Mental Health Commission of Canada

Commission de la santé mentale du Canada

PSP Adult Mental Health Module

Dorothy Luong, Andrew Szeto, Rivian Weinerman, Scott Patten

www.mentalhealthcommission.ca

1 OPENING MINDS: CHANGING HOW WE SEE MENTAL ILLNESS

As part of its 10-year mandate, The Mental Health Commission of Canada (MHCC) 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 not to reinvent the wheel, but rather to build on the strengths of existing programs from across the county. As a result, OM has actively sought out such programs, few of which have been scientifically evaluated for their effectiveness. Now partnering with over 80 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 throughout international studies as a promising practice to reduce stigma. Over time, OM will add other target groups.

2 BACKGROUND

Opening Minds is partnering with programs in Canada reaching out to its initial target groups: youth, healthcare providers, the workforce, and news media. One of the partner programs for healthcare providers is the British Columbia Practice Support Program (PSP) created by the BC General Practice Services Committee (GPSC) to support family physicians in operationalizing training initiatives. One such initiative was the PSP Adult Mental Health Module which was developed to enhance the capacity and comfort of family physicians to diagnose and engage patients in the management of their mental health issues. This module trained family physician leaders to train other family physicians in the use of a wide range of tools that could be used by physicians in their own offices. It used a QI plan to study an approach that involved three learning sessions separated by two action periods of about seven weeks. There are three components of the module providing three options for the family doctor and client. CBIS (Cognitive Behavioral Skills Manual), developed by Dr. Weinerman and her team, presents an organized protocol approach taking physician and client from a diagnostic screening interview through to a care plan, to one-page self-management CBT skills handouts that can be done in realistic Family Practice time, fitting BC fee schedules. The Antidepressant Skills Workbook (ASW) developed by Dan Bilsker, PhD, is another self-management workbook coaching option for family physicians. Finally, there is the Bounceback program delivered by CMHA that includes a DVD handout and a community self-management telephone coaching program. The program is on the www.gpscbc.ca website. The program was evaluated by Hollander Analytical Services Limited at end of training and at three- and six-month follow-up. Results showed that this module was extremely successful in changing Family Physicians' practice and feeling they had improved patient care, increased their job satisfaction, decreased their reliance on prescribing antidepressant medications, and improved their patients' ability to return to work and stay at work. This change in practice was sustained over a 6- to 12-month follow-up period. Patients felt more comfortable and engaged. A major insight evolved as physicians became more knowledgeable and comfortable/confident, and linking with the AIDS literature which has shown that increasing physician's and client's information and coping skills reduces stigma, it was an easy extrapolation from the AIDS experience to hypothesize that this module could lead to less avoidance and stigmatization of patients struggling with mental health problems.

The module was revised in order to deliver a day-long program for family doctors attending the Family Medicine Forum, an annual conference for family physicians of Canada. Only CBIS and the ASW were used since Bounceback is not available for use outside of BC, and were delivered by Dr. Weinerman and her team, Dr. Dan Bilsker, and Dr. Bruce Hobson, one of the GP trainers. Dr. Hobson also created the hyperlinked algorithm which links all the tools of the program for easy computer use. Opening Minds has evaluated the program to determine if the components of the module presented in this way could be effective at reducing stigma.

The one-day workshop was administered in Montreal, Quebec, in November 2011 with approximately 30 attendees. The interactive program included an integration of role-playing, media, and other activities.

3 METHODOLOGY OF EVALUATION

Workshop participants were given a questionnaire package at two time-points: before the workshop began (pre-workshop) and immediately following completion of the workshop (post-workshop). The pre-workshop survey package contained the Opening Minds Scale for Health Care Providers (OMS-HC), questions pertaining to experiences with mental illness, and demographic questions (age, gender, training, and professional status). At post-workshop, participants completed the OMS-HC again.

3.1 Opening Minds Scale for Health Care Providers

OMS-HC is a 20-item questionnaire that measures healthcare providers' stigmatizing attitudes towards people with a mental illness. Participants were asked the extent to which they agree or disagree with each item. Items are rated on a 5-point scale: strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree.

To create a total scale score for the OMS-HC, all 20 items were summed for each participant. Total scores ranged from 20 to 100, with lower scores indicating less stigmatizing attitudes. Cronbach's alphas were .67 at pre-workshop and .47 at post-workshop.

A paired samples t-test was used to assess if there was a significant change in pre-workshop and post-workshop total scores.

4 RESULTS

4.1 Demographic

Approximately 30 family physicians participated in the workshop, of which 26 completed the pre-workshop survey and 18 completed the post-workshop survey. One participant completed the post-workshop survey but not the pre-workshop survey, resulting in 17 pre- and post-workshop surveys that were able to be matched.

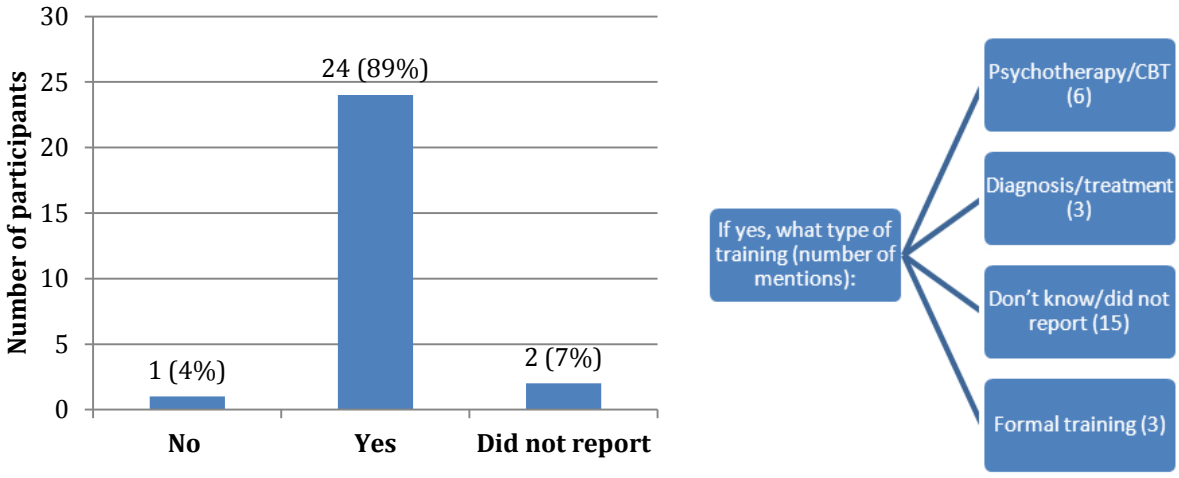
Table 1 displays the demographic characteristics of the respondents. The majority of respondents were females (74%) and were in their 30's (n = 11). Over half of the participants were family physicians (67%) with an average number of years in practice of 11.14 years (SD = 10.66). The majority of participants reported knowing a family member or close friend with a mental illness (67%) and nearly all of the participants reported having had treated a person with a mental illness (89%).

Figure 1 shows the percentage of participants reporting whether they value more training in the mental health field. The overwhelming majority of participants reported yes (89%), and selected psychotherapy/CBT, formal training, and diagnosis/treatment training as the types of training they would value.

Table 1. Demographic Characteristics of Respondents

Demographic variables (pre-test)	% (n)
Sex	
▪ Female	74% (20)
▪ Male	22% (6)
▪ Did not report	4% (1)
Age group	
▪ 18-29	7% (2)
▪ 30-39	41% (11)
▪ 40-49	22% (6)
▪ 50-59	26% (7)
▪ Did not report	4% (1)
Professional status*	
▪ Family physician	67% (18)
▪ Other physician	3% (11)
▪ Other (e.g. resident)	5% (19)
▪ Did not report	1% (4)
Has a mental illness	
▪ No	78% (21)
▪ Yes	7% (2)
▪ Prefer not to answer	12% (3)
▪ Did not report	1% (4)
Knows a family member or close friend with mental illness	
▪ No	26% (7)
▪ Yes	67% (18)
▪ Prefer not to answer	1% (4)
▪ Did not report	1% (4)
Has treated a person with mental illness	
▪ No	7% (2)
▪ Yes	89% (24)
▪ Did not report	1% (4)
Note: * Average number of years in practice was 11.14 years (SD = 10.66)	

Figure 1. Number of Participants Indicating Whether or not they Would Value Additional Training in the Mental Health Field, with Types of Training Mentioned



4.2 Evaluation Results: Opening Minds Scale for Health Care Providers

4.2.1 Overall Change

Figure 2 shows the total scores on the OMS-HC (matched) for pre-test and post-test. Stigmatizing attitudes decreased by approximately 10% from pre-workshop to post-workshop, reflecting a change in average score from 48 to 43. The paired samples t-test indicated that this difference was statistically significant, $t(16) = 3.86$, $p < .001$.

Figure 2. Overall Average Scores on the OMS-HC (matched)*

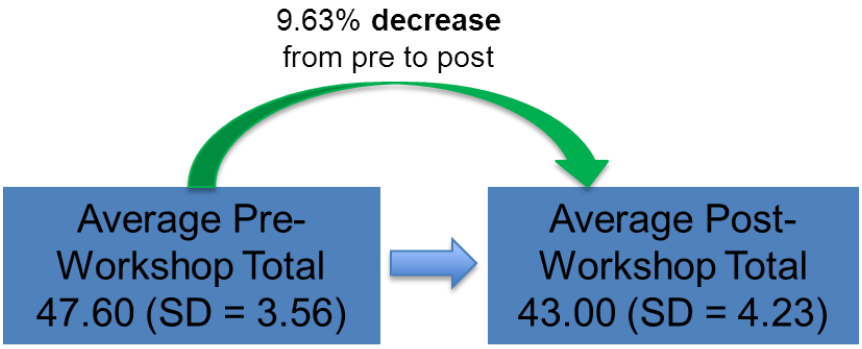
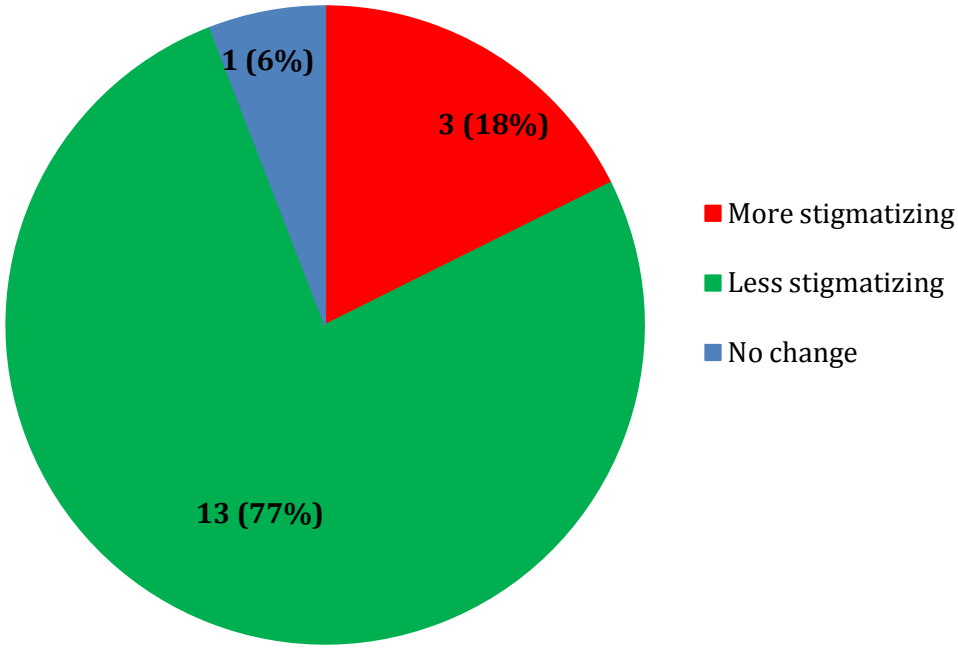


Figure 3 displays the number and percentage of participants that had a total score increase (i.e., more stigmatizing), decrease (i.e., less stigmatizing), or a score that had no change from pre- to post-workshop. The majority of respondents, 77%, were less stigmatizing after the workshop while only three participants had scores that indicated their attitudes had become more stigmatizing after the workshop.

Figure 3. Participants' Total Score Change from Pre-Workshop to Post-Workshop



4.2.2 Item-by-item Change and Subscales

In Appendix A, Tables 1A and 2A display the percentage of participants choosing each of the scale options for each time period at pre- and post-workshop for the entire sample and for the matched sample, respectively. These items of the OMS-HC (with the exception of Item 16 – *The best treatment for mental illness is medication*) can be grouped by similar content into four different categories of stigma:

- Social Distance (Items 1, 3, 9, 19)
- Discrimination (Items 2, 6, 8, 12, 14, 15, 17, 20)
- Helping (Items 4, 5, 7, 10)
- Social Responsibility (Items 11, 13, 18)

Note that these are not strict subscales, but a grouping of items based on similarity in content. The average scores of each stigma content areas were created by summing all the items in that content area

and dividing by the number of items in the content area, with average scores ranging from 1 to 5 and lower scores being an indication of less stigma.

Table 2 depicts the average scores for each content area at pre- and post-workshop, along with the results of paired samples t-tests. After the workshop, scores on all four stigma content areas decreased, representing a reduction in stigma of 13% for social distance, 8% for discrimination, 8% for helping, and 17% for social responsibility. These percentage changes were found to be significant, according to the paired samples t-test ($p < .05$).

Table 2. Stigma Content Areas

Content Area	Means*		Percentage Change	Pair Samples T-Test	
	Pre	Post		T-value	P-value
Social Distance	2.31	2.01	13	2.25	0.039
Discrimination	2.22	2.04	8	2.78	0.013
Helping	3.29	3.01	8	2.56	0.021
Social Responsibility	1.73	1.43	17	2.50	0.023

Table 3A in Appendix A displays the pre-post average scores (matched sample) for each item, along with the results of the paired samples t-test. Overall, stigmatizing attitudes on the majority of items decreased, with the highest percentage change found on the following items:

Social distance
If a colleague with whom I work told me they had a managed mental illness, I would be as willing to work with him/her (19%).

Discrimination
I would see myself as weak if I had a mental illness and could not fix it myself (28%).

Helping
I would be reluctant to seek help if I had a mental illness (22%).

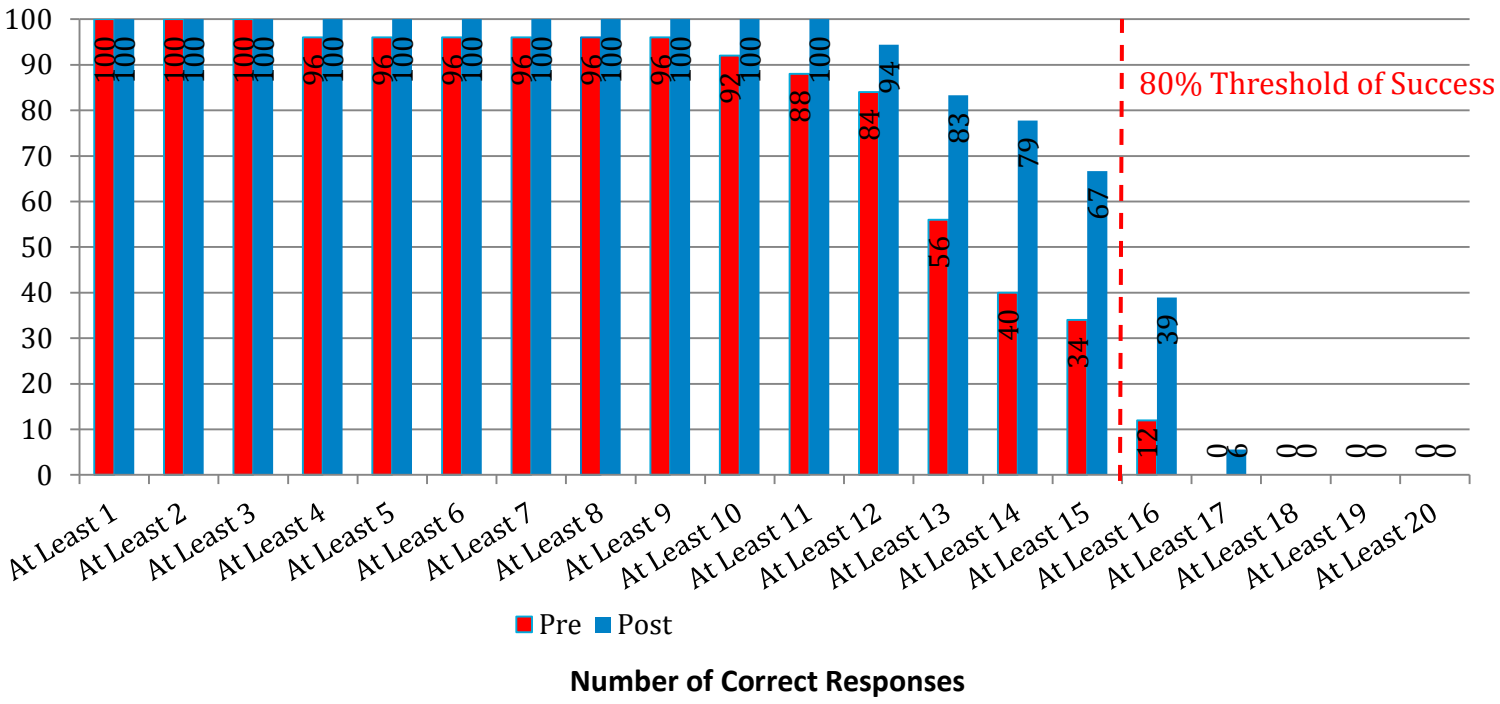
Social responsibility

It is the responsibility of healthcare providers to inspire hope in people with mental illness (22%).

There is little I can do to help people with mental illness (19%).

While there were two items on the scale where stigmatizing attitudes increased (*If a person with a mental illness complains of physical symptoms [e.g. nausea, back pain, or headache], I would likely attribute this to their mental illness; People with mental illness seldom pose a risk to the public*), the difference in score was not significant, i.e., < 10% change.

Figure 4. Cumulative Percent of Non-Stigmatizing Responses on OMS-HC for Pre-Workshop and Post-Workshop



4.2.3 80% Threshold

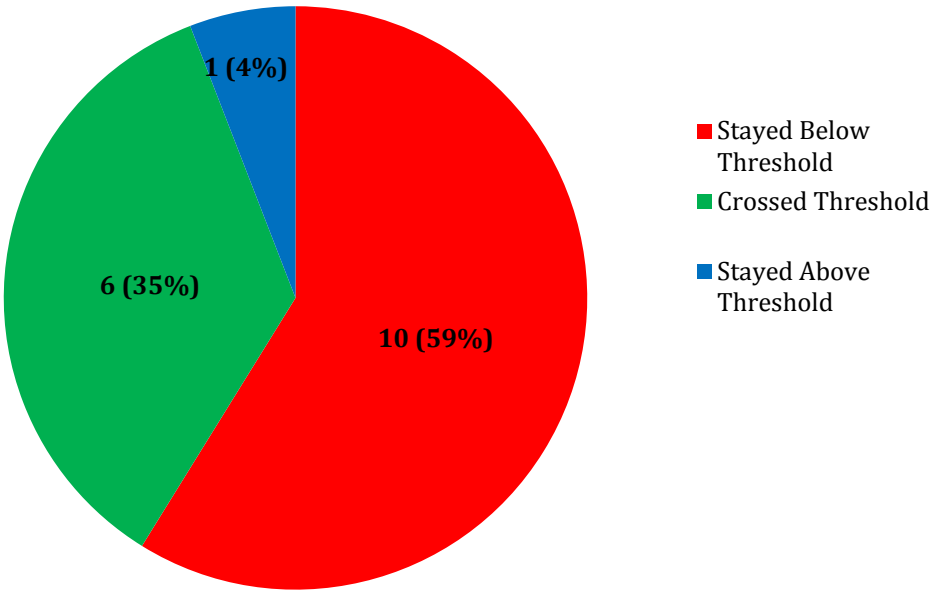
Figure 4 shows the cumulative percentages of participants who had non-stigmatizing responses for each possible score out of 20 at pre-workshop and post-workshop. This figure was derived by recoding each participant's response on the attitude scale to represent a stigmatizing or non-stigmatizing response. For example, "Most people with mental illness could snap out of it if they wanted to" was recorded as non-stigmatizing if the respondent selected *strongly disagree* or *disagree,* and recoded as stigmatizing if the respondent chose *neutral*, *agree*, or *strongly agree*.

A threshold of 80% (or at least 16 out of 20 "correct" – i.e., non-stigmatizing – answers) was used as an indication of success on the OMS-HC.

Prior to the workshop, only 12% of participants managed to cross this 80% threshold of success on the OMS-HC. However, by the end of the workshop, the number of participants who had crossed the 80% threshold level of success had increased to 40%. In general, there were a high percentage of participants achieving a large number of non-stigmatizing responses on this measure after the intervention. When the threshold level of success was lowered slightly to 70% (or at least 14 out of 20 "correct" – i.e., non-stigmatizing – answers), approximately 80% of participants had reached success after the workshop, compared to only 40% who did so pre-workshop.

Figure 5 displays the number of participants who moved across the 80% threshold of success after the workshop. While the majority of respondents stayed below the threshold (59%), 35% of respondents moved above this threshold post-workshop.

Figure 5. Threshold Categorization from Pre-Workshop to Post-Workshop



5 SUMMARY

This revised one-day training program derived from the BC PSP Adult Mental Health Module delivered by a team from British Columbia to Canadian family physicians at a national conference in Montreal, Quebec, had overall positive results. After the workshop, 77% of participants had less stigmatizing

attitudes on the OMS-HC as compared to the pre-workshop test. Additionally, after the workshop, 40% of participants achieved success (i.e., had 80% correct/non-stigmatizing answers) on the OMS-HC measure, as compared to only 12% prior to the workshop. The highest change in stigmatizing attitudes was seen in the area of social responsibility. With that said, there were a large percentage of participants (35%) who only completed the pre- but not post-workshop questionnaire. It is possible that those who completed questionnaires at both time points are different than those who only completed the pre-workshop questionnaire, such as having more stigmatizing attitudes. Therefore, the results presented are only representative of "completers" and may not apply to a more general sample. A paired samples t-test indicated that this was not the case, $t(9) = 0.152$, $p = .883$. In other words, there were no differences between the "completers" ($M = 47.60$; $SD = 9.68$) and "non-completers" ($M = 48.11$; $SD = 3.56$) on the OMS-HC at pre-workshop.[1] Generally, these results suggest that this shortened initiative was effective at reducing mental illness-related stigma; however, the results do not speak to the long-term effects of this initiative. Although these results taken as a whole are very encouraging, replication of these findings with larger samples (and less attrition of participants) are necessary before any firm conclusions can be made. In addition, it remains to be seen if the PSP module, if presented in its original form involving three learning sessions and two practice periods, would be more or less successful than this revised shortened program. Some evaluations are underway for the latter.

[1] This was also the case for the number of "correct" responses between "completer" ($M = 12.94$; $SD = 1.68$) and "non-completer" ($M = 12.25$; $SD = 4.30$), $t(8) = 0.439$, $p = .672$.

Appendix A

Table 1A. OMS-HC – Percent Across Scale Options (entire sample)

Number	Item	Pre-workshop					Post-workshop					Percentage Change from Pre to Post-workshop				
		Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	0.0	7.7	30.8	57.7	3.8	5.6	22.2	16.7	50.0	5.6	5.6	14.5	-14.1	-7.7	1.8
2	If a person with a mental illness complains of physical symptoms (e.g. nausea, back pain or headache), I would likely attribute this to their mental illness.	7.7	42.3	30.8	19.2	0.0	11.1	50.0	11.1	27.8	0.0	3.4	7.7	-19.7	8.6	0.0
3	If a colleague with whom I work told me they had a managed mental illness, I would be as willing to work with him/her.	0.0	8.0	8.0	52.0	32.0	0.0	0.0	0.0	61.1	38.9	0.0	-8.0	-8.0	9.1	6.9
4	If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	3.8	15.4	30.8	34.6	15.4	0.0	11.1	50.0	27.8	11.1	-3.8	-4.3	19.2	-6.8	-4.3
5	I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.	0.0	3.8	15.4	53.8	26.9	0.0	5.6	22.2	55.6	16.7	0.0	1.7	6.8	1.7	-10.3
6	I would see myself as weak if I had a mental illness and could not fix it myself.	11.5	26.9	26.9	30.8	3.8	11.1	61.1	11.1	16.7	0.0	-0.4	34.2	-15.8	-14.1	-3.8
7	I would be reluctant to seek help if I had a mental illness.	11.5	50.0	11.5	23.1	3.8	27.8	55.6	5.6	11.1	0.0	16.2	5.6	-6.0	-12.0	-3.8
8	Employers should hire a person with a managed mental illness if he/she is the best person for the job.	0.0	0.0	0.0	53.8	46.2	0.0	0.0	0.0	55.6	44.4	0.0	0.0	0.0	1.8	-1.8
9	I would still go to a physician if I knew that the physician had been treated for a mental illness.	0.0	3.8	3.8	53.8	38.5	0.0	5.6	0.0	55.6	38.9	0.0	1.7	-3.8	1.7	0.4
10	If I had a mental illness, I would tell my friends.	7.7	11.5	46.2	30.8	3.8	5.6	16.7	50.0	22.2	5.6	-2.1	5.1	3.8	-8.5	1.7
11	It is the responsibility of health care providers to inspire hope in people with mental illness.	0.0	0.0	15.4	53.8	30.8	0.0	0.0	0.0	50.0	50.0	0.0	0.0	-15.4	-3.8	19.2
12	Despite my professional beliefs, I have negative reactions towards people who have mental illness.	19.2	46.2	15.4	19.2	0.0	22.2	61.1	5.6	11.1	0.0	3.0	15.0	-9.8	-8.1	0.0
13	There is little I can do to help people with mental illness.	33.3	58.3	4.2	4.2	0.0	50.0	50.0	0.0	0.0	0.0	16.7	-8.3	-4.2	-4.2	0.0
14	More than half of people with mental illness don't try hard enough to get better.	12.0	64.0	16.0	8.0	0.0	11.1	72.2	11.1	5.6	0.0	-0.9	8.2	-4.9	-2.4	0.0
15	People with mental illness seldom pose a risk to the public.	0.0	11.5	23.1	53.8	11.5	5.6	11.1	22.2	44.4	16.7	5.6	-0.4	-0.9	-9.4	5.1
16	The best treatment for mental illness is medication.	11.5	38.5	46.2	0.0	3.8	16.7	50.0	22.2	5.6	5.6	5.1	11.5	-23.9	5.6	1.7
17	I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	28.0	56.0	12.0	4.0	0.0	27.8	66.7	5.6	0.0	0.0	-0.2	10.7	-6.4	-4.0	0.0
18	Healthcare providers do not need to be advocates for people with mental illness.	56.0	40.0	4.0	0.0	0.0	61.1	38.9	0.0	0.0	0.0	5.1	-1.1	-4.0	0.0	0.0
19	I would not mind if a person with a mental illness lived next door to me.	7.7	3.8	3.8	65.4	19.2	0.0	0.0	0.0	66.7	33.3	-7.7	-3.8	-3.8	1.3	14.1
20	I struggle to feel compassion for a person with a mental illness.	34.6	50.0	11.5	0.0	3.8	50.0	44.4	5.6	0.0	0.0	15.4	-5.6	-5.9	0.0	-3.8

Table 2A. OMS-HC – Percent Across Scale Options (paired sample)

Number	Item	Pre-workshop					Post-workshop					Percentage Change from Pre to Post-workshop				
		Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	0.0	5.9	35.3	58.8	0.0	5.6	22.2	16.7	50.0	5.6	5.6	16.3	-18.6	-8.8	5.6
2	If a person with a mental illness complains of physical symptoms (e.g. nausea, back pain or headache), I would likely attribute this to their mental illness.	5.9	58.8	23.5	11.8	0.0	11.1	50.0	11.1	27.8	0.0	5.2	-8.8	-12.4	16.0	0.0
3	If a colleague with whom I work told me they had a managed mental illness, I would be as willing to work with him/her.	0.0	6.3	12.5	56.3	25.0	0.0	0.0	0.0	61.1	38.9	0.0	-6.3	-12.5	4.9	13.9
4	If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	0.0	17.6	41.2	23.5	17.6	0.0	11.1	50.0	27.8	11.1	0.0	-6.5	8.8	4.2	-6.5
5	I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.	0.0	0.0	23.5	35.3	41.2	0.0	5.6	22.2	55.6	16.7	0.0	5.6	-1.3	20.3	-24.5
6	I would see myself as weak if I had a mental illness and could not fix it myself.	5.9	23.5	29.4	35.3	5.9	11.1	61.1	11.1	16.7	0.0	5.2	37.6	-18.3	-18.6	-5.9
7	I would be reluctant to seek help if I had a mental illness.	5.9	58.8	5.9	23.5	5.9	27.8	55.6	5.6	11.1	0.0	21.9	-3.3	-0.3	-12.4	-5.9
8	Employers should hire a person with a managed mental illness if he/she is the best person for the job.	0.0	0.0	0.0	52.9	47.1	0.0	0.0	0.0	55.6	44.4	0.0	0.0	0.0	2.7	-2.7
9	I would still go to a physician if I knew that the physician had been treated for a mental illness.	0.0	5.9	0.0	58.8	35.3	0.0	5.6	0.0	55.6	38.9	0.0	-0.3	0.0	-3.3	3.6
10	If I had a mental illness, I would tell my friends.	11.8	5.9	47.1	35.3	0.0	5.6	16.7	50.0	22.2	5.6	-6.2	10.8	2.9	-13.1	5.6
11	It is the responsibility of health care providers to inspire hope in people with mental illness.	0.0	0.0	11.8	64.7	23.5	0.0	0.0	0.0	50.0	50.0	0.0	0.0	-11.8	-14.7	26.5
12	Despite my professional beliefs, I have negative reactions towards people who have mental illness.	5.9	58.8	17.6	17.6	0.0	22.2	61.1	5.6	11.1	0.0	16.3	2.3	-12.1	-6.5	0.0
13	There is little I can do to help people with mental illness.	29.4	64.7	0.0	5.9	0.0	50.0	50.0	0.0	0.0	0.0	20.6	-14.7	0.0	-5.9	0.0
14	More than half of people with mental illness don't try hard enough to get better.	5.9	70.6	17.6	5.9	0.0	11.1	72.2	11.1	5.6	0.0	5.2	1.6	-6.5	-0.3	0.0
15	People with mental illness seldom pose a risk to the public.	0.0	11.8	23.5	52.9	11.8	5.6	11.1	22.2	44.4	16.7	5.6	-0.7	-1.3	-8.5	4.9
16	The best treatment for mental illness is medication.	17.6	41.2	41.2	0.0	0.0	16.7	50.0	22.2	5.6	5.6	-1.0	8.8	-19.0	5.6	5.6
17	I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	29.4	52.9	17.6	0.0	0.0	27.8	66.7	5.6	0.0	0.0	-1.6	13.7	-12.1	0.0	0.0
18	Healthcare providers do not need to be advocates for people with mental illness.	58.8	35.3	5.9	0.0	0.0	61.1	38.9	0.0	0.0	0.0	2.3	3.6	-5.9	0.0	0.0
19	I would not mind if a person with a mental illness lived next door to me.	5.9	0.0	0.0	70.6	23.5	0.0	0.0	0.0	66.7	33.3	-5.9	0.0	0.0	-3.9	9.8
20	I struggle to feel compassion for a person with a mental illness.	35.3	52.9	11.8	0.0	0.0	50.0	44.4	5.6	0.0	0.0	14.7	-8.5	-6.2	0.0	0.0

Table 3A. OMS-HC – Item Scores Group by Content Area (paired sample)

Number	Content Area	Item	Means*		Percentage Change	Pair Samples T-Test	
			Pre	Post		T-value	P-value
1	SD	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	3.53	3.24	8.3	1.16	.264
3	SD	If a colleague with whom I work told me they had a managed mental illness, I would be as willing to work with him/her.	2.00	1.63	18.8	1.86	.083
9	SD	I would still go to a physician if I knew that the physician had been treated for a mental illness.	1.76	1.59	10.0	1.00	.332
19	SD	I would not mind if a person with a mental illness lived next door to me.	1.94	1.65	15.2	1.23	.236
2	Dis	If a person with a mental illness complains of physical symptoms (e.g. nausea, back pain or headache), I would likely attribute this to their mental illness.	2.41	2.59	-7.3	-0.82	.422
6	Dis	I would see myself as weak if I had a mental illness and could not fix it myself.	3.12	2.24	28.3	4.24	.001
8	Dis	Employers should hire a person with a managed mental illness if he/she is the best person for the job.	1.53	1.53	0.0	0.00	1.000
12	Dis	Despite my professional beliefs, I have negative reactions towards people who have mental illness.	2.47	2.12	14.3	2.40	.029
14	Dis	More than half of people with mental illness don't try hard enough to get better.	2.24	2.12	5.3	0.62	.543
15	Dis	People with mental illness seldom pose a risk to the public.	2.35	2.41	-2.5	-0.27	.791
17	Dis	I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	1.88	1.76	6.3	1.00	.332
20	Dis	I struggle to feel compassion for a person with a mental illness.	1.76	1.59	10.0	1.00	.332
4	Help	If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	3.41	3.35	1.7	0.32	.750
5	Help	I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.	4.18	3.76	9.9	2.38	.030
7	Help	I would be reluctant to seek help if I had a mental illness.	2.65	2.06	22.2	2.42	.028
10	Help	If I had a mental illness, I would tell my friends.	2.94	2.88	2.0	0.32	.750
11	SR	It is the responsibility of health care providers to inspire hope in people with mental illness.	1.88	1.47	21.9	3.35	.004
13	SR	There is little I can do to help people with mental illness.	1.82	1.47	19.4	2.07	.055
18	SR	Healthcare providers do not need to be advocates for people with mental illness.	1.47	1.35	8.0	0.70	.496
16		The best treatment for mental illness is medication.	2.24	2.24	0.0	0.00	1.000