness – found that just over a third of participants felt the documentary was the content element that impacted them the most, just under a third of participants said this about the first-voice/personal testimony, and approximately 15% of respondents said this about the music video component of the program (Knaak & Patten, 2013).

4.2.3 Emphasize and Demonstrate Recovery

The need to **emphasize and demonstrate recovery** was another key program element identified by respondents. As mentioned above, healthcare providers often hold pessimistic beliefs about the likelihood of recovery (see also Schulze, 2007). Respondents thus emphasized that anti-stigma programs for healthcare providers, if they are to be effective, need to show that recovery is both possible and real.

The theme of recovery was specifically articulated by respondents to mean that programs should:

- emphasize that recovery from a mental illness is both real and probable (e.g., through education/training about effective treatment and recovery methods/principles and/or by correcting myths with facts); and
- show what recovery looks like by demonstrating competence and 'successful living' of persons with lived experience of a mental illness.

Most respondents felt the most effective way to demonstrate recovery was through social contact, where a first-voice speaker (or speakers) could tell their story from a place of recovery. This, respondents said, helps to disconfirm stereotypes healthcare providers may have about persons with a mental illness – demonstrating that persons with a mental illness are competent and capable, and can live full and successful lives. Respondents also emphasized that by seeing someone in recovery, it reminds healthcare providers that what they do *does* make a difference. This helps to combat feelings of helplessness among healthcare providers that what they do doesn't matter.

The following comments illustrate how respondents talked about the importance of demonstrating and emphasizing recovery: As the following comments illustrate:

> *It's important for healthcare providers to see that recovery is really possible. I think it works even better when they can see recovery in action. Getting up there and telling your story in a positive way evokes admiration and shows competence. It allows the [healthcare provider] audience to see that recovery is real. This changes their perceptions of people*

> *with a mental illness because the stereotype is that people with a mental illness aren't supposed to be competent or capable or funny or likeable.*
>
> *It's definitely important to address recovery. This is where the buy-in happens. It's really important to have that 'happily ever after' piece – that's when people's faces change.*
>
> *The key is communicating the lived experience of a mental illness in a way that evokes admiration and shows competence ... A live performance alone impresses upon people and demonstrates competence. It shows them that 'I am up here, doing this, I am modeling recovery'.*

4.2.4 Engage in Myth-busting (Correct False Beliefs)

While respondents felt that healthcare providers' knowledge about mental illness was generally higher than that of the general public, some degree of educational 'myth-busting' was believed to still be necessary for effective stigma reduction among this target group. The one area in which education was believed to be particularly important was that of the relationship between violence and mental illness. As the following comment illustrates:

> *The violence piece [in our program] always generates a lot of discussion. Often they are shocked to hear the truth.*

Another area in which clarification about myths and facts was believed to be important was in regards to language use. Respondents commonly noted, for example, that many healthcare providers either don't believe or are unaware that terms like 'frequent flyer' are experienced as stigmatizing to persons with lived experience of a mental illness. As the following comment from a program participant illustrates:

> *I have found myself using the 'frequent flyer' label in the past. I didn't realize it was stigmatizing. I will watch my language more carefully now.*

Another myth respondents felt was important to address was the commonly held belief that if healthcare providers interacted with persons with a mental illness in a warm, personal way, it would encourage patients to return (e.g., to ER) more frequently. As the following comment illustrates:

> *There's a clip in the video we use where an ER doctor talks about the long standing belief that if you are too personal or nice then the patient will come back again and again. This has been disconfirmed through research. It's simply not true. It's an important message to communicate, especially to ER staff, as many of them still believe this and think they are supposed to act distant.*

Respondents felt that providing facts and information about the prevalence of mental illness was also valuable, as was providing information and facts about recovery. Respondents commonly suggested using interactive true-false or multiple-choice questions, or a 'Jeopardy'-style game as an engaging and non-threatening way to assess healthcare providers' current level of knowledge and correct false beliefs.

4.2.5 Teach Healthcare Providers 'What to do' and 'What to say'

As mentioned above, a key theme that emerged from this research was that many healthcare providers lack competence and confidence in their ability to help, and this can contribute to stigmatization (see Section 4.1). Respondents opined that not knowing 'what to do' or 'what to say' can lead healthcare providers to experience anxiety or fear about interacting with persons with a mental illness, which then contributes to a desire for social/clinical distance, and feelings of hopelessness and helplessness. To this end, respondents believed that incorporating an element of skills training was an important ingredient for effective stigma reduction. The following comments illustrate:

> *Many of the questions that come up ... are about 'What can I do?' 'How can I help?' Healthcare providers are looking for answers to these questions.*
>
> *By increasing...confidence and comfort by giving them a useful approach and good tools, [healthcare providers] are more welcoming to their mental health patients and less stigmatizing .... Decreasing anxiety by providing tools leads to behaviour change.*
>
> *Healthcare providers want practical information that will help them better care for their patients with a mental illness -- communication skills, how to conduct an interview, how to be empathetic. They also want to know about resources and supports in the community they can direct their patients to.*
>
> *Healthcare providers want practical strategies. That's what they are really asking for. Those practical strategies like 'How can I make someone feel supported versus making them feel stigmatized? What's the right thing to say?'*

Respondents gave a number of suggestions in this regard. Role playing and scenario-based learning were commonly mentioned as favoured approaches for teaching context-specific skills and tools.

Teaching cognitive behavioural therapy and/or dialectical behaviour therapy skills were also emphasized as these are therapeutic techniques that aim to enhance healthcare providers' abilities to communicate with patients, and also to equalize the power relationship between patient and provider by engaging patients in the management of their mental health issues.

Tools/resources for teaching healthcare providers
'what to say' and 'what to do'

- PSP Adult Mental Health Module program and evaluation report
- CBIS (Cognitive Behavioural Skills Training) program and evaluation report
- 'Walk a Mile in my Shoes' scenario-based learning modules

It should be noted that offering programming with a strong focus on skills-training was mentioned as a particularly important ingredient for programs targeting physicians. Specifically, many respondents felt that in order to ensure maximum uptake and attendance among physician learners, a program that emphasized skills training (and which also included other key ingredients such as a first-voice testimony and a focus on recovery) and which was also led by a fellow physician, was the most promising approach. Some skills-based programs and tools available for sharing are listed in the box below.

4.2.6 'Set the Tone'

The final program ingredient mentioned by respondents as being key to building an effective program was to choose an enthusiastic facilitator who could set the proper tone and expectations for the program. Specifically, respondents believed the facilitator should set the tone by:

- modelling a strong 'person-first' approach (i.e., as opposed to 'pathology-first');
- being enthusiastic and passionate about the topic; and
- being able to effectively lead and direct the discussion.

The value of setting the tone by having an enthusiastic facilitator who models the desired approach and behaviour was discussed by respondents as an effective way to put the audience at ease and make them more responsive to program messaging. Respondents commented that the facilitator's ability to set the tone is an important factor in mitigating any potential audience defensiveness (respondents felt that healthcare providers may get defensive if they perceive they are being criticised or 'told to') and to effectively guide audience discussion in the event that it becomes stigmatizing. The following comments illustrate:

> *What I do is I facilitate the first-voice presentation. I set the expectations of what I want the students to focus on and hear, so I set the tone. Then, as the person tells their story, I take notes. So I can expand on things. And then I highlight things I want the student to pick up on. Mostly, I also say things like 'tell me more about you...' to get more of that person's back story. I don't know if this is priming or if this context matters or not, and I don't know if it is a key ingredient. But I definitely do this. And I do think it's important.*
>
> *You need to have a dynamic presentation team. You don't need professional facilitators...but you do need people who are passionate for the project and who know the content. The people delivering the program are your champions. They model the desired attitude and behaviour.*
>
> *Why does it work? I think its two things: skills– people don't know what to do and we give them skills so they have easy concrete things to help patients. And it's the tone we set. We are modeling for them, how to interact, what to do and what to say. We model listening, and we model that person-first behaviour.*
>
> *Our teachers are all very enthusiastic and passionate about their work. We have lots of enthusiastic teachers who have real hope for their patients, who have hope for recovery. I think this rubs off. It's a big part of why our program works.*

Respondents also commented that having a facilitator with professional commonalities to the target audience was valuable. As one respondent commented: "*I would encourage a physician to champion the physician program. You would get much better buy-in that way.*"

4.3 Prepare and Plan Effectively

As important as program content and identifying key learning needs are for successful anti-stigma programming, they are not all that matters. Respondents emphasized, for example, that the preparation and planning aspect of anti-stigma programming is also of key importance. As the following comment illustrates:

> *There is a lot of preparatory work to get it going. Don't underestimate how much time and effort is involved to get things off the ground…the planning and organizational piece is bigger than delivering the actual workshop.*

In the case of student programs, program planning is typically undertaken by the course instructor. For practicing healthcare provider programs, planning activities might be undertaken by a designated project lead or a committee. Four key activities for effective program preparation were identified. These are described below and are also highlighted in Figures 1 and 2 (first vertical band of the model).

4.3.1 Have a Passionate Champion as the Program Lead or Course Instructor

The first key planning element is having a **passionate champion as the program lead**. For student programs, this 'passionate champion' is typically identified as the course instructor/professor. For programs for practicing healthcare providers, respondents also commented on the importance of this criterion when selecting a project lead. Typically, respondents described the project lead as also being the most suitable person to deliver (or co-facilitate) the program. As the following comments illustrate:

> *Have a champion who is passionate about anti-stigma. The people behind the program are the key to its success. When there are champions who are enthusiastic and passionate about what they do it rubs off – enthusiasm is contagiou*s.
>
> *It is important to have someone who is well organized and passionate about the topic.*
>
> *When we first started, we hired professional facilitators. Then we stopped because we realized we were just as good. Maybe even better because we had a true passion for the program and we also know the content. The best facilitators are those who know the content who also have the passion for the project.*

Along with having a passionate champion as program lead, respondents also commented on the importance of providing champions with adequate support and resources. One program for practicing healthcare providers, for example, identified and trained anti stigma champions to be able to implement anti-stigma projects in their own departments/units. However, champions were not provided with dedicated resources for which to implement their projects (e.g., time, funds), and few were successful at fully implementing their intended projects.

4.3.2 Work Collaboratively/Build Partnerships/Involve Persons with Lived Experience of a Mental Illness

Another recommendation for effective program planning is to **work collaboratively, building partnerships wherever possible, and including persons with lived experience of a mental illness from the beginning**. The following comments illustrate:

> *Relationship-building is key to success. Always look for ways to partner and work with others. The more you can get people with power to make decisions and get on board with you, the better, easier and more successful your program will be.*
>
> *Involve consumers throughout. We had focus groups with consumers and family members which helped to shape the curriculum. One theme that came up a lot was the perception of violence. Consumers feel like [healthcare providers] are afraid of them. So we knew the importance of focussing on this when building the program.*
>
> *Saturate the hospital. That's how I got the ER; that's how I got one the of the physician groups. It was because I got the ear of the head of ER pediatrics and they recognized the need and they are supporting it.*

While respondents from student programs did speak about the value of building partnerships and working collaboratively with others [e.g., to find first-voice speakers and/or solicit other forms of involvement from persons with lived experience of a mental illness for their program; or to try to get the program embedded into the wider program curriculum (see Section 4.7. Maintain the Momentum; Best practices for Program Sustainability)], it is important to note that the value of building partnerships and working collaboratively was more strongly emphasized by stakeholders of practicing healthcare provider programs. This is likely because course instructors/professors typically have considerable autonomy building and delivering their classes. Programs for practicing healthcare providers, as they are often delivered in hospitals or health centres, typically require considerably more coordination.

In general, working collaboratively was mentioned as a valuable way to:

- specify key learning needs and/or program content areas for the target audience (see Section 4.1);
- identify potential opportunities and challenges that might be encountered along the way;
- gain access to program resources and tools; and
- get higher levels of program endorsement and participation (see Section 4.4).

Examples of different ways to work collaboratively, build partnerships, and involve persons with lived experience in program planning are listed in the box below.

Examples of ways to work collaboratively, build partnerships, and involve persons with lived experience in program planning

- Establish a program working group or advisory committee
- Conduct a needs assessment with staff, departments and/or other key stakeholders
- Conduct focus groups and/or consultations with people with lived experience
- Network with other organizations or individuals already running successful anti-stigma programs to get insight, ideas, advice, support and access to program resources
- Present programming ideas to leadership and managers
- Reach out to other units/departments, etc.
- Partner with organizations that support persons with lived experience of mental illness to recruit program speakers, presenters, client-educators, etc.

4.3.3 Find Existing Programs and Best Practices

Also recommended by respondents as a valuable planning activity was to **find existing programs and best practices.** In this context, many respondents indicated that adapting an existing program, if a suitable one could be found, was preferred over designing something new.

More information about OM partner programs that have demonstrated success (i.e., reducing stigma), and which are available for sharing, can be found at http://www.mentalhealthcommission.ca/English/initiatives-and-projects/opening-minds.

4.3.4 Build in Evaluation from Beginning

The final main activity for effective program planning identified by study participants was to think about and incorporate an evaluation strategy from the beginning. **Building in evaluation** early -- at the planning stage – was described as important for the following main reasons:

- it helps to ensure that the program would be designed with adequate allotted time for participants to complete evaluation forms, ensuring high response rates and more reliable data.
- it helps to ensure that the desired program information was collected – e.g., participant feedback about the value of the program, recommendations for improvement, measures of program efficacy, satisfaction measures, etc.

- because reliable and valid evaluation data is a crucial tool for helping to secure program sustainability, especially for programs for practicing healthcare provider.

While most programs' evaluations included one or more measures of program efficacy [i.e., a scale measure for assessing attitudes towards mental illness such as the OMS-HC (see Modgill et al., 2014), along with program satisfaction measures], some programs also sought feedback (typically qualitative) from persons with lived experience of a mental illness involved in program delivery. This information was also described as being extremely informative and useful for program sustainability.

A number of respondents emphasized that program evaluation, while extremely important to do, did take up valuable program time. This was particularly the case for practicing healthcare provider programs. For this reason, many felt that shorter evaluation measures were preferred over longer ones.

Evaluation Tools Available for Sharing

- The Opening Minds Scale for HealthCare Providers (the OMS-0HC) is a 15 item validated scale that measures healthcare attitudes and behavioural intentions of healthcare providers towards mental illness. Within the scale are three subscales each measuring a different dimension of stigma – negative attitudes, willingness to disclose, and preferred social distance. This scale is a valid and reliable way to measure program efficacy
- Opening Minds has copies of its standard pre and post evaluation surveys, available for sharing

4.4 Get Leadership on Board *(practicing healthcare provider programs)*

Getting support from leadership was identified as another crucial stage of the process for successful anti-stigma programming, particularly for practicing healthcare provider programs (see Figure 1, first vertical band). For student programs, respondents said that support from leadership (e.g., the faculty or department) was less important for designing and delivering their program/course than it was for ensuring that anti-stigma programming was embedded at all levels of training (see Section 4.7). The following comments illustrate the value of getting leadership buy-in:

> *Work from the top. It's critical to get senior leadership on board. If you don't have that support, it won't fly. At our hospital, they have a leadership forum. We got in there and did a 30 minute abbreviation of the program. That sold them.*
>
> *Recruitment was a challenge for us. Next time, I would try to get a physician who works in the ED to champion the physician program. And I would go to a higher level. There's better endorsement if it comes from the top.*
>
> *We had endorsement from [health region]. We got education money for staff to come in on a day off.*

> *Getting support from leadership gave us two full days of nurse education time.*
>
> *Our struggle was not having that backing from higher up. Without being able to do a resource replacement, it didn't give the proper or full importance to the program. It made the delivery feel piecemeal. We were moved around, we didn't just have one designated room or time. Also, delivering the program during shift is difficult. It's hard for people to shift gears that quickly. It doesn't really allow the experience and information to percolate properly.*

There were two main reasons provided for the need to get support from leadership. First, respondents felt that leadership support helps to set the tone regarding the program's value and priority, which in turn helps to maximize program participation (see Section 4.5). Ideally, getting leadership on board also means getting dedicated program resources such as education time, resource replacement, permission to deliver the program through existing delivery channels, etc.

Respondents noted, however, that getting leadership support is not always easy, especially in large organizations where there are many competing demands for staff education and training. It was in this context that respondents shared a number of strategies for getting the attention and endorsement of leadership. These are listed in the box below.

Strategies for Getting the Attention and Endorsement of Leadership

- Find out when and where meetings of leadership are happening, and get on the agenda
- Demonstrate the need, value and benefit of providing anti-stigma programming by using existing evidence. This includes providing relevant statistics, staff feedback or needs assessment information, evaluation results from other successful programs, etc.)
- Demonstrate previous success if using an adopted/adapted program (see Section 4.3.3)
- Demonstrate the program to leadership. If program includes a personal testimony component (identified as a key program ingredient – see Section 4.2.1), this element in particular should be included in the program demonstration
- Come to leadership with a package and a plan, but recognize the benefit of working with organizational and departmental realities. You need to be flexible and wiling to adapt

"If you are in a general hospital, I would say work on mental health first. If you can get the Chief Psychiatrist on board, that that gives more credence to your program and makes it more likely to get leadership to hear our message."

4.5 Maximize Participation *(practicing healthcare provider programs)*

Getting desired levels of program participation was identified as another key stage in the process of successful anti-stigma programming (see Figure 1, first vertical band). Again, this theme was relevant mostly for programs targeting practicing healthcare providers, not student programs. For programs targeting practicing healthcare providers, respondents emphasized that participant recruitment was often a challenge, given competing priorities for training needs, time and other resources. As well, there can be a low priority given to the value of anti-stigma programming more generally, as there is often a perception that stigma is not a problem for healthcare providers or in in healthcare environments (see Section 4.1). In this vein, respondents mentioned a number of strategies and activities to help ensure programs achieve desired levels of participation.

4.5.1 Leverage Existing Channels/Opportunities for Program Registration, Participation, and Delivery

One strategy is to use **existing channels for program delivery** (e.g., grand rounds, education days, existing class time) whenever possible. Another strategy is to **make program attendance mandatory**, if at all possible. If mandatory attendance is not a feasible option, respondents said that **offering incentives** could also work well to help ensure robust participation levels. Useful incentives mentioned by respondents included offering education credits, payment for training time, and/or providing refreshments. As one respondent commented:

> *What do I think are the most important things for program success? Make it easy for people to come. You need to give them an incentive.*

It was in this context that many respondents also commented on the value of being flexible and working with existing staff schedules as much as possible. Another commonly mentioned strategy was to **work through department/unit managers** to set expectations for, and encourage, program attendance (see also Sections 4.2 and 4.3), as was being sure to **register staff ahead of time** and to ensure the process for registration is simple for staff to use. Respondents also suggested that getting managers to help with registering staff was useful for hospital-based programs.

4.5.2 Think Strategically about Program Length

Thinking strategically about program length was identified as another valuable strategy for maximizing participation levels. Specifically, respondents believed that programs perceived as being too long were likely to be poorly attended. As the following comments illustrate, respondents had different ideas about how long was 'too long' for a program for practicing healthcare providers, although most believed the ideal length was somewhere between one and two hours:

> *You have to think about program length from a participant perspective. Obviously it has to be long enough to cover the content. But too long and it will be difficult for staff to commit.*
>
> *Our workshop is three hours. It's a bit of a stretch for healthcare providers to commit to this length of time. Two hours would be better.*
>
> *I think one hour is good for hospitals. Over an hour is long for hospital interventions. Longer programs make it harder to get them into the room. We need 1.5 hours to get the surveys*

> *done and to have time for discussion, plus doing the actual program. It’s tough to get staff to commit to this amount of time.*

As such, for longer content programs, many respondents believed that delivering the program over a series of shorter sessions was preferred over offering one long session:

> *Multiple shorter sessions are preferred over one long session. That’s the feedback we’ve gotten as well from healthcare providers.*

4.5.3 Market Strategically and Thoroughly

The final key strategy for maximizing participation was **marketing the program strategically and thoroughly**. Respondents provided such advice as ‘saturate the hospital,’ ‘work from the top,’ and ‘use all promotion and marketing channels at your disposal’ (e.g., posters, blogs, email ads, leadership endorsement, working through unit managers, etc.) to illustrate the importance of thorough program marketing. The following comments also illustrate:

> *Our hospital sessions didn’t work that well – really low participation. We advertised by posting around the hospital, but we didn’t actually go from department to department. That might work better for next time. Also, we didn’t go to leadership first. We would try that next time as well.*
>
> *Use all the promotional channels in the hospital. Internal newsletters, posters, emails, you name it. Walk the hospital to get into the staff lounges to hang your poster. Talk to all the people when you are there. It has to be sometimes 4 or 5 times visiting a unit before it clicks.*
>
> *We are lucky that leadership supported it. … But you still have to let everybody know who you are and what you are doing. Find out all of the people who are leaders and make sure they know who you are and what you are doing and send them stuff. You have to saturate the hospital. Sell them on the need. Get them supporting you.*

Strategic program marketing was described by respondents as the way to sell the value of the program to participants. Programs need to be marketed so that participants don’t feel targeted, and also so that they feel the program will be beneficial to them and their work. Some examples of strategic marketing activities used by programs to help maximize program participation are illustrated in the following excerpts:

> *Do a needs assessment with staff ahead of time so they feel like they have a say. It ends up being a way to market the program because you can then go back to them and say, ‘hey, you guys asked for this.’*
>
> *Package, promote and title the program in a way that appeals to the audience’s main concerns and what they perceive as important. We learned this lesson the hard way. We ran an anti-stigma program under the anti-stigma banner and it flopped. I think we only had three people sign up. We decided to repackage the exact same program and market it as being about mental illness and violence. As soon as we did that, we filled the room.*
>
> *Market the program to the whole organization or department to avoid anyone or any particular group feeling like they are being specially targeted.*

4.6 Maximize Audience Receptivity: Best Practices for Program Delivery

How the program was delivered was another major theme that emerged from the research as being key to running a successful anti-stigma program. Respondents spoke at length about how program delivery should focus on such strategies as ‘putting the audience at ease,’ ‘encouraging interaction,’ ‘making the connection,’ ‘reinforcing key messages,’ ‘ensuring equal status between first-voice speakers and audience,’ ‘providing support for first-voice educators,’ and ‘being flexible and adaptable in program delivery’. These strategies were described as ways to help make the audience more receptive to the program content and key learnings. Each of these activities is described in more detail below. They are also highlighted in Figures 1 and 2 (see middle band of model).

4.6.1 Put the Audience at Ease

Making efforts to **put the audience at ease** was discussed as being a particularly important activity for programs for practicing healthcare programs, ensuring that the audience does not feel ‘told to’. As the following excerpt illustrates:

> *As a facilitator, I try to use inclusive language when I introduce the workshop. Not ‘I am the expert and I am here to teach you’ perspective. I don’t want the audience to feel that way. I think if you approach it that way you are going to lose your audience. You will lose people anyway because of the topic being discussed. But what I want them to realize is that I am no different than they are.*

Specific strategies mentioned by respondents as ways to help put the audience at ease include the following:

- add a bit of humour
- reinforce what healthcare providers are doing well
- offer refreshments and food
- introduce the topic in a disarming way

Specific tools used by programs to help ‘put the audience at ease’ by introducing the topic of stigma in a disarming way are listed in the box below.

Tools/resources for putting the audience at ease

- Porcupine exercise – an interactive exercise that gets people thinking about mental illness from a more personal and reflective perspective.
- Ear-ache exercise – an interactive exercise that compares and contrasts the experience of having a mental illness with the experience of having an earache
- Famous People PowerPoint - a PowerPoint presentation that aims to normalize the topic and discussion of mental illness. It is played at the beginning of the program and features famous people from all walks of life who have a mental illness.
- Other?

4.6.2 Make Program Interactive and Engaging

Another best practice for program delivery is to make the program as **interactive and engaging** as possible. This was emphasized as important for both student and practicing healthcare provider programs. As one respondent commented: *it has to be interactive – this is what gets people to reflect*. Specific suggestions for how to make the program interactive and engaging included the following:

- Leave sufficient time for questions and answers/discussion – this was deemed especially important if the program included a person with lived experience in program delivery (i.e., as a first-voice presenter and/or program facilitator or co-facilitator);
- Have an interactive warm-up activity to get people talking (like, for example the 'earache exercise,' the 'porcupine exercise,' a true/false or Jeopardy-style game. See the box above);
- Include small group activities or role-playing activities to encourage discussion, problem solving and cohesion.

4.6.3 Reinforce Key Messages

Another best practice for program delivery was to **reinforce key program messages** throughout the delivery of program. As one respondent noted, "*the message(s) needs to be communicated over and over again because we are competing with so many negative stereotypes from the media and elsewhere.*" The messages most commonly mentioned by respondents as important to continually emphasize are highlighted in the box below.

Reinforce Key Messages

- small things make a big difference –small gestures of kindness stay with people for a long time; so do derogatory comments and being pushed off
- healthcare providers have an important role in recovery – what they do matters
- recovery is real – people with a mental illness can and do live successful lives
- the illness is not the person -- remember to see the person first

4.6.4 Ensure Equal Status between First-voice Educators/Speakers and the Audience

In as much as including social contact from persons with lived experience of a mental illness in the form of a personal testimony or life story/recovery narrative was deemed an important program ingredient, so was the positioning of their role in program delivery. Specifically, respondents mentioned that first-voice speakers should be seen as having **'equal status'** vis-a-vis audience members and facilitators/teachers. They should not be seen as 'patients' but as facilitators/co-facilitators, teachers/experts, client-educators, etc.

Respondents emphasized that ensuring equality of status for first-voice speakers demonstrated competence, and also helped to break the divide between 'us' and 'them,' a key aspect of the process of stigmatization (Link & Phelan, 2000). The goal, respondents said, was for the audience to see first-voice speakers as being 'like them' as much as possible. As the following comments illustrate:

> *If I could do it again, I would … include a 'work alongside' component, where healthcare providers are learning from the members. The environment is critical. It's important to have an environment where we are treating all people as equals, seeing people [with lived experience of a mental illness] as capable.*
>
> *I like how [first-voice presenter] helps me co-facilitate. I think it's positive for the group to see. It's good to see her in a facilitator/instructor role and to have the speaker involved in all aspects of program delivery. But not all first-voice presenters do this. If I had to do it over again, I would set it up as a true co-facilitating workshop.*
>
> *For our program, it is the peer support worker who delivers it. People often comment how they never would know s/he has a mental illness until they start telling their story. It's very effective to see them in a position of authority like that. It challenges what they believe to be true.*

4.6.5 Focus on ‘Making the Connection’

Respondents also emphasized the importance of first-voice speakers being able to successfully **‘make the connection’** with the audience. As the following comments illustrate:

> *In our program, I usually see things shift with the first-voice presentation or the video. It’s like they suddenly get it. They’ve made a connection.*
>
> *The story has to have some of that personal content – that heart-wrenching component. You want people to say, ‘look at this person in front of me. I never would have guessed that person would have struggled that much.’ Whatever you can do to make the connection.*
>
> *We look carefully at how we construct the assignment [for the students] so that the contact and the connection part becomes as important as the final product or the grade.*
>
> *The personal testimony has to make that personal connection.*
>
> *It’s about telling a story that will resonate and touch people at that personal level.*

4.6.6 Provide Support for First-voice Speakers

It was in this context that respondents also emphasized the value of providing support and training for first-voice speakers, including giving guidelines for story development, presentation training, support during the delivery of the personal testimony, appropriate monetary compensation, and ensuring that speakers are connected to a professional relationship in case they need additional assistance or support. As the following comments illustrate:

> *The program has a big impact on our [peer workers/first-voice speakers.] A huge piece of it is the emotional labour it takes to do this job … one thing we do have in place to support them is that we have our speakers record their stories in digital form so they can decide on any given day if they want to do it live or show the digital version.*
>
> *It’s very important to provide professional support for first-voice speakers. Programs can be difficult sometimes, and sometimes things get said that can be very stigmatizing for the person with lived experience. So we make sure all our speakers are connected to a professional relationship in case they need debriefing or assistance. We also make sure that they don’t deliver the program on their own. We always have more than one person doing the program.*
>
> *Our client educators were paid for their time. They were hired and paid as teaching assistants.*

In addition to the ‘Personal Testimony Tips’ described in Section 4.2.1 above, key suggestions respondents had for presenters delivering personal testimonies or other first-voice narratives include the following:

- Make eye contact;
- Have notes but do not read fully from notes when presenting;
- Speak authentically and honestly; be yourself and speak from your own experience;
- Have a clean and tidy appearance;

- Adding a bit of humour can be effective, if it feels comfortable;
- Model recovery;
- Tell your story as a narrative, but allow for conversational interaction;
- If possible, tweak your story to fit with the specific audience you are speaking to;
- Rely on professional and/or co-facilitator supports for debriefing, support during presenting, etc.;

4.6.7 Be Flexible and Adaptable/Attend to Context

A final best practice for successful program delivery was to be **flexible and adaptable** in delivering the program. It was in this context that respondents mentioned that a program may have to be truncated or condensed for some groups, or it may have to be offered in a different way. Some respondents also spoke about needing to adapt a program session in response to external events (e.g., high profile news cases), either in terms of re-scheduling or in terms of incorporating a guided discussion of the event into the workshop or program session.

Adapting to context was mentioned as being important so that learners feel connected to the material. As one respondent said, "*the content becomes more real when it's relatable*." Also, program participants frequently commented on the value of including department or organization-specific information, and on the importance of program content/examples being applicable to participants' specific work situations.

4.7 Maintain the Momentum: Best Practices for Program Sustainability

Respondents generally agreed that successfully combatting stigma in healthcare ultimately requires more than a single program or course. While a single intervention was a very good first step, respondents believed that sustaining change required ongoing anti-stigma programming and other strategies. As many respondents opined, 'one-off' programs don't change culture. Positive program effects likely won't be sustained over the long term without ongoing programming, such as booster sessions, progressive programming, and other continued efforts to combat stigma in the organization. To this end, program sustainability emerged as another main stage in the process of successful anti-stigma programming. Key strategies are described below, and are also highlighted in Figures 1 and 2 (see right vertical band of model)

4.7.1 Get Program Embedded/Build a Program Sustainability Plan

There were a number of valuable strategies or best practices identified by respondents as ways to think about, and encourage, program sustainability. One strategy was to **get the program embedded** to ensure ongoing programing. Some commonly mentioned examples include:

- getting anti-stigma programming as a mandatory part of hospital or department orientations for new staff;
- having anti-stigma programming as a mandatory part of annual skills training for practicing healthcare providers (e.g., staff come in for a 'recertification day');

- for student healthcare programs, getting stigma reduction embedded as part of regular course delivery and/or part of the core curriculum.

One respondent also mentioned their program developed a **sustainability plan** to assist with this effort (see box below).

Program Sustainability Plan

We did a lot of literature review to think about sustainability and what the meant to us. In the end, we landed on a few key elements for sustaining the change. These synthesized into an 11 point sustainably model. Access this anti-stigma sustainability model here.

4.7.2 Offer Regular Boosters and/or offer over Multiple Sessions

For practicing healthcare provider programs, **offering periodic booster or refresher sessions** to program participants a period of time after the initial program was commonly mentioned as another best practice for sustaining positive change. The following comments illustrate:

> *Ideally, I would go in and blitz and then go back again later. It's not enough to do one session only.*
>
> *One long day might make us all warm and fuzzy but it might not last. Getting reminders periodically is likely to work much better. We all need to be reminded.*
>
> *I definitely think we are going in the right direction with the booster sessions – I don't think you can just have 'level 1' and expect things to change too much.*
>
> *I would include a follow-up session, or put together a guide for doing short follow-up sessions as small independent groups in our own offices. I think this would help 'keep it alive' as far as using the resources go.*

Tools and resources that can be easily used for 'booster session' programs, and which are available for sharing, are listed in the box below.

Booster Session Programs and Resources

- Ontario Shores' 'Walk a Mile in My Shoes' program
- That's Just Crazy Talk DVD
- Videos/discussion topics and questions
- AHS webinars
- ER role playing scenarios

Another, similar strategy, is to offer the program over **multiple sessions**. As the following comments illustrate:

> *I would think that multiple sessions or going in periodically would be good.*
>
> *Our program involves students meeting with client educators*[1] *over the course of the whole term. The continuity is beneficial because it allows the student to see and understand that recovery is not linear.*
>
> *Our program has three sessions separated by action periods. Separating it out over three sessions keeps it so they don't get overwhelmed, and it gives them time to put the skills they learned into practice. The action periods are the most important and critical part of our program.*
>
> *Instead of the one long workshop, I would possibly break it down into two presentations separated by a period of time, to allow for more time to work with the materials provided.*
>
> *I would like to see more opportunities for participants to have time to practice the communication skills -- ongoing follow-up or monthly check-ins for folks to practice and learn the information so it is integrated at a deeper level.*

4.7.3 Continue Moving Forward: Address Larger System/Curriculum Issues

Respondent's also discussed the larger context of combatting stigma in healthcare. Specifically, they described how stigma is not only manifested through negative attitudes and behaviours, but also at a system level – that organizational policies and procedures can negatively influence the quality of care and treatment received by persons with a mental illness. As such, respondents believed that successfully combatting stigma thus ultimately also requires attention to **larger system issues**. As the following comments illustrate:

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[1] In some programs, persons with lived experience of a mental illness involved in program delivery as first-voice speakers are known as 'client educators.'

> *[The discussion part of the program is valuable because] it allows the conversation to open up about the struggle with the system. I was often surprised at the level of emotion expressed by staff for better resources, more training, and system issues that made their job difficult – that made it difficult for them to properly care for people with a mental illness.*
>
> *In ER, there's a triage issue that needs to be dealt with. Clients with a mental illness sit around too long based on their triage ranking. They are being let to sit around because they know they will take longer to deal with.*
>
> *In training, there is so much to learn in terms of content. There's not much time to talk or learn about the human experience, what it's like to work with people, and the experiences of the people we work with. Part of stigma in healthcare is caught up in that – the process piece. It's a system issue. A paradigm thing. Our priorities need to shift to create more space in our curriculums for focussing on that process piece, the human experience.*

4.7.4 Continue Moving Forward: Work towards Culture Change

Finally, respondents emphasized how the problem of stigma is woven into the very cultural fabric of healthcare organizations, as well as the culture at large. For this reason, program sustainability should focus on the **ultimate goal of culture change**. Respondents talked about needing to take the long view, focussing on reaching as many people as possible through anti-stigma programming, and by working to shift the attitudes of healthcare providers more generally, from 'pathology-first' thinking to 'person-first' thinking. The following comments illustrate this idea more fully:

> *One-off things don't change culture. It needs to be, in my mind, a movement ultimately. It needs a lot of champions demonstrating in their individual workplaces a well-mannered intolerance of intolerance. Continuing to raise awareness in ways that are effective.*
>
> *Is it a David and Goliath situation? Or can you tip the balance with a few effective strategies, if implemented consistently? I actually do think it can be done. But it has to be longitudinal. I think it's about numbers – the numbers of people who are influenced and who are currently unaware.*
>
> *What we really need to do is graduate psychiatrists and doctors and nurses that really understand people's experiences…And I think right now students learn by treating their patients instead of learning from the patients themselves. In much of the development of the curriculum, they don't think there is much to be learned from this approach. Yet I think there is so much to be learned because it can result in a massive attitudinal shift. It can totally transform the way healthcare providers plan to practice.*

4.8 "Swimming Upstream": Key External Factors/Challenges

The stages and strategies described above were all identified as important considerations for building and delivering successful anti-stigma programs for healthcare providers. In addition to these strategies for success, respondents identified a number of key challenges to providing successful anti-stigma programming for healthcare providers. These are highlighted in Figures 1 and 2 (bottom band of model) and described in more detail below.

4.8.1 Organizational/Curriculum Priorities, Resource Scarcities (e.g., time, funding)

The first major challenge is the reality of **resource scarcity**. Respondents speaking about programs for practicing healthcare providers emphasized how there was a *"constant struggle for priority"* and a reality of **shifting organizational priorities** for training time, funding and other resources. As one respondent commented:

> *There is a constant barrage of competing priorities…if we are presenting our program to leadership, there are likely a number of other important issues coming up as well, many of which may be real time immediate needs. Someone once told me, be prepared to be a mosquito. Just don't get smacked.*

For respondents speaking about student programs, the problem of resource scarcity and organizational priorities were generally articulated as an issue of competing **curriculum priorities** – that there was so much content to learn, the 'soft' learning, of which anti-stigma programs are considered a part, tend to be given a lower priority.

> *How do we get all the requirements for training done in this finite period? There is so much learning that has to happen that the more novel ideas – like getting students to understand more about the human experience – keep getting put off. It's not like there's outright opposition. It's more like it gets squeezed out.*
>
> *Does the school support it or not support it in terms of de-stigmatizing? I think we don't really support it at all. There might be a few individuals, but they get swallowed up by the overall culture of how to diagnose, how to interview; learning all the hard stuff – the science – that the human experience gets squished out.*

4.8.1 Multiple Stigmas

Another ongoing challenge for designing and delivering successful anti-stigma programs pertain to the issue of **multiple stigmas.** For one, many respondents acknowledged that the problem of stigmatization was complex and multifaceted and that mental illnesses were only one of many stigmatizing phenomena – homelessness, poverty, addiction and/or substance dependency, homophobia, racism, and ageism were all mentioned as additional factors that can contribute to the stigmatization of persons with lived experience of a mental illness. As the following comment illustrates:

> *For many people, there's double or triple stigmas they are dealing with. Mental illness and sexual orientation. Mental illness and being a recent immigrant. Mental illness and substance abuse. Mental illness and homelessness. But nobody seems to want to talk about it. It's as if they don't see it as relevant.*

As well, respondents acknowledged that different mental illnesses are associated with different levels of stigma. Addictions and substance abuse, for example, were mentioned as being more stigmatized than many mental illnesses. As well, respondents mentioned borderline personality disorder as a particularly challenging disorder towards which to reduce stigma. In this context, respondents expressed that an ongoing tension for anti-stigma programming is the consideration of whether disorder-specific or more general programming is the preferred or more practical approach. Examples of programs targeting specific disorders that have shown to be successful are provided in the box below.

Programs targeting specific disorders

- That’s Just Crazy Talk (bi-polar disorder)
- Borderline Personality Disorder (BPD) Community Grand Rounds Presentation on Dialectical Behaviour Therapy -- (BPD)
- Cognitive Behaviour Skills Training (CBIS) Program – (depression and anxiety disorders)
- BC PSP Adult Mental Health Module (depression and anxiety disorders)

4.8.3 Influence of Wider Culture/Culture of Healthcare

The **influence of the wider culture**, including the **broader organizational culture of healthcare**, was another important factor mentioned by respondents as an ongoing challenge to successful anti-stigma programming in healthcare contexts. As the following comment illustrate, healthcare providers are not immune to the influences of media and other cultural forces that shape attitudes and beliefs about persons with mental illnesses.

> *We are not a clean slate when we go into a health profession. We are not without stigma. We have all the same influences from our larger culture as everyone else. We draw from large spectrum.*
>
> *This is a culture issue. And the culture of large institutions is very hard to change.*
>
> *Some theories suggest that medical education actually increases stigma … it entrenches as a result of the culture of medicine and medical training. Medical training distances the human experience. We prioritize the pathology over the person. And the culture basically encourages them to see psychological illness in themselves or their colleagues as a weakness. That attitude must influence at least somewhat how they see their patients.*

5 SUMMARY AND CONCLUSIONS

The findings described in this report describe the views and experiences of people actively involved in anti-stigma programming -- including program leads, persons with lived experience of a mental illness involved in program design and/or delivery, and program participants – on the questions of how to design and deliver successful anti-stigma programs for healthcare providers.

As described, there are a number of key steps and strategies involved in the process of designing and delivering successful anti-stigma programming. These stages and steps are summarized in model form, in **Figure 1** (practicing healthcare provider programs) and **Figure 2** (programs for students). As described and highlighted in the models, there were a few key differences in best practices for student and practicing healthcare provider programs, mostly related to the differing contexts of university programming versus in-service/continuing education programming. One major difference, for example, is that programs for practicing healthcare providers require strategies for maximizing participation and getting leadership on board to support the program. Student programs do not typically require marketing strategies and participation incentives to the same extent as they tend to have a more captive participant audience and teachers/professors tend to have more autonomy to design and deliver their courses as they see fit.

As for program content ingredients, respondents mentioned similar key learning needs and key program ingredients for both practicing and student programs. However, there were some differences in the relative emphases placed on the different ingredients. For example, respondents from student programs strongly emphasized the importance of having live social contact interactions between students and persons with lived experience of a mental illness. It was the human connection and interaction -- the experience of getting to know/seeing the person behind the illness, and the ability for students to learn from, and be accountable to, persons with lived experience of a mental illness -- that was emphasized so strongly for student programs. For programs for practicing healthcare providers, live social contact was still preferred, but it was not considered as crucial a program ingredient.

Whether live or by video, respondents for programs for practicing healthcare providers strongly believed that personal testimonies and stories emphasizing hope and recovery were important for reducing stigma among practicing providers. For practicing healthcare provider programs, there was also a strong emphasis placed on the need to teach practical skills (including communication skills) to enhance healthcare providers' confidence and competence in working with persons with a mental illness; basically, ways to improve their ability to 'help'. Education and/or reminders about language usage and body language were also emphasized as being important for practicing healthcare provider programs.

It is worth noting that the key content elements identified in the model(s) under "Build the Program: Include Key Ingredients for Effective Stigma Reduction" have been validated through additional quantitative analyses, whereby program outcomes were measured against the presence or absence of the six key content elements identified in the model(s). These results showed that programs that included all six of these program ingredients performed significantly better than those that did not. Individual analyses of each of the six ingredients showed that including multiple forms of social contact and emphasizing recovery were characteristics of the most effective programs. (See Knaak, Modgill & Patten 2014 for more details).

Overall, the results of this research provide a useful tool or resource to guide the development of anti-stigma programs for practicing and student healthcare providers. While the generalizability of many aspects of the model is limited because of the qualitative nature of the research, the quantitative validation of the 'key content elements' component of the model provides confidence in the generalizability of these program ingredients to positive stigma reduction outcomes.

The process for designing and delivering successful anti-stigma programs described in this report is based on input and information from a number of different programs offered in various jurisdictions and to various healthcare providers groups in Canada. Future research should focus on the continued refinement of the general model(s) provided here, through the collection and continued synthesis of anti-stigma program information, including program outcomes data, participant feedback, as well as results from process evaluations or feedback with highlights best practices, programming challenges and key learnings.

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