TOGETHER AGAINST STIGMA:
CHANGING HOW WE SEE MENTAL ILLNESS
A REPORT ON THE 5TH INTERNATIONAL STIGMA CONFERENCE

Ottawa, Canada
June 4–6, 2012
Co-published by the Mental Health Commission of Canada, the Canadian Human Rights Commission, the World Psychiatric Association Scientific Section on Stigma and Mental Health, and the Public Health Agency of Canada

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EXECUTIVE SUMMARY

Mental illness[1] is a universal problem; however, the stigma associated with it prevents two-thirds of those who experience mental illness from seeking help. Stigma—the negative attitudes toward people with mental illness, and the negative behaviours that result—is a major barrier preventing individuals from asking for support and, often, preventing support from being readily available.

Stigma can limit people's employment, housing and educational opportunities—and isolate them from friends and family who might otherwise provide crucial support. It is often internalized by those with mental illness, further isolating them.

A RECORD-SETTING EVENT

Held in Ottawa, Canada, from June 4–6, 2012, the 5th International Together Against Stigma Conference drew more delegates than any previous meeting on the topic of stigma and mental health. Some 670 attendees from 29 countries came together for a programme of 115 sessions and 95 posters, built from 279 submitted abstracts.

The international character of the conference underscored the fact that stigma is not exclusive to any one country or culture. It is pervasive, encountered at all levels of society and institutions, among families and within the healthcare profession itself.

One of the strongest messages to emerge was that any effort to reduce stigma must involve persons who have experienced mental illness. This event included more than 100 such individuals—as attendees, volunteers and presenters. Its diverse audience also included researchers, mental health professionals, policymakers and media.

PROCEEDINGS IN BRIEF

DAY 1: MEDIA DEPICTIONS
Day 1 of the conference focused on the media's role in perpetuating stigma—and on the potential of media to contribute solutions. Recognized personalities Lloyd Robertson and Glenn Close shared stories of their families' experiences with mental illness; Robertson also participated in a panel discussion on the Canadian news media's handling of mental health topics. Parallel sessions that day examined how film, television and advertising depict mental illness and how the arts and creative activities can serve as pathways to recovery. Findings were presented on the causes, impacts and perceptions of stigma around the world.

DAY 2: HEALTHCARE PROVIDERS/YOUTH
Day 2 included several presentations on stigma in healthcare settings—from the attitudes of care providers to programs seeking to effect change. Stigma in healthcare can be particularly devastating and can contribute to disability and mortality. Day 2 also looked at how stigma affects youth, a key demographic because many mental illnesses first present during adolescence. Strong emphasis was put on the importance of facilitating contact between people with and without mental illness to foster understanding.

DAY 3: HUMAN RIGHTS/THE WORKPLACE
Day 3 examined the larger-scale issue of human rights, such as how individuals experiencing mental health issues continue to be compromised by stigma, particularly in the workplace, and how organizations nationally and internationally are trying to address rights issues. Many of the workplace-focused sessions looked at barriers to entry for people with mental illness seeking jobs. Multiple panel discussions tackled human rights-related topics, including the

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[1] Throughout this document when we refer to mental illness, we are referring to the broad spectrum of mental illnesses.

rollout of the United Nations' groundbreaking *Convention on the Rights of Persons with Disabilities.*

TAKEAWAYS

A number of observations and key messages repeatedly emerged over the course of the conference. Among the most prominent were:

1. The importance of including people with lived experience (those with mental illness and their family members) when designing services, developing and delivering solutions and executing programs to combat stigma.

2. The effectiveness of contact-based education—interactions between those with lived experience and those who might hold stigmatizing attitudes—in reducing stigma.

3. There is a need to go beyond changing attitudes to change behaviours.

4. More research is needed to better understand how stigma affects help-seeking.

5. Working with the media to raise awareness of mental health issues is an effective approach with potential to have a positive impact on public perceptions.

6. Engagement in creative arts not only facilitates recovery from a mental illness but may also help break down barriers and reduce stigma.

7. Programs must be tailored to specific audiences; one-size-fits-all approaches are less effective.

8. Prejudice and discrimination are prevalent within the health system and must be recognized.

9. Youth are an essential audience to reach through anti-stigma programs, as mental health issues often first present in the teenage years.

10. Work opportunities for people with lived experience of mental health problems and illnesses have to be fostered.

11. It is important to capitalize on the workplace as an environment for anti-stigma intervention.

12. It is important to adopt a human rights and social justice framework to bring about structural changes and support for those who experience mental illness.

Mental illness affects people of all ages
from all walks of life.

Mental illness can take many forms—
including depression, anxiety and schizophrenia.

Many people living with mental illness say
**the stigma they face is often worse
than the illness itself.**

THREE DAYS. A WORLD OF CHANGE.

On June 4, 2012, close to 700 delegates from 29 countries gathered in the main ballroom of the Delta Ottawa City Centre in Canada's capital. They were there to kick off a packed three-day agenda of presentations, panels, symposia and workshops focused on the vitally important topic of stigma and mental health. The conference was a watershed moment.

No previous stigma conference had attracted so large and diverse a crowd. The number of delegates nearly tripled that of the 4th International Stigma Conference in 2009. The programme of 115 sessions and 95 posters was built from a record submission of 279 abstracts.

The sheer volume of interest suggests a shift in global awareness of mental health as a crucial concern for all societies, and of the powerful, often devastating impact exerted by the stigma that surrounds it.

The international character of the conference underscored the fact that stigma is not exclusive to any one country or culture: it is pervasive, encountered at all levels of society, institutions, among families and within the healthcare profession itself.

If there was one clear, overarching message to emerge from the proceedings, it was that any effort to reduce stigma must involve those who know it best: the individuals who have experienced a mental illness. This event included more than 100 such people with lived experience of mental health problems and illnesses—as attendees, volunteers and presenters—giving weight to the conference's title, Together Against Stigma.

The 5th International Stigma Conference attracted participants from:

Argentina
Australia
Belgium
Brazil
Canada
Chile
Colombia
Denmark
England
Germany
India
Indonesia
Ireland
Italy
Japan
Lithuania
Mexico
Netherlands
New Zealand
Nigeria
Poland
Saudi Arabia
Scotland
Spain
Sweden
Switzerland
Turkey
Uganda
United States

"One of the best conferences I have attended in 25 years."

~ Evaluation survey response

HOW WE GOT HERE

Mental illness is a universal problem; however, the stigma associated with mental illness prevents two-thirds of those affected from seeking help. Stigma—the negative attitudes toward people with a mental illness, and the negative behaviours that result—is a major barrier preventing individuals from asking for support and, often, preventing support from being readily available.

Many people living with a mental illness say the stigma they face is often worse than the illness itself. It can manifest in the loss of friends and loved ones—the people most critical to one's social support network. It can limit employment, housing and educational opportunities. Through all these forms of reinforcement, those with mental illnesses often internalize stigma. They come to self-stigmatize, which can be an obstacle to accessing care—and to their quality of life.

ABOUT THE CONFERENCE

In 1996, the World Psychiatric Association created Open the Doors, a global program to fight stigma and discrimination related specifically to schizophrenia. The first Together Against Stigma International Conference was held by the members of that program in Leipzig (Germany) in 2001, with the aim of fostering multidisciplinary interest in anti-stigma programs—breaking down the silos between disciplines and driving efforts from theory into practice. Since then, Together Against Stigma conferences have been held in Kingston (Canada), Istanbul (Turkey) and London (United Kingdom).

In 2005, the World Psychiatric Association's General Assembly ratified the creation of a Scientific Section focusing on stigma and mental health, bringing together more than 65 international scientists focused on stigma reduction.

The World Psychiatric Association's Scientific Section on Stigma and Mental Health co-sponsors the Together Against Stigma conferences. This fifth instalment was hosted by the Mental Health Commission of Canada through its Opening Minds[2] anti-stigma initiative, which seeks to reduce stigma by changing the attitudes and behaviours of Canadians toward people who have a mental illness. It is the largest systematic effort undertaken in Canadian history to reduce the stigma and discrimination associated with mental illness.

The aim of the 5th International Stigma Conference was to convene researchers, mental health professionals, policymakers, members of the media and persons with lived experience to discuss effective interventions to reduce stigma and discrimination against those with mental illness.

> *"Sometimes as a researcher you wonder if anyone beyond the academics in your field really cares about what you're doing. It was a nice reminder that what we do is being put into a bigger context, that people are interested, that it matters."*
> ~ Evaluation survey response

AN AMBITIOUS AGENDA

Together Against Stigma: Changing How We See Mental Illness was structured around five themes. To ground the conference, Days 1 and 2 began with personal stories from people with lived experience of mental health problems and illnesses.

- Day 1 focused on the media—how it represents mental illness and the role it can play in shaping positive attitudes.
- Day 2 looked at best practices for reducing stigma among healthcare providers and youth.
- Day 3 considered the impact of stigma in the workplace and the human rights implications of stigma more broadly.

After beginning with a series of plenaries related to its thematic focus, each day progressed through two waves of parallel sessions—accommodating the volume and variety of presentations.

The diverse programme included presentations of scientific research, survey results and measures; reviews of specific initiatives highlighting best practices; and personal accounts of lived experience that resoundingly reinforced the messages that recovery is possible and that stigma must be overcome.

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[2] For more on *Opening Minds,* see page 11.

Large audiences attended the evening performances by Toronto's Elevated Grounds troupe and actress **Victoria Maxwell**, as well as a gathering about the Mental Health First Aid program attended by **Betty Kitchener**, one of its creators. A silent auction of works by persons with lived experience raised $2,825, all of which went directly to the artists.

> *"After 30 years of working in the field of mental health you don't expect to feel excited, but I left with a sense of excitement. …At the end of the first day I was experiencing new learning."*
> ~ Evaluation survey response

ACKNOWLEDGEMENTS

The 5th International Stigma Conference would not have been possible without the generous support of many sponsors, partners and volunteers. Thanks go to:

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Bell Canada
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Canadian Human Rights Commission
Public Health Agency of Canada

DAY 1: MEDIA DEPICTIONS

The first day of the conference set the tone for the entire session. A packed and varied agenda organized around a central theme—in this case, the media's role in perpetuating stigma and its potential to become part of the solution—led attendees from full-house plenary sessions and panel discussions to presentations of the latest research and hands-on experimental workshops.

The day began with some well-known faces taking the podium: renowned Canadian broadcaster **Lloyd Robertson** served as emcee and, later, shared his personal story of living with a mother who had a severe mental illness. He also participated on a panel that engaged in a frank discussion of the Canadian news media's handling of mental health topics. Award-winning American actress **Glenn Close**, her sister **Jessie Close** and nephew **Calen Pick** shared their family's struggles with mental illness and how Close was inspired to create the awareness-raising organization Bring Change 2 Mind. **Norman Sartorius** announced that, contrary to popular perception, stigma is on the rise—and that addressing it will require fundamental paradigm shifts in how we approach mental health.

Toward the half-day mark, First Nations representative **Aileen Lindsay** offered a welcoming prayer for the conference attendees.

The afternoon session branched off in several directions—from discussions of how film, television and advertising depict mental illness, to the use of arts and creative activities as pathways to recovery. Researchers presented findings on the sources, impacts and perceptions of stigma

around the world. Some proposed innovative models for reducing stigma, including actively engaging families in care and incorporating the voices of those with lived experience into research and policy. Others presented programs showing how collaboration between advocacy groups and media can yield positive results.

"I accomplished nothing by getting ill and everything by getting well."
~ Jessie Close

WELCOME

David Goldbloom, Chair of the Mental Health Commission of Canada, opened the 5th International Stigma Conference by acknowledging it to be the largest gathering ever on the issue of stigma—drawing 670 delegates from 29 countries. Goldbloom called attention to its theme, Changing the Way We See Mental Illness.

PRESENTERS
David Goldbloom, CA
Heather Stuart, CA
Lisa Raitt, CA
Louise Bradley, CA

He noted the phrase begs a question: How do we see mental illness today? Mostly as a burden, a weakness—something to be feared. The topic is routinely avoided or trivialized. As a result, people can be disinclined to seek help—or to give it. Those who do seek care often do not find the support they need: their families, schools, workplaces and other institutions are not equipped to provide it.

Heather Stuart, Chair of the World Psychiatric Association's Scientific Section on Stigma and Mental Health (a co-host of the conference), identified Norman Sartorius as one of the first to recognize stigma as an obstacle—perhaps *the* obstacle—to dealing with mental illness. Echoing Goldbloom, she observed one of the aims of these anti-stigma conferences is to bring together experts from different backgrounds: those with lived experience (more than 100 of whom were in attendance), their families, scientists, advocates, policymakers and government decision makers. She thanked the MHCC for providing bursaries and waiving fees for individuals who would not otherwise have been able to attend.

The Honourable **Lisa Raitt**, the Minister of Labour Canada, recounted her personal story of struggle with post-partum depression in the early 2000s—and the fear of stigma that kept her silent about the experience. Even when, as Minister of Labour, she declared mental health a priority for her department, she couched it in terms of productivity benefits and innovation. Only when she received an award in October 2011 for her mental health advocacy did she publicly admit to her own lived experience.

Raitt reported that Canada is currently working on mental health standards for workplaces to parallel those in place for physical health. She noted that while the country's labour code addresses accidental injuries and issues such as workplace violence, it considers their physical effects only. Yet the mental health implications must also be dealt with, and removing stigma is an important first step.

Louise Bradley, President and CEO of the Mental Health Commission of Canada, rounded out the opening speeches by reflecting on a pair of recent personal conversations. In the one case, a friend undergoing chemotherapy talked openly about her ups and downs, surrounded by

supporters. In the other, a friend receiving help for depression said she was constantly relieved to find her doctor's waiting room empty, so that no one would see her there.

The Mental Health Commission of Canada's Opening Minds initiative[3] is drawing on the collective work of anti-stigma programs across the country. Rather than reinventing the wheel, Opening Minds surveyed the landscape, partnered with as many programs as possible, and is working to identify best practices in stigma-reduction such as contact-based education (education involving people with lived experience), creating tools for broad dissemination, and catalyzing structural change.

Bradley mentioned the launch of Canada's first national mental health strategy in May 2012: a blueprint for improving the systems that support people with mental illness. She concluded that substantive improvement will only truly happen when stigma is reduced and people are no longer ashamed to seek the help they need.

STIGMA AND THE FAMILY

Standing up, speaking out
Joined by her sister **Jessie Close** and nephew **Calen Pick**, award-winning actress **Glenn Close** shared her family's story of struggles with mental illness—and how that experience led her to establish Bring Change 2 Mind, a charity dedicated to eradicating the stigma around mental health issues.

PRESENTERS
Glenn Close, US
Jessie Close, US
Calen Pick, US

Real-world heroes
Close began with a few words about heroism. She defined it as the courage to go against the odds, to demonstrate resilience and compel others to take notice of facts that cannot be ignored. In her family, those facts include her sister's diagnosis of bipolar disorder and her nephew's diagnosis of schizophrenia.

Recalling her "average old Connecticut Yankee" heritage, Close said mental illness was not in her family's vocabulary—despite instances of alcoholism, depression and, in the case of one uncle, suicide. It was only when Jessie, always labelled "the wild one," was diagnosed with bipolar disorder that Close began to see things in a new light. It caused her to reflect differently on some of the roles she had performed over the years, particularly the often-vilified Alex Forrest from *Fatal Attraction*.

Eager to raise awareness of mental health issues, Close began to educate herself. During a visit to Fountain House in New York City, she had to confront her own prejudices—including the question of whether being associated with mental health causes would affect her career. Through volunteering and increasingly impassioned advocacy, she was inspired to launch Bring Change 2 Mind, convinced that "stigma is perhaps the last and most challenging civil rights issue of our time."

Everything I do is to stay alive
Jessie took to the stage cradling her beloved service dog and anti-anxiety companion, Snitz. Funny and unflaggingly honest, she described her tumultuous life—marked by alcoholism, drug use and a succession of marriages. After her first psychotic episode at the age of 22, she attempted suicide.

Today her mantra is: "I accomplished nothing by getting ill and everything by getting well." Considering her experience, she suggested there is a fierce double standard surrounding the

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[3] Read more about *Opening Minds* on page 11.

people who have a mental illness. As long as we get beautiful insights from people who are suffering, they are heroes. If they fall into substance abuse or other difficulties, "they're no fun." She questioned what might be the root of stigma—is it abhorrence, disgust?—and also whether it is possible for people to truly understand mental illness without personal experience.

Not that "experience" is easy. The actions of people with mental illness can hurt and embarrass their families. Jessie admitted being afraid of her own son's schizophrenia at times—despite her own mental health problems. Yet she noted some positive progress where stigma is concerned. For example, U.S. President Barak Obama has begun sending messages of condolence to the families of soldiers who have killed themselves, which had not been done before. Within mental health circles, acceptance is growing. Outside, there is still a great deal of resistance. People have to be reached one at a time.

Taking the leap
Next, Pick offered a glimpse into his personal experience with schizophrenia. He spoke about the feelings of distrust and uncertainty the condition engenders—in others and in oneself. His inner world was primarily one of images, both positive and negative; he had to confront that fact every time he tried to verbalize that self-experience. It took a great deal of patience and strength to break through his schizophrenia. Having succeeded, he concentrates today on living positively, encouraging those he meets to look within themselves for truth and to nurture what he calls "the good seed."

Close concluding the session saying it took a major leap to create Bring Change 2 Mind. She concluded it is good to jump off cliffs at regular intervals in one's life. People must come to the edge together in order to raise awareness and help eradicate stigma.

LESSONS LEARNED

It is time to shift the paradigm
Stigma, unfortunately, is alive and well. Addressing its causes and devastating consequences is not easy because it requires the rethinking of traditional beliefs. Yet such rethinking is critical if we are to establish the new paradigms needed in anti-stigma intervention.

PRESENTERS
Norman Sartorius, CH
Bernice Pescosolido, US

Why stigma has not budged
Common sense dictates that as people become more educated, stigma will decrease—but this has not been the case with mental illness. According to **Norman Sartorius**, stigma has actually increased over the past decade. Part of this stems from the "commodification" of health, which sees growing numbers of jurisdictions leaving healthcare to the private sector—making it difficult for people with mental illness, who often have little money, to afford the services they need.

These comments were echoed by **Bernice Pescosolido**, who presented the results of a national U.S. study on stigma, the first of its kind in 60 years. While Americans have become more knowledgeable about mental health, stigma has not dissipated—despite the claims of many recent articles. The study found a fourfold increase in spontaneous mentions of dangerousness associated with mental illness, and more people responded negatively when asked about forming closer personal/professional relationships with people who have a mental illness.

Behaviour is what needs to change
Sartorius discussed why many commonly held beliefs about treating mental illness need to change. Specifically, he recommended moving from fixed long-term plans to "rolling horizon"

approaches that can weather and adapt to government and institutional turnover. He suggested people other than psychiatrists should lead anti-stigma programs—as determined by their strength of personality, not their academic credentials.

Rather than a one-message-fits-all approach directed at the largest possible audience, he called for targeted, specific messaging and for anti-stigma programming to be part of routine, ongoing work instead of time-limited campaigns.

Finally, Sartorius said programs should not be measured by whether they change attitudes but behaviour.

While Pescosolido felt changing attitudes had value (in her opinion, attitudes are the "litmus test" for society), she did agree with Sartorius about taking an approach based on "rethinking, reworking and myth busting." She said society needs to overcome some prejudices about culture and recovery. Although countries that spend more on public health have been shown to be less likely to stigmatize, in fact, people in many less developed countries are more likely to recover from schizophrenia than those in the West.

Pescosolido concluded stigma should be reduced "using a scalpel rather than a machete"—starting with a handful of broad messages such as the importance of intimacy, responsibility and meaningful inclusion before moving onto more targeted messages for different audiences.

Celebrating *Mythbusters*

The Canada Health Services Research Foundation (CHSRF) has been publishing its *Mythbusters* articles for more than a decade, summarizing the best available evidence to challenge sometimes deeply held attitudes on healthcare issues. Joanna Cheek, a psychiatry resident at the University of British Columbia, received a CHSRF award on Day 1 of the conference for her work on whether reframing mental illnesses as brain diseases actually reduces stigma. In addition to having her article published in *Mythbusters*, she took home a $1,500 prize. Her article is posted on the CHSRF website at:
chsrf.ca/Libraries/Mythbusters/Myth-Stigma-EN.sflb.ashx.

KEYNOTE AND ROUNDTABLE DISCUSSION: MEDIA DEPICTIONS OF MENTAL ILLNESSES

Making mental health part of the national conversation
Mental illness today receives more attention than ever before—from the media, government and the public. Yet stigma persists. Though one in five Canadians will live with a mental illness each year, two-thirds will not receive the care

PRESENTER
Lloyd Robertson, CA

they require. And a recent poll suggested that 50% of Canadians would hide a family member's mental illness from friends and colleagues. Combating stigma is critical to ensuring those who live with a mental illness are supported and accepted, and able to access the care they need to recover.

A newsman's personal story
Host of television's *W-5* and former Chief Anchor and Senior Editor of the *CTV National News*, **Lloyd Robertson** started the session by talking about his mother, who lived with a mental illness that today would likely be described as a mixture of bipolar disorder, obsessive-compulsive disorder and perhaps mild schizophrenia. She would spend days in the bedroom crying and wailing, hours drying dishes and was occasionally gripped by destructive rages. Tormented by

paranoia, she would frequently warn her son that neighbours, schoolmates and friends were out to harm him or the family.

The Robertsons kept her illness a secret for years. Other children were never allowed to visit, and Mrs. Robertson's frequent stays in institutions were tacitly ignored by friends and neighbours. Stigma prevented any of this from being discussed outside the home. At the time, people with lived experience were considered a drain on society and were kept out of sight to avoid making "normal" people uncomfortable.

Despite this, Robertson's father maintained a remarkably progressive view. He often explained to his son that his mother had a disease like any other, except that instead of afflicting her heart or lungs, it affected her brain. In 1948, Mrs. Robertson underwent a pre-frontal lobotomy—a fact that was hidden from her children for many years. While she was calmer, her paranoia remained, likely due to the fact that the surgery could not address her underlying psychological issues.

Missing out on a typical childhood weighed heavily on Robertson, and he admitted to feeling both shame and fear that he too would develop a psychological condition. But as he grew older, he became interested in investigating mental health and bringing associated issues such as stigma out into the open.

From his perspective, mental illness is more discussed and accepted today than ever. As examples, he cited the 2006 Canadian Senate report, *Out of the Shadows*—the first national study of mental illness and addiction—and the federal government's mental health strategy.

But stigma still remains. Sensationalistic media reports spotlight rare but high profile cases of crimes committed by those living with an untreated mental illness, perpetuating damaging stereotypes.

With approximately 20% of Canadian children between the ages of 14 and 17 experiencing a significant episode of mental illness, combating this stigma is critical. The answer is to continue the fight to address how mental illness is portrayed in the media, as well as continuing to fund research into the brain—such as the recent injection of $100 million to the Canadian Brain Fund—to ensure mental illness is better understood, better addressed and better treated.

Roundtable discussion

The session then switched to a panel discussion among journalists, researchers and advocates of how the media covers mental health issues and how this coverage builds or reinforces societal stereotypes.

MODERATOR
Mike Pietrus, CA

PANELLISTS
Erin Anderssen, CA
Esther Enkin, CA
Rob Whitley, CA
Scott Anderson, CA
Chris Summerville, CA
Lloyd Robertson, CA

Esther Enkin said the media could do a better job of covering mental health issues and expressed optimism that both societal attitudes and media coverage would continue to evolve. She used the metaphor of "water dripping on a stone" to describe this evolution, drawing comparisons to cancer awareness. Once cancer survivor groups began to form and promote positive messages, the media picked up on them and societal attitudes shifted. In this sense, the media both leads and follows public opinion. (She mentioned that CBC recently instituted a policy about news coverage of suicide.) Enkin cautioned against criticizing "the" media, because the media are increasingly diverse. The modern era offers people and groups the means to connect and communicate without having to rely on the conventional media.

Rob Whitley described preliminary findings of the media monitoring project he has undertaken on behalf of Opening Minds: the analysis of thousands of articles related to mental illness published in mainstream newspapers in Canada between 2005 and 2011. A large percentage

feature crime and violence, even though people with a mental illness are far more likely to be victims of crime rather than perpetrators. Furthermore, people with, and experts in, mental illness are rarely quoted in the articles and themes such as recovery and treatment are rarely featured. He described massive variation in both the quality and quantity of coverage by individual newspapers.

Erin Anderssen described how her approach to stories related to mental illness has changed during her career. Early on, as a crime reporter, her stories often focused on legal responsibility; more recently, this has shifted to treatment (e.g. the availability, accessibility and timeliness of treatment). She encouraged people to recognize that some news organizations do a much better job than others of exploding myths and avoiding stereotypes.

Chris Summerville agreed some news organizations do a good job, but said most do not. He noted that conventional media struggle for accuracy in relation to two main issues: that mental illness does not always lead to criminality, and that recovery—the ability to live beyond the limitations of the illness—is not only possible, but probable. He said many of the professionals attending the conference were living proof of the reality of recovery.

Scott Anderson said news organizations rely on the professionalism of individual journalists to avoid unfair coverage. It is true that dramatic and unusual events such as plane crashes receive prominent coverage, but he countered that the safety of air travel also receives coverage, although it is much less prominent. He discouraged organizations from attacking the media for unfair or biased coverage and encouraged them to be proactive and positive. During his time as a managing editor, for instance, he recalled that members of Mothers Against Drunk Driving (MADD) often came into the newsroom to suggest stories worthy of coverage, but could not recall a mental health organization ever suggesting stories.

Robertson observed the links between language and stereotypes, and how language continues to change. During his career, for example, he saw terms such as Father Christmas and Mother Nature fall out of favour. He also explained that the news business faces intense time pressures. In his view, coverage will change over time.

PARALLEL SESSION 1: SYMPOSIA, WORKSHOPS, PANEL DISCUSSIONS AND ORAL PRESENTATIONS

SYMPOSIUM: OPENING MINDS—MENTAL HEALTH COMMISSION OF CANADA

An evidence-based approach

As mental health issues are discussed more openly by the media and public, the number of anti-stigma programs is growing. Yet today relatively few of these are based on evidence of what works. As a result, they can have widely divergent results—with some possibly doing more harm than good. The Mental Health Commission of Canada's Opening Minds initiative aims to change that.

PRESENTERS
Heather Stuart, CA
Scott Patten, CA
Mike Pietrus, CA
Romie Christie, CA

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Heather Stuart explained that Opening Minds tries to identify what is already working and why, and looks for opportunities to expand effective programs to the national level. As well, it identifies key gaps in the fight against stigma and creates new programs to fill them. Rather than target the general public, Opening Minds concentrates on four specific audiences:

Youth
This group is especially critical, as 70% of adults with a mental illness say their symptoms first developed before the age of 18, and stigma and bullying are prevalent among school-age children.

Healthcare providers
These are also important because they often interact with people with mental illness. People with lived experience of mental health problems and illnesses often identify healthcare providers as having stigmatizing attitudes and behaviour, although the providers themselves tend to deny they harbour stigma.

Workforce
Stigma in the workforce is particularly damaging, as many workers would prefer to hide mental illness—and deny themselves treatment—than face real or perceived discrimination.

Media
The media play an integral role in how mental illness is popularly perceived—with the power to either proliferate stigma or fight against it.

Opening Minds promotes "structural" changes that improve equality and social justice and promote contact-based education delivered by people with lived experience. Other approaches have proved less effective. For example, protest initiatives attacking offensive language and behaviour are often met with a backlash. Traditional education to improve literacy about mental illness often does not reduce stigmatizing behaviour. And while social marketing campaigns can be effective delivery tools, they work best when there are products—such as program toolkits—to disseminate.

Opening Minds in action
The group then heard about two successful Opening Minds programs:

Mental Illness and Addictions: Understanding the Impact of Stigma was delivered through Ontario's Local Health Integration Network (LHIN) to 272 healthcare providers at seven hospital sites. Focused on contact- and peer-based training, it was evaluated using attitude tests at three points in time: pre-delivery, post-delivery and three months later. Immediately after the training, 28% more participants said they would become close friends with someone living with a mental illness, and 30% more would go to a healthcare professional who had been treated for a mental illness. Some of those improvements had eroded after three months, suggesting the need for a long-term training model complete with refresher courses.

Talking About Mental Illness (TAMI) provided contact-based education to 952 students in Ontario's Durham and York regions during the 2011–12 school year. Using a pre- and post-delivery evaluation design similar to the LHIN project, TAMI also showed positive results and has since been adapted for schools in Yellowknife.

Other Opening Minds programs include symposia for journalism students to examine how mental illness is portrayed in the media, online training and implicit association tests (IAT) for physicians, a media monitoring study and justice conferences. By examining existing programs—and using evidence-based evaluation methods to determine effectiveness—Opening Minds is working toward a unified national anti-stigma strategy that will deliver ongoing, contact-based education and enable, encourage and support structural change throughout the country.

SYMPOSIUM: CHANGING MEDIA REPRESENTATIONS

A powerful force

The mass media exert a profound influence over public perceptions of mental illness. Sensational and misinformed depictions perpetuate stigmatizing attitudes. If society is to change its views of people with mental illnesses, it is important to change the ways the mass media present them.

PRESENTERS
Barbara Hocking, AU
Rebecca Palpant, US
Jennifer Stuber, us
Barbara Demming Lurie, US

Approaching the media as an ally

Barbara Hocking of the Australian mental health charity, SANE, began with a catalogue of case studies: melodramatic headlines (*Mental Illness Gets Hijacker Off Hook*); an ad for spicy burritos dubbed Straight Jacket, Raving Lunatic and Sanity Check; and an obsessive-compulsive disorder action figure.

With seasoned media professionals on staff to lend insight and credibility, the SANE Media Centre works actively with members of Australia's mass media to improve the way mental illness is portrayed. SANE's perspective is that the media are an ally—with power to shape decision-makers' attitudes, sometimes even more than the most carefully prepared policy brief.

SANE also maintains a StigmaWatch feature on its website that allows people to report stigmatizing representations. Once validated, select reports are published in SANE's Stigma Files. Importantly, SANE also congratulates media members when they produce work that does not contribute to stigma and is finding that depictions are, on the whole, improving.

Building an informed journalistic practice

Rebecca Palpant, Assistant Director of the Carter Center in Atlanta, Georgia, spoke about her organization's mental health anti-stigma initiative. The Roslyn Carter Fellowships for Mental Health Journalism were introduced 17 years ago to improve media representations of mental illness by training journalists in best practices and introducing them to mental health issues.

The program has awarded 126 fellowships to journalists in four countries including South Africa, New Zealand and Romania, and receives nearly 100 applications a year for its six U.S. slots. Rather than characterize the news media as "getting it all wrong," the fellowship program focuses on helping journalists be great.

Once fellows have completed the three-day program, their work is tracked by the Center. More than 1,400 mental health-related pieces have been produced by graduates, and the potential audience of the 2009–10 class alone was more than 60 million. The Center's ambition is now to transfer the concept to other countries, with Colombia next on the list.

Guidelines for reporting on mental health

Jennifer Stuber, Assistant Professor at the University of Washington, is also working with journalists on how they report mental health stories. Appreciating that journalists are skeptical of having "outsiders" with any kind of agenda shape their work, Stuber made sure to involve journalists in developing a mental health media advocacy campaign.

Her project looked at gaps in existing journalistic guidelines related to mental health issues, including headline choices and specific language. The initial focus was on print, then branched out to radio and online media, employing a four-part strategy of praise, protest, personal contact and partnership. The ongoing challenge is to keep the mental health community and journalists engaged in a way that is replicable and whose effects will continue to expand.

Good stories do not have to be sensational
Barbara Demming Lurie works with the U.S. Substance Abuse and Mental Health Council as a consultant to TV shows and films on depictions of mental health problems. While no creator sets out to denigrate people with mental health problems and illnesses, the need for drama and action often leads to stories that involve individuals getting into trouble. A Screen Actors Guild study found that three times the number of dangerous characters on film and TV were mentally ill.

The Council works with artists to help them find a good story—and is deliberately soft on the "anti-stigma" message. Like journalists, entertainment writers and producers do not want to be told to change. Demming's challenge to them is to tell stories without reverting to clichés, a strong incentive given the value placed on originality in the field.

The Council established the Voice awards to salute those in the entertainment industry who present positive depictions of people with mental illness.

SYMPOSIUM: CONSUMER VOICE AND SOCIAL PARTICIPATION

Nothing about us without us
Guided by a housing-first philosophy, At Home/Chez Soi is a research demonstration initiative developed by the Mental Health Commission of Canada (MHCC), focused on finding the best ways to house homeless people with mental health problems and illnesses, and to help them access meaningful employment. A panel of individuals who have either been homeless or dealt with a mental health issue gathered to talk about their experiences and their advocacy efforts with At Home/Chez Soi.

PANELLISTS
Joelyn Foadi-Frenette, CA
Jijian Voronka, CA

PRESENTERS
Dawnmarie Harriott, CA
Janina Komaroff, CA
Freeman Simard, CA

Destigmatizing the language
Speaking from personal experience—a diagnosis in her health record led to prejudice and discrimination against her during a custody battle—**Dawnmarie Harriott** focused on how language can either oppress or empower. Her point: Paying attention to language is crucial when attempting to change social patterns. For example, she advocated using "mental health issues" instead of a more stigmatizing phrase such as "mental illness." This language focus has also been picked up by the National Consumer Panel, an advisory group working in consultation with At Home/Chez Soi and the MHCC. The Panel is made up of people with lived experience who are committed to fighting stigma, and recommends integrating people with lived experience into language initiatives as well as developing more peer research analysis of those with lived experience.

Seeing the system from a user perspective
At Home/Chez Soi's Peer Qualitative Research Group includes people with lived experience and aims to overcome the disconnect between what individuals need and what the mental healthcare system offers. **Janina Komaroff** described the group's mission to improve the quality, relevance and utility of mental health research while allowing people with lived experience to act as knowledge producers and be integrated into academia. In the upcoming months, the group will publish some of its own findings on the importance of food, housing and financial support in order to inform policy and provide a model for other organizations to emulate.

***Talking to the Media*: A guide for homeless persons**
Recognizing the sometimes traumatic effects of being approached by journalists for interviews, At Home*/*Chez Soi*'s* National Consumer Panel developed a pamphlet to inform homeless persons about their rights and options when asked to share their stories. Titled *Talking to the Media*, the

pamphlet gives tips on creating a pseudonym, emphasizes individual ownership of story content and suggests ways to establish a respectful and non-intrusive encounter. A survivor of residential schools, **Freeman Simard** explained how the homeless endure stigma daily and require supports when trying to educate the public about their lived experiences.

SYMPOSIUM: INTERNATIONAL PERSPECTIVES ON STIGMA

What does stigma look like where you are from?
The challenges faced by Canadians in overcoming stigma about mental illness are just as great, if not more severe, in developing countries. Not surprisingly, different cultures have their own approaches to dealing with both mental health issues and stigma.

PRESENTERS
José Geraldo Verent Taborda, BR
Enrique Sepulveda, CL
Isabel Regina Perez Olmos, CO
Vilma Ortiz, CL
Juan Pablo Osorino, CL
Tsuyoshi Akyama, JP

Seeing stigma as a psychological disorder: Chile
Chilean doctors **Enrique Sepulveda** and **Vilma Ortiz** discussed the clinical ways their colleagues and the government of Chile treat mental disorders, then described how people with mental illness are stigmatized in the workplace and when seeking treatment.

Sepulveda said a trend in Chile is to use a "psychopathological method" of understanding mental illness and related stigmas. He said he considers stigma "an expression of a pathologically deviated way of thinking of the form of delusional ideas," and suggested stigma itself should be dealt with as a psychological disorder.

Ortiz then looked practically at one specific issue of stigma: How it relates to the workplace. She described the problems and stigma faced in Chile when individuals request a "medical license," a leave of absence from work. Many are reluctant to make such requests even though they are entitled to do so. Mental health leaves tend to be much longer compared to those for physical problems: on average 11 days for mental health leaves versus three days for physical matters.

Barriers to care: Colombia and Brazil
In Colombia, issues of stigma relating to mental illness are still in the early stages of being studied and quantified. **Isabelle Perez Olmos** said that in a study of 500 people using outpatient psychiatric services, more than half claimed they experienced discrimination and stigmatizing behaviour. More often than not, this led to them concealing or avoiding their illness.

Brazilians with mental illness face the reality that in one of the most populous nations in the world—with almost 200 million people—there are fewer than 20,000 beds in psychiatric care facilities. **Jose Verent Taborda** said stigma is often promoted by the police and government, or else marginalized as a "social condition" not requiring policy-level action.

Who am I without my work: Japan
Professor **Tsuyoshi Akiyama** described a uniquely Japanese situation. In a nation with a culture of achievement and where people often define themselves by their jobs, leaving your job to treat a mental illness can often lead to a cycle of depression and self-questioning. "Accepting vulnerability," he said, is difficult but necessary. He said people's professional colleagues and managers typically have no information about mental illness, and even counsellors and physicians have only basic knowledge. To return to high-demand jobs, people need to achieve a new self-identity or way of thinking and focus on regaining and improving their relationship skills. He noted the importance of treating the individual, not the condition.

WORKSHOP: USING ART AND MUSIC

Creating connections, erasing stigma

Creative arts can be powerful tools for promoting mental health recovery and combating stigma, especially among youth. In this experiential workshop, **Maya Williams, Barb McLean** and **Zoe Nudell** walked attendees through a typical Thursday night at The Spot, a peer-to-peer community arts program that gives Halifax youth and younger adults aged 16–30 the chance to experience the joy of collective creation for a few hours each week.

PRESENTERS
Maya Williams, CA
Barb McLean, CA
Zoe Nudell, CA
Nancy Beck, CA

A collaborative initiative of Connections Halifax, the Nova Scotia Sea School and the Halifax Regional Municipality, The Spot does not require participants to declare they have a mental illness or lived experience. All it takes is a passion for creativity. The Spot provides an environment in which participants can get to know each other in ways that eventually lead to deeper conversations about mental health and the stigma that surrounds it.

Community-based and decidedly non-institutional, The Spot is delivered Thursday nights at The Pavilion, a stand-alone, all-ages venue in the Halifax Common urban park. While it brings youth and younger adults together, it also facilitates access to health services through Connections Halifax—an organization that builds supportive relationships with those living with mental illness.

A participatory experience

To begin this workshop, participants and presenters greeted each other with simple bows, then gathered around large sheets of paper. Taking up markers, pens, brushes and paints, they engaged in a "critical listening" exercise by listening to songs normally chosen by youth attending The Spot. While *Rehab* by Amy Winehouse and *Sad, Sad Song* by M. Ward played, participants were encouraged to offer a "gesture" by writing or drawing whatever came to mind.

Afterward, the group discussed their gestures and the motivations behind them. Several common themes emerged. Many participants drew eyes with tears running from them, meant to represent the pain, loneliness and despair of a mental illness—establishing a sense of greater connectedness between themselves and the other participants.

The workshop concluded with a person living with schizophrenia saying that using art was integral to his recovery and continuing wellness. Creating visual art was the only way for him to express himself, which helped him gain confidence and the satisfaction that people have finally been able to "hear" what he had been trying to get out.

Moving forward, The Spot hopes to expand to a full-time program and include other creative arts: film, photography, dance and movement, culinary arts and farming. A street-level café is planned as a venue for creative works and a way to build the confidence of The Spot's participants.

WORKSHOP: CALIFORNIA'S STATEWIDE PROGRAM

A sweeping strategy

In 1999, the U.S. Surgeon General declared stigma the number one obstacle to improving mental health. Five years later, California voters responded by passing Proposition 63, the *Mental Health Services Act*, to build a mental health system of prevention, wellness, recovery and equity for California's diverse populations.

PRESENTER
Stephanie Nicole Welch, US

The California Mental Health Services Authority has since developed a statewide strategic plan with stigma reduction at its centre. The plan currently includes 10 programs that aim to increase the availability of age-, gender-, culture- and language-specific anti-stigma programs, all of which work toward the goal of fostering permanent change in the public's perception and understanding of mental illness. Two of these 10 programs are currently in place, the most extensive being a social marketing campaign.

Tailoring the message
To set the baseline for this campaign, California's Mental Health Services Authority surveyed 1,050 adults of influence—landlords, employers, law enforcement officials, and healthcare and mental health professionals—who greatly affect the quality of life of those with mental illness. The results found that only a slight majority believed people with a mental illness experienced discrimination, and only a third knew how to support somebody with a mental disorder. The study also found a surprising amount of "soft stigma"—that is, unwillingness to stand up against those actively discriminating against people with mental illness.

Ingrained stigma was also found among children. A survey of 650 students aged 11–13 found that more than two-thirds believed violent behaviour was linked to people with a mental illness. Fifty-eight percent thought those with a mental illness required lifelong medication and counselling.

These results compelled the Authority to address the entire "lifespan" of stigma and discrimination, tailoring specific communications strategies for four different age groups. These messages include addressing misconceptions among those 9–13, providing support to those feeling isolated (aged 14–24) and providing support to those actively experiencing discrimination (over the age of 25). Separate messaging was also prepared to help parents bring up the topic with children under the age of eight.

The social marketing campaign has delivered exceptional results. For example, one aspect of the campaign focused on driving traffic to the ReachOut website, a unique online community providing mental health information and offering interactions with trained peer counsellors. Over the past six months, California-based traffic to ReachOut has increased by 431%.

Telling the story of success
California's Mental Health Services Authority requires its contractors to use 15% of their budget toward evaluation. Modelling that requirement, it spent 15% of its budget on an independent evaluation by the RAND Corporation. This helped establish baselines and community indicators, identify programs for replication and promote continuous quality improvement initiatives among its interventions.

PANEL DISCUSSION: THE FAMILY

Getting families involved
This panel explored the role of the family in mental illness recovery, emphasizing the advantages of family-centred approaches and the need to incorporate them into provincial, territorial and national mental health strategies.

The advantages of family-centred care
Chris Summerville, CEO of the Schizophrenia Society of Canada, promoted family-centred care as an essential model for dealing with mental illness recovery. Family-centred care is an inclusive, respectful approach to planning, delivering and

PRESENTERS
Chris Summerville, CA
Karyn Baker, CA
Florence Budden, CA
Marian Dalal, CA

evaluating mental health services.

It is also a radical departure from tradition.

Collaboration with families is not routine in clinical practice. Many practitioners do not want to do family therapy (in some jurisdictions, because they are not compensated for it). Surveys show that service providers do not often ask patients if they can speak with family members, yet patients say they would be comfortable to have their relatives consulted. Summerville encourages providers to ask: "Can we involve one of your family members or someone you trust?"

By reducing social isolation, the holistic family-centred approach minimizes the risk of relapse. It is not always possible, and it is not always easy when possible, but it should always be the goal because it reduces the stress levels of families and helps them support their loved ones with mental illness more effectively.

Stigma as a social justice issue

Florence Budden, President of the Schizophrenia Society of Canada, echoed the importance of the family in care. Drawing on her 24 years in mental health as a nurse and now as a nurse educator, she talked about the many families she has met who have taught her about lived experience. She emphasized that families need to be central in ensuring those who need it get help, and that in order to do this they need to increase their knowledge. Labelling stigma a "social justice" issue, she also noted the need to improve health professionals' knowledge in order to avoid perpetuating stigma in the field and to help reduce stigma in communities.

Dealing with discrimination at home

Karyn Baker and **Marian Dalal** from the Family Outreach and Response Program in Toronto (Canada) shared some of their experiences running an eight-week program to address stigma at home and give families the skills and knowledge to help their relatives in recovery. Though the literature suggests the best way to combat stigma is through contact with people with lived experience, the emotions families face are complicated and wide-ranging: guilt, shame, helplessness, fear, sadness, and stress at having the responsibility to manage care without much or any support. Addressing issues of language, power dynamics, decision-making, medication, side effects and self-management, the Family Outreach and Response Program is run by family members and individuals with lived experience, alongside social workers.

Dalal works closely with Toronto's Somali community, and said discrimination is significant within ethno-specific families: many regard relatives with mental illness as sources of shame, exclude them from family celebrations, and try to conceal diagnoses and hospitalizations to preserve their collective reputation and dignity, or protect siblings' potential (e.g. for marriage). They also often treat them as incompetent, which promotes learned helplessness. At the same time, Dalal noted that no matter their ethnic backgrounds, families share the wish to be there for their relatives. She said the Family Outreach Program acknowledges the significance of families' effort to help—with empathy and sensitivity.

A Q & A period closed the session, during which participants talked about the need for leveraging of best practices across provincial jurisdictions.

ORAL PRESENTATIONS: PARTICIPATORY ACTION AND RESEARCH (PAR)

PRESENTERS
Barbara Schneider, CA
James Livingston, CA
Michele Misurelli, CA
Beth Broussard, US
Michael Compton, US
Jenna van Draanen, CA
Alex Zsager, CA
Suzanne Feldman, CA

In research, lived experience counts
In this session, three teams spoke to the benefits of involving people with lived experience in research, preferably in significant decision-making capacities. All noted the difficulty of securing research grants for this kind of participatory action research (PAR), and pointed out the need to retain objectivity in choosing participants. They also said there can be challenges associated with establishing the credibility of research prepared by non-professional researchers.

Promoting social change through participation
Barbara Schneider defined the concept of PAR as an "ethic of engagement" rather than a research method. She characterized it as "research with, versus on, the people" living with mental illness—and as an inherently political endeavour that promotes positive social change and empowerment.

Michelle Misurelli talked about the Unsung Heroes Peer Support Group, whose members live with schizophrenia and have contributed meaningfully to research on housing and care in Calgary by choosing topics, gathering data, conducting interviews and providing unique insight into what people with schizophrenia want from healthcare professionals. The research supported by Unsung Heroes produced two important recommendations: that physicians should always explain their diagnoses to patients; and that they should always treat patients with dignity and respect. The work of Unsung Heroes was captured in a book entitled *Hearing (our) Voices*.

James Livingston then presented the work of Team PEER (Patients Empowered & Engaged as Researchers), which was conducted out of the Forensic Psychiatric Hospital in Vancouver and involved patients who had been found not criminally responsible for offences. Applying PAR principles of engagement, the research team involved participants at every stage, from weighing in on the team logo to voting on research methods. Team PEER also asked participants to journal their experiences, which elicited illuminating responses as to what the research patients valued and enjoyed. PAR, Livingston said, focused on "valuing the lived experience versus the learned experience."

Developing anti-stigma messages
Beth Broussard presented work from the George Washington University (GWU) School of Medicine and Health Sciences on common misperceptions of dangerousness and unpredictability in people with schizophrenia. The GWU team focused on two largely African-American wards of southeast Washington, D.C., involving community members in creating and testing a set of messages aimed at reducing stigma. Participants contributed to the development of taglines and photographs for a set of anti-stigma postcards, and are helping carry out an evaluation of the project at job fairs, farmers' markets and other venues. The team will eventually interpret and disseminate the results in consultation with its community advisory board.

Making participation and inclusion matter
Alex Zsager, **Suzanne Feldman** and **Jenna van Draanen** described the People with Lived Experience Caucus established by the Toronto chapter of the housing-first program At Home/Chez Soi. Feldman, a person with lived experience caucus member, described her experience: "I felt needed and wanted—I came out of my shell and became more responsible. I learned that my opinions do count." A recent evaluation found that, since it was established three years ago, the caucus has contributed to stigma reduction and bringing people with lived experience "to the table" has changed the nature of discussions. The caucus experience has also

revealed the importance of language, drawing to light the negative impact of terms such as mental illness versus mental health.

ORAL PRESENTATIONS: USING MEDIA AND THE ARTS TO REDUCE STIGMA

Mediating impressions

This session took a diverse look at the media and stigma: in one case, at whether public service announcements with positive messaging can counteract negative images in dramatic TV programming; in another, at the effectiveness of a mass multimedia campaign; and in a third at how participation in creative artwork can improve the self-image of people with lived experience.

PRESENTERS
Tamara Daily, US
Sara Evans-Lacko, GB
Diana Rose, GB
Nicolas Rüsch, GB
Claire Henderson, GB
Graham Thornicroft, GB
Natalie Steele, CA
Tamara Chipperfield, CA
Helen Sadler, CA
Carol Skinner, CA

This is a public service announcement

Tamara Daily of the University of Mount Union described her study on awareness of public service announcements and their impact on attitudes toward people with a mental illness.

The study had 163 college students complete standardized questionnaires after watching three videos: *Committed*, an episode of the popular crime drama *CSI* focusing on criminals with mental illness; an episode of *CSI* in which mental illness did *not* feature prominently; and a documentary about the space shuttle Challenger. There were two versions of each video: one with regular commercials and one with public service announcements prepared by the Substance Abuse and Mental Health Services Administration, an American advocacy group. Study subjects were randomly assigned to one of six test groups (three programs, two versions of each program). The results suggested that *Committed* had the greatest negative impact on attitudes. Regardless of whether they had seen the public service announcements, those who saw *Committed* were more likely to report that people with mental illness made them feel afraid and endangered. Public service announcements had a limited ability to cancel out the negative impacts of viewing highly stigmatizing material.

Campaigning for change

Sara Evans-Lacko of King's College London described a British national campaign launched in 2009 that used a wide variety of media, including television, billboards and social marketing to influence attitudes about mental illness. A study evaluating the campaign's impact surveyed approximately 1,000 people before and after each of three phases. Results indicated that the campaign significantly influenced knowledge, attitudes and feelings of social distance, and that further progress could be achieved if people had social contact with people with a mental illness.

Remaking self-image

The final presentation of this session featured four facilitators of an Ottawa-based arts program for people with a mental illness: **Tamara Chipperfield, Helen Sadler** and **Carol Skinner** all described how creating art helped them express themselves and shift their self-perception to an identify beyond the "patient" label.

PARALLEL SESSION 2: SYMPOSIA, WORKSHOPS, PANEL DISCUSSIONS AND ORAL PRESENTATIONS

WORKSHOP: MENTAL HEALTH STRATEGY—CANADA

Changing directions, changing lives

In May 2012, the Mental Health Commission of Canada (MHCC) released a comprehensive report on the status of mental health initiatives in Canada. The document, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, received significant coverage in the media. As presenter **Howard Chodos** explained, now that the report is out, the real work begins.

PRESENTER
Howard Chodos, CA

An indisputable step forward

Until the MHCC released *Changing Directions, Changing Lives*, Canada had no comprehensive strategy for dealing with mental illness. Chodos, a member of the committee that crafted the report, said the report's main focus is the "struggle to adopt new attitudes and strategies towards mental illness." He noted that Canadians are demographically and geographically diverse. Therefore, a national strategy must account for differences and, at the same time, take into practical consideration the fact that healthcare is under provincial jurisdiction. The structure of Canada's health system means that across the country there might be 10 different approaches to a single issue.

While this makes the landscape complex, it in no way takes away from the effort to establish a national strategy on mental health. In Chodos' words, the creation of the *Changing Directions, Changing Lives* report and its proposal of a broad outline for a national strategy is an important step forward, one that will help remove mental illness "from the shadows."

Among its several themes, the report emphasizes: prevention, the most likely factors contributing to the perpetuation of stigma and the rights of people with mental illness.

Preventing people from falling into a cycle of depression due to their mental illness is crucial, and contact-based education is key to showing both those affected and those around them that recovery is possible. Chodos said it is important to "focus on strengths, not suffering; the ability to recover, not the burden to the system." Hope, empowerment, self-determination and responsibility are the main goals.

There must be a balance between having a full range of services available to treat mental illness and appreciation for the fact no two people experiencing the same condition should necessarily be treated the same way. As well, it is important to recognize that mental illness does not have to fundamentally define an individual.

WORKSHOP: ANALYZING MEDIA PORTRAYALS

Holding a mirror to the media

The presentation focused on a massive project to research the portrayal of mental health in Canadian newspapers. Given that the public relies on popular media as a primary source of health

PRESENTERS
Sarah Berry, CA
Rob Whitley, CA

information, mainstream news media exert a strong influence on attitudes toward mental health.

Sarah Berry and **Rob Whitley** described their project to investigate how mainstream news media cover stories related to mental health. The project, which is being conducted on behalf of Opening Minds, began in 2010 and will continue through 2013. It involves the collection and analysis of articles published in mainstream Canadian newspapers as well as television and radio news stories.

A massive study of media representations
The study, the largest ever of its type in Canada, relies on searchable newspaper databases such as Infomart. A team of coders—including students, professionals and people with lived experience—was trained to collect data from more than 10,000 newspaper articles in both English and French. For each article, the coders recorded basic information (such as the name of the publication and publication date) and specific measures. Some of those measures were objective (e.g. is an expert in mental health quoted in the article?) and some were subjective (e.g. is this stigmatizing?).

The criteria used to select articles were the subject of much consideration. Sample criteria were developed, tested and refined by coding articles and analyzing the results. Under the final criteria, news articles and editorials were included while book reviews and obituaries were excluded. Articles with terms such as psychotic, schizophrenia and mental health were included, even if used as metaphors (e.g. to denigrate the recent performance of a hockey team). Metaphoric uses were found to be overwhelmingly negative and stigmatizing.

Preliminary results indicated that 45% of the articles linked mental illness with violence or criminality. A large number described crimes committed by people with a mental illness. Some newspapers were more consistently negative than others, and longer, more in-depth articles tended to be less stigmatizing.

This study provides valuable data on media portrayals and will help establish research standards for future studies. The absence of standards was both a blessing and a curse; it freed researchers to be creative, but may cause some to question the validity of the study's findings. This is part of the reason that it is imperative to follow the wider strictures of social science (e.g. be logical, replicable, systematic) when conducting such research.

WORKSHOP: CREATIVE ARTS IN RECOVERY

Opening the door to recovery
When it comes to promoting recovery and combating stigma, innovative creative arts programs are proving to be effective alternatives to the traditional clinical approaches. In this workshop, attendees were shown the documentary *Opening the Door,* which chronicles how one such arts program helped participants reach mental wellness by focusing on the creative process. Attendees were invited to reflect on the film in a facilitated discussion.

PRESENTER
Joanne Marie Books, CA

24 weeks in 22 minutes
In 2010, the Thunder Bay branch of the Canadian Mental Health Association introduced 24 weeks of writing, dance and visual arts into a skills-development program serving adults with lived experience of mental health problems and illnesses. The idea came from the program's users and was funded through a grant from the Ontario Arts Council. One of the unique requirements was that participants (rather than the program coordinators) were to select the media and artists.

Three professional artists led the program's 18 participants through creative exercises using art-making as an opportunity to build self-confidence, trust others, take risks and face fears. Gradually, participants learned that if they were able to take risks within this program, they would be able to do so in their everyday lives.

During the entire 24 weeks, the term mental illness was not used once. Participants were able to avoid self-stigmatizing behaviour because they were there to put on a play, choreograph a dance routine or create visual art—in short, to identify themselves as artists, not as persons living with a mental illness. When they realized fear, anxiety and negative emotions had been held at bay during the program's workshops, participants reported feelings of overwhelming self-confidence and hope and were able to draw on their positive experiences during times of anxiety or depression.

The entire experience was captured in a 22-minute documentary film, *Opening the Door*, which is hoped will raise awareness of how creative arts can fit into an alternative model of mental health recovery and wellness, encouraging other mental health providers to replicate the model.

INTERACTIVE DISCUSSION: PEOPLE WITH LIVED EXPERIENCE OF A MENTAL ILLNESS

Taking on stigma—alphabetically

The aim of this discussion was to gather ideas, examples and inspiration about how people with a mental illness can be stigmatized and also how they can make a difference in reducing stigma. The discussion involved a number of different group activities with teams at tables working together to identify keywords and visualize an ideal future through art.

PRESENTERS
John Dick, CA
Karen Liberman, CA

One exercise involved brainstorming keywords for each letter in the abbreviation PWLE (people with lived experience), representing what can be done to make a difference. Answers included:

Prognosis	Wellness	Love	Experience
Pain in their neck/pain in their a**	Wit	Life	Emotions
	Willingness to change	Longevity	Empowerment
Power, because knowledge is power	Worth	Listening	Empathy
	Wisdom	Liberty	Emotions
Perseverance	Words	Leadership	Exotic
Partnership	Wordlessness	Laughter	Eccentricity
Personal growth	Welcome	Lessons	Educate
Persistence	Why	Linking	Excellence
Passion	Wholeness	Loneliness	Every day continuing
Peer support	Why? Why Not?	Letting go	Evolution
Pressure		Light	
Progress		Live	

Another exercise involved drawing a picture of an idealized future that illustrates how society will interact with people with lived experience. Joined hands—representing unity, equality and the willingness to both ask for and offer help—were a recurring visual theme, as were images of nature representing peace and calmness.

A brainstorming session had participants listing barriers that prevent people with lived experience form making a positive impact. Responses included (in alphabetical order):

Bureaucracy
Cost of medication

Education
Fear
Funding
Health system
History
Idiocy
Isolation
Lack of credentials for peer support workers to make a liveable wage
Money
Preconceptions
Prejudicial/judgmental employers
Resources
Self-stigma
Skewed media
Stephen Harper
Stereotypes
Stigma
Support
Symptoms
Workers compensation and insurance companies

Finally, the group shared ideas for immediate, practical projects and activities that could make a difference. Highlights included:

Choose to focus on people's strengths to help them contribute and help others
Continued peer support work and mentoring
Media advocacy on behalf of people with lived experience
Recognition and funding for peer support
Share knowledge
Share our stories in whatever capacity it finds itself, public speaking whatever
Volunteer, tell your story and do not ever stop

ORAL PRESENTATIONS: ATTITUDES AND OPINIONS

PRESENTERS
Sara Evans-Lacko, GB
Nicolas Rüsch, GB
Georg Schomerus, GB
Keon West, GB
John Roswell, CA
Per Birger Vendsborg, DK
Julie Hagedorn-Moeller, DK
Anders Dannevang, DK
Johanne Bratbo, DK
Kristen Kistrup, DK
Anne Lindhardt, DK

Broadening the research base
Substantial progress has been made in measuring and tracking public attitudes and describing subjective experiences of stigma. Yet little research has examined how stigma expressed by the public directly affects people with a mental illness; this has created an evidence gap when it comes to developing anti-stigma programs and messages.

How you see me affects how I see myself
Sara Evans-Lacko of King's College London explored the association between public stigma and individual reports of stigma in 14 European countries. She and her fellow researchers used the Eurobarometer survey to collect public data and the Global Alliance of Mental Illness Advocacy Networks to collect individual data. Their findings suggest that public attitudes and behaviour clearly affect how people with mental illness regard their condition, their expectations of discrimination and their self-efficacy. This suggests that a reduction in public stigma may lead to more favourable self-appraisals by individuals with a mental illness.

What do you consider to be a mental illness?
Nicholas Rüsch of the Department of General and Social Psychiatry at the Psychiatric University Hospital in Zürich examined population survey data from England to find out what the public considers to be a mental illness and how those concepts affect attitudes about and disclosure of

a mental illness. The results showed that individuals with illnesses that the public classified as major mental disorders were more likely to seek help, but were less likely to disclose it to their employer compared to people with conditions considered to be stress- or behaviour-related.

In a systematic review and meta-analysis of trend studies, **Georg Schomerus** observed that while biogenetic causal models and professional help-seeking recommendations have increased, social acceptance of people with mental illness has not improved, and has even deteriorated in some respects.

Would you date someone with a mental illness?
John Roswell from the Digby Clare Mental Health Volunteers Association presented pre- and post-test results from a study of high school students' attitudes and knowledge of mental illness. The pre-test results came before a series of forums on adolescent mental health; the post-test results after. At the forum, two young adults with bipolar affective disorder told personal stories of their experiences with their mental illness. The post-test indicated some significant changes in the knowledge levels of the students, with an average of 6% more answering knowledge questions correctly. Interestingly, although there was no overall increase in the percentage of students who answered the attitudinal questions correctly, the percentage of those who said they would date someone they knew had a mental illness increased by 12%.

ORAL PRESENTATIONS: STIGMA AND SOCIAL STRUCTURES

Inclusion, exclusion and how stigma gets built in
The two presentations in this session looked at how stigma manifests and can be addressed through social structures: in the one case, an entire U.S. state; in the other, on the campuses of Canadian universities.

PRESENTERS
Eduardo Vega, US
Patrick Corrigan, US
Sergio Aguilar-Gaxiola, US
Meagan De Jong, CA
John Walker, CA
Tara Syed, CA
Monica Nunes, CA
Jack Ferrari, CA
Patricia Furer, CA
Donald Stewart, CA

Recognizing agents of change
Eduardo Vega detailed the work of the California Center for Dignity, Social Inclusion and Stigma Elimination, part of an unprecedented $60-million effort by the California state government to work on stigma reduction.

He began by stressing the "tremendous social-change effort"
being made to reduce stigma associated with mental illness, and noted that those involved do not often give themselves enough credit: indeed, one of the California Center's cornerstones is to expand the scope of involvement to include "change agents"—be they family members, community members or other champions, effecting change at a personal level. The Center equips these change agents with the tools, strategies and skills to go out and reshape attitudes toward mental illnesses.

Almost everyone at the Center has lived experience with a mental illness, which is incorporated into all aspects of decision-making. This, coupled with an interdisciplinary approach and a diverse base for outreach to different cultures and languages, supports the Center's goal of facilitating contact ("everyday people having everyday conversations") as the best way to reduce stigma. Through a cross-systems evaluation, the Center aims to maximize its evidence base to develop tools and resources for the community—moving from emerging practices, through developing best practices, and ultimately to establishing evidence-based practices.

Access to health insurance = access to care
Meagan De Jong presented the results of an evaluation by the Mobilizing Mind Research Group of extended health insurance programs for students in Canadian post-secondary institutions. She

noted that 25% of young adults experience anxiety or depression. Yet the coverage offered by many post-secondary institutions is limited and sometimes not available at all. These limited resources often lead to long wait lists. A study of institutions across the country (except Quebec) found that:

- 76% of universities offer some form of coverage
- Coverage percentages and maximums varied from institution to institution, but were often inadequate compared to average fees for counselling sessions
- Students also face several non-financial barriers to taking advantage of counselling, therapy or drug supports, either due to issues of access or awareness

De Jong closed by noting that it is "important to study the students, to apply the results to youth who do not have access" to mental healthcare, and noted that the team would like to expand its study to include Quebec.

ORAL PRESENTATIONS: APPROACHES TO STIGMA REDUCTION

The impact of stigma on care
This session reviewed research from Canada and Australia on efforts to reduce stigma among mental health professionals dealing with seniors, pharmacists serving persons with a mental illness, and mental health professionals working in organizational, clinical and experiential roles.

PRESENTERS
Kimberley Wilson, CA
Claire O'Reilly, AU
J. Simon Bell, AU
Elizabeth Nguyen, AU
Timothy Chen, AU
Marc Corbière, CA
Esther Samson, CA
Patrizia Villotti, CA
Jean-Francois Pelletier, CA

Reducing the stigma faced by seniors
Kimberley Wilson from the Canadian Coalition for Seniors' Mental Health spoke about a Mental Health Commission of Canada (MHCC) project to eliminate stigma for seniors with a mental illness by improving the attitudes and behaviours of the healthcare professionals who work with them.

After reviewing existing evidence and grey literature (which revealed a limited focus on seniors' mental health), project leaders developed a conceptual framework with a clear definition of stigma, and mapped key messages that dispel myths and address common stigmatization of these disorders in late life. Today, the team is consulting healthcare providers to learn about their experiences and the kinds of interventions they are looking to access. So far, 46% have indicated they have some kind of anti-stigma programming in place; those without said it had not occurred to them to adopt any, yet felt it was important.

The opportunity exists to further develop key messages and contribute to the literature, but leadership is required. Priority target audiences for those messages include nurses, physicians, and students in healthcare programs, with key topics being dementia, delirium, schizophrenia and separating aging from mental illness. Focus groups including seniors with lived experience of mental health problems and illnesses from a range of geographical settings and socio-economic circumstances are also being conducted to gather their perspective.

Bringing people with lived experience together with pharmacists
Claire O'Reilly, National Vice President of the Pharmaceutical Society of Australia, presented on contact with people with lived experience in pharmacy education. In Australia, 11% of medications dispensed are psychotropic, and pharmacists' involvement with people with mental illness includes providing screening and referrals, general support and advice on medications (particularly on side effects).

In O'Reilly's experience, traditional education is not as effective in reducing stigma in healthcare as contact-based approaches. As well, the lack of mental health education is a barrier to successful service provision by pharmacists. She cited a study on the impact of contact-based teaching on pharmacy students' attitudes toward people with a mental illness. Qualitative feedback from participants included comments that educators with lived experience made the terminology and concepts around mental illness more meaningful, and that encountering people with lived experience pushed learners out of their comfort zones, forcing them to re-evaluate their opinions and attitudes.

Anti-stigma strategies: What works?
Marc Corbière from l'Université de Sherbrooke closed the session with a presentation on strategies to fight stigma. Noting that stigma leads to social exclusion and can be expressed differently in different contexts, Corbière reviewed three approaches to reducing stigma: protest (diminishing negative attitudes), education and contact with persons with lived experience, particularly one-on-one. A survey of attendees at an Association for Psychosocial Rehabilitation in Québec stigma conference found a wide range of approaches and considerable creativity in efforts to reduce stigma toward people with a diagnosed mental disorder. The approaches were organized into six main categories: education, contact, protest, normalization, recovery and social inclusion, and reflexive consciousness (introspection).

ORAL PRESENTATIONS: STIGMA AND HELP-SEEKING

What kind of a barrier is stigma?
Each year, 27% of Europeans experience a mental illness, yet three-quarters (74%) go without treatment. Something is clearly keeping people from care. It is logical to assume stigma shares at least part of the blame, deterring people from seeking help. Three recent European studies found that stigma does indeed play a role—in various ways—and that deeper, larger scale research is needed to more clearly understand how, why and to what degree.

PRESENTERS
Elise Pattyn, BE
Piet Bracke, BE
Oliver Schauman, GB
Sarah Clement, GB
Tanya Graham, GB
Francesca Maggioni, GB
Sara Evans-Lacko, GB
Craig Morgan, GB
Nicolas Rüsch, GB
June Brown, GB
Graham Thornicroft, GB
Simone Farrelly, GB

The fear of being labelled
Ghent University's **Elise Pattyn** contributed to a cross-regional study that considered stigma to be something socially constructed and shaped by shared cultural meaning. She and her colleagues determined that cultural stigma deters help-seeking from specialized resources in the mental health field. People are not averse to consulting general practitioners, but do not want to be exposed to the health system in a way that might lead them to be labelled mentally ill.

Barriers at every stage
A systematic review conducted by King's College London Institute of Psychiatry and the SAPPHIRE program examined the link between stigma, help-seeking and service use. **Oliver Schauman** reported the review found no "unilaterally strong" evidence but did note a clear trend of mixed and negative associations between stigma and help-seeking. Early qualitative findings suggest stigma impacts help-seeking at all levels and stages, from the first perception of need to ongoing engagement with treatment after diagnosis.

Stigma and the therapeutic relationship
Another King's College London SAPPHIRE study looked at the effects of stigma within the mental health field, specifically its impact on how clinicians and patients think and feel about each other in the context of the therapeutic relationship. **Simone Farrelly** explained that strong therapeutic

relationships are important because they have been shown to minimize hospital visits and improve medication and treatment adherence.

Through a cross-sectional study in South London, the team found that 54% of people who said they had been treated unfairly when receiving care believed it was because of their mental illness. There was a strong statistical link between past or current experiences of discrimination and poor therapeutic relationships. Negative experiences did not affect people's sense of self, and there was no association between internalized stigma and the therapeutic relationship. The study determined there is a need to improve clinicians' awareness of how their behaviour and interactions affect users, and to empower service users.

ORAL PRESENTATIONS: CHANGING THE STORY THROUGH CLIENT VOICE

Of tales and tellers
These three presentations each looked at storytelling from a distinct perspective. The first, at how children's attitudes can be shaped through stories; the second, at how video can capture the impact of stigma in a compelling first-person way; and the third, at how the stories of people with lived experience have a role in policy development.

PRESENTERS
Jessica Grass, CA
Holly Kramer, CA
Jennifer Chambers, CA
Jane Paterson, CA

Shaping children's perceptions with storytelling
Using the power of storytelling to change attitudes and encourage children to incorporate conversations about mental health into their daily lives, *Iris the Dragon* is a charity that produces children's books and educator's tools promoting mental wellness. **Jessica Grass** read an excerpt from one of the storybooks to demonstrate how the topic of mental health can be transformed into an easily understandable issue while also teaching lessons, morals, and values. With over 100,000 books circulated, *Iris the Dragon* addresses a variety of behavioural and neuro-developmental conditions with emphasis on the family, school, and community in contributing to children's education and overall wellness.

The role of hope and optimism in personal stories of stigma
People with substance abuse problems also experience stigma. **Holly Kramer** from the Toronto Harm Reduction Task Force, an active network of individuals and organizations dedicated to reducing harms associated with substance abuse, produced a series of short video clips to illustrate the impact of stigma using those with the most powerful voice. Each narrative concludes with a positive note on how the individual has overcome obstacles and found peace. Accompanying the final DVD is a discussion guide where storytellers listed their challenges and strengths. None identified substances as a challenge but said drugs mask the real problem.

Taking direction from clients: Developing the CAMH Bill of Rights
Funded by the Centre for Addiction and Mental Health, the Empowerment Council is a voice for clients of the centre. It is responsible for representing their interests and advocating for policy that reflects their needs. **Jennifer Chambers** explained how the Centre for Addiction and Mental Health Bill of Rights was developed in collaboration with clients to assert and promote the dignity and worth of those who access the Centre's services. In response to the cruel and misinformed treatment of some clients with substance abuse and mental health problems, the bill details rights —such as the right to quality services that comply with standards—and has facilitated a better dialogue between clients and staff.

ORAL PRESENTATIONS: MEDIA DEPICTIONS

Casting dark shadows
This was the second of the day's sessions to look at the impact of mass media, including the entertainment media, on perceptions of mental illness and the mentally ill.

PRESENTERS
Colleen L. Haynes, CA
Rebecca Palpant, US
Francesca Lassman, GB
Sarah Clement, GB
Elizabeth Barley, GB
Sara Evans-Lacko, GB
Paul Williams, GB
Rowena Pagdin, GB
Mike Slade, GB
Nicolas Rüsch, GB
Sosei Yamaguchi, GB
Graham Thornicroft, GB

Stigma at the box office
Colleen Haynes observed that madness is a recurring theme in Hollywood films and that people living with mental illness are typically depicted as violent, untreatable and irredeemable.

Because of their reach, movies provide the viewing public with many of its perceptions about the mentally ill and contribute to stigma and marginalization. These films make a lot of money at the box office. It is easy to see how Hollywood's mythologized view of the mentally ill has been perpetuated. In 2010 *Shutter Island* made $295 million, while the Canadian government will spend just $110 million on mental health initiatives over 10 years. Haynes said there must be greater public education and discourse on how the mentally ill are portrayed in the mass media.

Investigative journalism as a catalyst for change
Rebecca Palpant said journalists can play a powerful role in influencing the development of policies for social inclusion and ending discrimination by exposing the failures of the mental health system, discriminatory practices, abuses of power and inadequate funding. For example, after being tipped off by workers at a state mental hospital, the *Atlanta Journal Constitution* devoted 18 months of front-page articles to exposing 130 unexplained patient deaths. As a result of this coverage, key stakeholders were brought together, including the U.S. Department of Justice and the Carter Center Mental Health Program, to develop much-needed reforms for mental health in the state of Georgia. When journalists perpetuate inaccuracies and sensational images related to mental illness, they are part of the problem. But when they demonstrate leadership, they can contribute to the solution and help those with a mental illness in a real and tangible way.

Using media to modify perceptions
The final presentation of the session, given by **Francesca Lassman**, looked at the effectiveness of mass-media interventions against stigma. Because they can be scaled up with relative ease, print, audio-visual and online media have the potential to contribute to large-scale change. To date, however, there has not been extensive research into this area. To provide guidance for future research and initiatives, Great Britain's SAPPHIRE program conducted a Cochrane systematic review of current knowledge on mass media interventions. While there was limited evidence to indicate mass media interventions reduce discrimination, such interventions can reduce prejudicial attitudes. Also, first-person narratives were more effective than third-person narratives. However, the quality of the evidence was quite low making it difficult to draw firm conclusions.

DAY 2: HEALTHCARE PROVIDERS/YOUTH

The impact of stigma encountered within the health system itself can be particularly devastating, with some research showing it has an impact on both disability and mortality. The second day's agenda included several presentations on stigma in healthcare settings, looking at everything from the attitudes of care providers, to programs seeking to effect change. It also considered the way stigma affects youth, a key demographic given that many mental health illnesses first present during adolescence.

Sessions featured a mix of perspectives and approaches to the topic of stigma, from academic research to the anecdotal accounts of persons with lived experience. Throughout the day there was a strong emphasis on the importance of facilitating contact between people with mental illness and those without to influence attitudes about mental health. A key question, addressed by a handful of studies, was whether the efficacy of contact-based education could be reproduced through "mediated" experiences such as films and theatre.

Presenters described a range of outreach and awareness-raising programs, often identifying best practices. A few sessions looked at the impact of cultural context on the phenomenon of stigma, with culture in some cases being vocational, as in the case of the Canadian military, and in others ethnographic.

"Blessed are the cracked, for it is they who let in the light."
~Karen Liberman

PERSONAL PERSPECTIVES

Through the eyes of experience
The day got underway with presentations from three individuals with lived experience who shared openly and freely their struggles, observations about stigma, and what helped them get through.

PRESENTERS
Karen Liberman, CA
Erin Hodgson, CA
Pat Corrigan, US

The journey from victim to advocate
The entertaining and dynamic **Karen Liberman** began by contrasting her present self—a mental-health advisor with executive credentials, a spouse, mother and grandmother— with the person she was about 15 years ago—suicidal, feeling like a failure and a burden on society. Liberman's mother lived with a mental illness. Her family never talked about it. It became a shameful secret, and that lesson of silence shaped the rest of Liberman's life. When she began to struggle with mental illness herself—something that began gradually—she denied it and refused to seek treatment. In her words "I wasn't going to be one of those people." When she finally broke down, she blamed those around her (principally her husband). She was hospitalized 17 times—once for six months—underwent electroconvulsive therapy 24 times and tried 27 different medications. Today, looking back, she sees the experience as its own kind of "credential". Her recovery saw her evolve from a victim, to a patient, to a consumer, to an advocate, to a person with lived experience … to "a loudmouth who can stand up in front of you and say that I'm proud."

"Be the change you wish to see in the world"
Liberman believes every interaction in life either builds or reduces stigma. As proof of her conviction, a speech she gave at **Erin Hodgson's** high school led the then Grade 12 student to publicly declare her own mental illness. Hodgson lived with an intense form of obsessive-compulsive disorder in childhood and did not respond well to various therapies. She said it is impossible to overstate the damage caused by internalized stigma. From an early age, she was bullied and ostracized by peers, and her family never talked about her illness. As a teen, she carved the words "I am alone" into her arm. A suicide attempt in college was her low point, leading to hospitalization and electroconvulsive therapy (ECT) just before her 20th birthday. Yet with therapy, she began to recover. Asking why she should feel ashamed about an illness over which she has no control, she became a resolved young woman determined to "pay it forward," educate young people and fight stigma. It has been an uphill battle. Hodgson wanted to volunteer with Big Brothers Big Sisters but was declined due to her history of psychological problems. She has a criminal record due to her suicide attempt. Yet, at the age of 26, she is about to graduate with a bachelor's degree in psychology and begin postgraduate studies, and currently volunteers with a program called Stop the Stigma. She ended her presentation with quote from Mahatma Gandhi: "You must be the change you wish to see in the world."

Calling for some TLC3
Pat Corrigan wears two hats: that of a licensed clinical psychologist, and that of a person recovering from a mental illness. He called on researchers to test, measure and improve interventions that combat stigma. One of his biggest concerns is that many interventions lead to unintended negative consequences.

Corrigan conducted meta-analysis of completed studies to explore various perspectives on how to combat stigma and measure success. Education was among the approaches that did not prove successful at reducing stigma. Contact, on the other hand, led to much better results, proving two or three times more effective than education. And personal contact such as public speaking was more effective than videos or movies. Corrigan called for interventions based on what he calls the TLC3 approach: **t**argeted, **l**ocal, **c**ontinuous, **c**redible **c**ontact.

BUILDING BETTER PRACTICES TARGETING HEALTHCARE

Making contact with care providers
For many, the stigma associated with having a mental illness is worse than the symptoms. Having a diagnosis can be damaging, even when one is in the care of health practitioners. Stigma is pervasive in the healthcare sector, and can often result in patients refusing treatment, avoiding treatment or receiving substandard care for physical ailments unrelated to their mental conditions.

CHAIR
Peter Byrne, GB

PRESENTERS
Graham Thornicroft, GB
Thomas Ungar, CA

The health impact of stigma
The United Kingdom's **Graham Thornicroft** reminded participants that up to 30% of the world's population lives with some form of mental illness, yet fewer than a third of people seek help. Stigma contributes heavily to under-treatment and is rooted in three problems: ignorance (knowledge), prejudice (attitude) and discrimination (behaviour).

Among health practitioners, stigma can lead to "diagnostic overshadowing," in which physical ailments are dismissed as part of a patient's psychological condition. Stigma and discrimination can limit individuals' access to healthcare, which has a detrimental effect on life expectancy. For example, in Nordic countries, psychiatric patients' lives are consistently 15 to 18 years shorter than those of the general population.

Thornicroft said contact seems to present the best avenue for reducing stigma—with the nature of the contact impacting effectiveness. This was demonstrated in a controlled study that compared a traditional lecture, in-person training, and a filmed intervention. As part of the in-person training, two individuals with lived experience interacted directly with groups of students (including medical and nursing students) and police officers. Compared to the traditional lecture, these sessions produced consistent improvement. The filmed intervention was less effective than the in-person training, but significantly better than the lecture. Results persisted at a four-month follow-up. As film is less expensive than numerous in-person sessions, it is a more viable approach for a large-scale campaign.

Toward a national training strategy for Canada
Thomas Ungar reinforced Thornicroft's presentation, saying stigma against persons with mental illness can take a number of forms in the healthcare sector, from low compassion, to lesser-quality care, to reduced access to care. Current medical training is insufficient, and while some curricula deal explicitly with reducing stigma, the behaviour of colleagues and teachers can counteract it.

In awareness of this, the Ontario Central Local Health Integration Network (LHIN) developed a course that features contact-based education as a key ingredient—Mental Illness and Addictions: Understanding the Impact of Stigma. Now three years old, it has been replicated in seven British Columbia communities and demonstrably improved the attitudes of healthcare practitioners. A follow-up evaluation of the Central LHIN course showed some slippage over time, though still with improvements over the baseline levels. A second phase of the program is being developed that involves booster sessions.

Ungar suggested an ongoing, accredited national training program might be the best solution, based on direct contact with persons with lived experience, or pseudo-direct contact through filmed presentations. Such a program should also include more and better psychiatric training during medical school and residency, regardless of a student's specialization. Basic competencies in mental health should be emphasized. In addition to contact-based education,

anti-stigma efforts in healthcare should be careful to recognize that different contexts may require different approaches, and that training should be staged to suit learners' levels of knowledge.

BUILDING BETTER PRACTICES TARGETING YOUTH

The youth experience

As many mental health disorders first appear during adolescence, understanding the impact of stigma on youth is important. For example, stigma affects youth differently than adults—and can interfere with their education, employment, relationships and health habits, having negative consequences that may persist for the remainder of their lives. The 2010 Canadian Community Mental Health Survey Rapid Response Module, funded by Opening Minds, found nearly 60% of respondents who had been treated for a mental illness under the age of 25 reported facing stigma—much higher than any other age group.

CHAIR
Simon Davidson, CA

PRESENTERS
Anthony Jorm, AU
Heather Stuart, CA

Tools for parents, teachers and peers

Few youth seek professional help for mental health problems. Many feel embarrassed or shy about disclosing their problems and are concerned about how others will perceive them. The social context must be altered to make disclosure more acceptable and to make those closest to youth—parents, teachers and peers—more receptive to talking about mental health. As **Anthony Jorm** explained, Australia has found that one way to achieve this is through training in the Mental Health First Aid program.

Built on a model of listening non-judgmentally and providing appropriate support, the Mental Health First Aid program can be given to a person experiencing a mental health crisis until professional help is available. Australia currently provides a 14-hour course to improve how adults assist adolescents. Teachers have been given training to provide more consistent information to students. As most teens lack the skills to respond effectively to peers in crisis, the country is currently studying key messages for a three-hour course of Mental Health First Aid for high school students.

Changing attitudes and behaviours among students

The Mental Health Commission of Canada's Opening Minds initiative has done extensive work with youth, measuring contact-based interventions using a stigma stereotype scale—which measures student attitudes on the likelihood of recovery, potential for violence and other aspects of mental illness—and a social tolerance scale—which looks at behaviours such as the desire for social distance from those with mental illness.

Heather Stuart described a pilot study of 754 youth before and after contact-based education that found programs were mostly successful at changing attitudes and behavioural intentions. The study also showed that, for best results, contact-based education should be delivered continuously over multiple sessions rather than as a one-off event. For an even more complete picture of youth stereotypes and social tolerance, Opening Minds is now collecting data from 10,000 survey responses from a number of partner programs.

PARALLEL SESSION 1: SYMPOSIA, WORKSHOPS, PANEL DISCUSSIONS AND ORAL PRESENTATIONS

SYMPOSIUM: STIGMA IN THE MILITARY

Combatting the barriers to care

In the 2002 Canadian Community Health Survey Canadian Forces Supplement, 13% of Canadian Forces members reported an unmet mental health need. Fewer than half of those with problems sought help. Forces' leadership wanted to know why. Does military culture present special barriers to help-seeking? How can members be better equipped to deal with the unique stresses of a military career?

Gathering intelligence

Miriam Weins presented highlights from a 2006 Health and Lifestyle Information Survey that identified the most common mental health problems reported by regular members of the Canadian Forces were: distress indicating a need for help (15%), post-traumatic stress disorder (PTSD, 8%) and depression (7%).

CHAIR
Deniz Fikretoglu, CA

PRESENTERS
Miriam Weins, CA
Mark Zamorski, CA
Kerry Sudom, CA
Bryan Garber, CA
Kim Guest, CA
Suzanne Bailey, CA
Wendy Sullivan-Kwantes, CA
Karen Richards, CA

Eleven percent of those with mental health problems did not seek help. The full list of barriers was large, but the most significant were people's preference to manage the issue alone (64%, consistent with broader public results), fear of the effect on one's career (37%) and fear of asking for help (25%).

Coming out of the survey, the Forces saw the need to train members in coping/self-management skills, and to better educate them about confidentiality, the importance of seeking help early to improve one's outcomes and minimize the potential career impacts, and the support services that exist.

Mental health support during—and after—deployment

Getting help for mental health problems "in theatre" can be especially challenging. **Kerry Sudom** described a study of perceived barriers to care among Forces' personnel in Kandahar, Afghanistan. Researchers surveyed members serving on two consecutive rotations of combat and peace support and found the fear of stigma, practical challenges associated with access, and negative attitudes toward mental healthcare were the main barriers. Only a minority of individuals were interested in seeking help, and those with disorders were likelier to perceive barriers to care.

When members return home from serving abroad, the Forces facilitates the transition back to normal life through "third-location decompression." In 2010, the Forces revamped the program it had been using since 2006—evolving from a U.S. model, Battlemind, to an experience more closely aligned with Canadian realities.

Suzanne Bailey explained that through the Third Location Decompression program, members receive education in overcoming the barriers to care. Called the Road to Mental Readiness, this training is designed to help them recognize the difference between the "sprained ankle" equivalent of a mental health issue, and a "broken leg" that requires greater attention. It is delivered by teams of trained peers and clinicians. The peer component is important to establishing credibility with members.

A full-spectrum approach
Deniz Fikretoglu described the Forces' efforts to shape members' attitudes toward mental health early in their careers. Researchers studied new recruits during their first week of training. Recruits are mostly 17 to 20 year olds who have not had much contact with the mental health system. They were presented with a hypothetical situation and asked open-ended questions. The scenario resonated with subjects because it reflected the stresses and dynamics they were experiencing during the radical transition from civilian to military life. While they saw the benefit of seeking help, recruits spontaneously brought up the word stigma, saying they feared they would be treated differently for seeking help, and that they might see themselves differently as well. This confirmed the Forces' commitment to address stigma early and directly in training, and to try to demystify the mental healthcare process.

SYMPOSIUM: GLOBAL PATTERNS

DISC: A measurement scale for stigma
Depression is the third leading cause of disability in the world—responsible for the loss of 98 million life years annually. Because of stigma, the treatment rate for depression is alarmingly low. For every 1,000 sufferers, only 15 to 20 are appropriately treated. The Anti-Stigma Programme: European Network (ASPEN) and the INDIGO Study Group sought to gain a qualitative and quantitative understanding of stigma by interviewing persons with schizophrenia and depression in 40 countries.

CHAIR
Graham Thornicroft, GB

PRESENTERS
Tine Vera Van Bortel, GB
Norman Sartorius, CH

Stigma and schizophrenia
One of the key aims of the INDIGO study was to develop and validate a way of measuring people's experiences of discrimination, whether actual or anticipated. The scale, called the Discrimination and Stigma Scale (DISC), used a variety of carefully worded questions to collect data on the types and severity of discrimination. The INDIGO group first developed the DISC scale to examine stigma and schizophrenia, interviewing 736 people with schizophrenia in 28 countries. The researchers found responses could be grouped into several categories, including stigma in personal relationships, housing, education, family life and work. The INDIGO schizophrenia study revealed that persons with mental illness faced discrimination in a number of areas, and many felt that simply receiving a diagnosis of mental illness put them at a disadvantage. Key areas of discrimination included making or keeping friends, maintaining relationships with neighbours and finding a job. Results were fairly consistent across all countries. The study also identified the pervasiveness of anticipated discrimination, in which a person with a mental illness avoids taking an action, such as applying for a job, due to an expectation of discrimination. Many respondents felt the need to conceal their diagnoses, or did not apply for a job because they assumed they would not be hired.

What DISC revealed about depression
When INDIGO approached the subject of depression, the group applied the methodology of the previous study, interviewing groups of 25 people from 40 international sites. In preliminary results from Europe, nearly 80% of respondents reported some form of discrimination in at least one category, and between 25% and 33% had avoided taking some form of action due to anticipated discrimination. Comparisons between countries were not possible due to the small sample sizes of the individual groups.

A separate study, the First Episode Discrimination Outcomes Research Assessment (FEDORA), used DISC to look at experiences of discrimination or stigma among those who had experienced a first episode of depression or schizophrenia. Phase one was conducted in Austria, Croatia, Poland, Romania and Sweden and involved 204 participants. On average, those with

schizophrenia reported discrimination in 2.5 life areas, while those with depression reported discrimination in 3.0 life areas—a statistically significant difference. The highest reported average incidences of discrimination occurred in Poland (4.7 life areas), and the lowest in Austria (1.4). The next stage of this study will look at discrimination faced by those with a longer-standing diagnosis of depression or schizophrenia.

SYMPOSIUM: STIGMA AND MENTAL ILLNESS IN RESOURCE-POOR SETTINGS

Stigma is at home everywhere

This international session focused on stigma in the countries of Kosovo and Nepal, and in Mexico City. While experiences differ significantly from one culture to the next, it seems universally true that those who live with a mental illness are more likely to be stigmatized than those who suffer from diseases such as diabetes. All presenters suggested the views of people with a mental illness should be given greater weight by clinicians and the community at large.

CHAIRS
Duncan Pedersen, CA
Rob Whitley, CA

PRESENTERS
Hanna Kienzler, CA
Jazmin Mora-Rios, MX
Guillermina Natera, MX
Ram Prasad Sapkota, CA

The impact of violence

In his role as chair, **Duncan Pedersen** began the session with an overview of factors that affect the intensity and nature of stigma associated with mental illness. Socioeconomic status, for instance, is often inversely related to stigma. This is particularly true in societies that value competitiveness and personal accomplishment.

Hanna Kienzler's presentation looked at the consequences of the intense violence that took place in Kosovo during the 1998–1999 Yugoslavian war. Torture and sexual assault were rampant. Today, the region is the poorest in Europe and its justice and healthcare systems function poorly. The presentation focused on the growth of "intimate partner violence" and its impacts on stigma and mental health issues. Kosovar society does not consider intimate partner violence to be a human rights issue; indeed, it wasn't considered a criminal offence until 2003. Many believe that women suffer in silence, a position stigmatizing in itself because it portrays women as passive victims. Advocacy groups are calling for enhanced services for survivors as well as better community education.

Culture and stigma

Next, **Ram Prasad Sapkota** described the Nepalese experience. Formal psychiatric care came to Nepal in 1961, and the country's only mental hospital was built in 1984. Its first mental health policy was established in 1997. The concept of mental illness is largely unknown. Nepali, the most common of the 93 languages spoken in the country, does not have a word for it. There is a word for stigma, however: *kalanka*. *Kalanka lagnu* refers to disgrace, loss of honour or social status. This term is often applied to individuals with a mental illness and to their families. They often struggle to find jobs and spouses.

Some of the cultural challenges encountered in Nepal are the beliefs that severe mental illness is punishment for misdeeds in a past life, and that mental illness runs in families—meaning an individual may be fated to belong to a "clan of crazy." These and other factors lead to a vicious cycle in which stigma delays help-seeking and problem identification, which in turn creates opportunities for the illness to become more severe.

Interventions aimed at reducing stigma need to examine local cultures, concepts and beliefs to be effective.

Perceptions of stigma
Jazmin Mora-Rios gave the final presentation, describing a study by four psychiatrists and one anthropologist of 23 people diagnosed with schizophrenia in Mexico who were treated as outpatients. Data were collected during in-depth interviews, often over multiple sessions. All but one of the subjects reported stigma; most identified the source of stigma as the media, relatives and healthcare personnel. The stigma was most likely to affect study participants' economic and emotional wellbeing. The study noted that clinicians often ignored patients' concerns about stigma.

WORKSHOP: DISCLOSURE

Coming out proud
Given the stigma and misunderstanding that surround mental illness, one American professor has taught his students that if they are going to come out, it is best to "come out proud."

PRESENTERS
Patrick Corrigan, US
Blythe Buchholz, US

According to **Patrick Corrigan** of the Illinois Institute of Technology, when people emerge from the shadows and tell their stories about living with a mental illness, it is like "an atomic bomb for erasing stigma." He points to the lesbian, gay, bisexual and transgender (LGBT) community as an example of how to change minds and break down stereotypes, and notes that in the U.S. about 10% of the community is gay, while about 25% has a mental illness. Corrigan wants people with mental illness to embrace who they are and include the mental illness in their identity, saying the most harm comes when people agree with or succumb to stigmatization. This leads to a questioning of self-worth and a cycle of depression—what he calls the "why-try effect." Conversely, pride can play a key role in stamping out stigma. There are many reasons to disclose a mental illness, from the desire to share a burden or secret with someone else, to the desire to strengthen the "out-community," or even to gain work-related medical benefits.

Corrigan has defined five stages of coming out:

1. Social avoidance, or staying away from "normal people"
2. Secrecy, or participating in "normal society" while hiding a mental illness
3. Selective disclosure
4. Indiscriminate disclosure
5. Broadcasting, or "coming out blazing"

He acknowledged that coming out proud is not for everyone. When a person decides he or she wants to tell a friend or co-worker about a mental illness, there are considerations. It may be important to get a sense of how someone might respond before disclosing a mental illness—for example, by asking about a TV character with a mental illness, or bringing up a news story and gauging their reaction.

PRESENTERS
Gretchen L. Conrad, CA
Julie Daly, CA
Tracey Kent, CA
Susanna Konsztowicz, CA
Trevor Anzai, CA
Cynthia Clark, CA
Rick Coldrey, CA
Sheila Deighton, CA
James Thomas, CA
Estelle Malcolm, GB
Guy Shefer, GB
Sara Evans-Lacko, GB
Claire Henderson, GB
Graham Thornicroft, GB
Kristin Ann Sokol, US
Nev Jones, US
Drexler James, US
Patrick Corrigan, US

ORAL PRESENTATIONS: SCHOOL-BASED PROGRAMS

Taking anti-stigma to school
First instances of mental illness occur most often in youth aged 15–25, making early intervention, youth awareness and anti-stigma

strategies critical. An effective way to reach a large portion of this demographic is through school-based programs, four of which were featured during these oral presentations.

A personal path to recovery

On Track is a first-episode, early intervention program. In partnership with the Ottawa chapter of the Schizophrenia Society, On Track makes presentations to students in Ottawa-area high schools to challenge common misconceptions of psychosis.

One peer speaker with On Track, **Trevor Anzai** had a psychotic experience in Grade 12. He lived "in a different reality," experiencing delusions and manic depression. Initially hospitalized for two weeks, Anzai spent two years recovering as an outpatient in On Track, and is learning to live with his illness by speaking to others about it. Student evaluations highlight the impact peer speakers have in normalizing, demystifying and destigmatizing psychosis.

High 5 for Life

James Thomas' sister Chantal took her own life at the age of 18. Determined to understand why, Thomas began producing a documentary on teen suicide that connected him with mental health experts and people with lived experience. He learned his sister faced a number of the leading risk factors of suicide, including mental illness, drug and alcohol addiction, and sexual and psychological abuse; he realized he was struggling with many of the same risks. After reaching out and seeking help, Thomas decided to share his experiences with High 5 for Life, a multimedia mental health and suicide prevention presentation targeted at youth. During his presentations at high schools across Ontario, he shares both his sister's and his own story while teaching the basics of suicide prevention and offering a new understanding of a destigmatized perspective of mental illness.

Green schools: rethinking mental health stigma

Green Schools was part of England's Time to Change national anti-stigma program and was run by the charity Rethink Mental Illness. Green Schools offered programs for young people aged 11–14 who had been permanently excluded from mainstream education. It also had programs for adults living with mental illness. Green Schools helped young people return to the mainstream through individual plans that included instruction in behaviour management, engaging others in a positive way, and physical activities. Adult users benefitted from fitness, wellbeing and horticultural programs. The unique integration of the two programs saw youth engaging in activities alongside adults living with a mental illness. Participants from both groups benefitted from increased self-confidence and decreased self-stigmatization. Despite the reported success of the Green Schools project, funding was cut and the school was forced to shut down after only three years in operation.

Promoting an environment of solidarity and support on college campuses

In a 2006 National College Health Association survey, college and university students across the United States disclosed varying levels of experience with mental health problems. Forty-four percent reported being depressed to the point of being unable to function, 30% reported living with an anxiety disorder and 9% reported seriously considering suicide.

In response to these alarming numbers, Illinois Institute of Technology PhD student **Kristin Ann Sokol** began a community-based participatory research study to create a mental health anti-stigma program. The resulting Campus Solidarity Campaign will promote solidarity and support on college campuses for students living with mental illness. Funded by Active Minds and The Scattergood Foundation, the Campus Solidarity Campaign will be launched in November 2012 at the Active Minds national conference and on selected pilot campuses.

ORAL PRESENTATIONS: STIGMA AND CULTURE

How context and access affect stigma

This pair of presentations looked at stigma among different cultural groups—in the first case, multiple groups in the U.S., and in the second, within Iran. They found that culture has a definite impact on stigma and that access to care may help reduce stigma at the cultural level.

PRESENTERS
Tahirah Abdullah, US
Tamara L. Brown, US
Ebony S. Vinson, US
Helia Ghanean, SE
Lars Jacobsson, SE
Marzieh Nojomy, IR
Jazmin Mora-Ríos, MX
Guillermina Natera, MX

Working within the cultural context

Tahirah Abdulla presented the work of her team at the University of Kentucky to define a framework for the interrelation of culture and stigma as it applies to mental illness.

She defined culture as a set of shared beliefs and values that influence norms, practices, institutions and psychological processes. Given that diagnoses of mental illness are often based on how a patient conforms to expected behaviours, Abdulla observed that they are necessarily entrenched in culture.

Culture can influence the cues, stereotypes, prejudice and discrimination that construct stigma. The University of Kentucky team conducted a literature review that brought to light several factors germane to multiple ethnocultural groups in the U.S. For example, a high value placed on emotional self-control by Asian-Americans may stigmatize therapy that often encourages emotional outlets such as crying. The communal orientation of American (Native) Indian cultures, on the other hand, can stand at odds with the practice of institutionalization. The results of the study point to future research avenues, including validation of salient cultural values, and the use of focus groups to more precisely identify the stigmatizing beliefs held by each cultural group. Abdulla expressed an interest in pursuing a more qualitative study focusing on African-Americans.

The importance of access to care

In 2008 and 2009, **Helia Ghanea** and her colleagues at Sweden's Umea University and Tehran Medical University conducted a study in Tehran to investigate public knowledge and attitudes to mental illness. In Iran, 73% of people have mental health coverage and access to medical professionals. However, the intensely religious nature of Iranian society may have a stigmatizing effect on mental illness, particularly because individual suffering is considered to be the "will of God." Men showed fewer stigmatizing attitudes, possibly because of increased socialization and perhaps greater contact with people who have a mental illness. Those who were better educated showed more stigmatization. Respondents' attitudes were more open than those found in a similar study done in Nigeria, where access to care for people with a mental illness is negligible. Access to care may be a key destigmatizing factor. In Nigeria, the Islamic concept of the will of God was cited only very rarely.

ORAL PRESENTATIONS: MEASURES AND MODELS

Making stigma visible

Research indicates people are notoriously inaccurate at self-description and concerned with appearing unprejudiced. This means they require alternative methods to self-report for studying prejudice to accurately expose this reality.

PRESENTERS
Scott Burton Patten, CA
Caroline E. Mann, US
Yoko Hamamitsu, JP
Katrin Schenk, US
Sharika Prioty, US
Catriona Lynne Hippman, CA
Emily Morris, CA
Erin Michalak, CA
James Livingston, CA
Gregory Murray, AU
Jennifer Boyd, US
Angela Inglis, CA
Prescilla Carrion, CA
Jehannine Austin, CA

Mapping social behaviour

Scott Patten of the University of Calgary described a simulation study of "interacting agents" representing those with and those without a mental illness. Using an adaptation of the classic

"flocking" model, which charts group behaviours, the simulation was programmed so that preferred social distance was dependent on the presence of a mental illness.

The model proposed higher levels of stigma in areas of greater social isolation. However, it also proposed that the variability of stigma levels within the population may be a determinant of social connectedness, even in situations where the mean level of stigma (overall stigma) does not change. Also, the model proposes that lower levels of stigma may result in greater social affiliation among those without illness. It was suggested that mean change in stigma levels should not be the sole focus of evaluation in anti-stigma programs.

Designing new tools

Catriona Hippman of the University of British Columbia described the development of the FaMIL-IS scale, the first and only valid, reliable instrument for measuring internalized stigma in family members of individuals with a mental illness. Phase I of development involved interviewing a focus group of individuals with a mental illness and their immediate family members on the topic of internalized stigma. From this, 130 verbatim quotations were chosen as potential scale items. In Phase II, the quotations were reframed so they could be answered using a Likert scale response and modified to clarify meaning. In Phase III, the scale was tested for reliability and validity, testing high on both accounts.

Caroline Mann of North Carolina's Meredith College presented the Implicit Association Test (IAT). This test uncovers hidden prejudices by using participants' reaction times to elucidate underlying preconscious attitudes. Thirty participants were shown images of six (fictional) individuals, half of whom had a mental illness and half of whom had a physical illness. The images of these virtual individuals were flashed on a screen, followed by positive or negative words the participants had to categorize. Respondents were faster to pair someone with a mental illness to a negative word, than a positive word, indicating an implicit negative bias.

ORAL PRESENTATIONS: KEY ELEMENTS

PRESENTERS
Catherine Bancroft, CA
Eugenia Canas, CA
Yifeng Wei, CA
Stan Kutcher, CA
James Livingston, CA
Sagar Parikh, CA
Erin Michalak, CA
Victoria Maxwell, CA
Vytas Velyvis, CA
Sharon Hou, CA

Reaching youth effectively

What does it take to successfully engage youth in programs that reduce stigma in their schools and communities? Sometimes, the key element is a contact-based approach—that is, the active involvement of those with lived experience. In other cases, it is about building the basic mental health literacy of students and teachers.

The powerful truth of contact-based programs

Toronto's Stop the Stigma initiative involves youth with lived experience in every aspect of its activities. **Catherine Bancroft** explained that in addition to designing the program, youth also act as ambassadors, training other students to run programs in their own schools and speak about their experiences.

Having real people tell real stories is what makes the contact-based approach shine. Hearing about a mental illness from somebody who has lived through it helps raise students' awareness of the problems their peers might be facing and it makes them more likely to speak openly about their own experiences.

Similarly, mindyourmind.ca encourages students to share their stories through blogs, videos and music. For those posting to the site, **Eugenia Canas** said sharing offers a chance for self-reflection and facilitates access to additional support. For visitors, the site delivers powerful

experiential learning through personal stories. Like Stop the Stigma, mindyourmind.ca has youth involvement built into its core.

The contact-based approach does not apply to youth only, as pointed out in a presentation by **James Livingston**. When combined with creative arts, it can also reach audiences that may not be responsive to conventional methods of addressing stigma. In a study funded by the Canadian Institutes of Health Research, healthcare providers and people with bipolar disorder watched a one-hour performance by Victoria Maxwell, a woman with bipolar disorder. The goal was to determine if theatre experiences could change people's attitudes about people with a mental illness. While fewer improvements were shown among people with bipolar disorder (possibly because living with stigma creates less shakeable attitudes), healthcare providers showed significant and meaningful improvement across all survey subscales.

Building a foundation of mental health literacy
Mental health literacy—knowledge of, and skills related to the biological, psychological and social aspects of mental health—should serve as the foundation for mental health promotion and intervention. **Yifeng Wei** described how mental health professionals collaborated with educators to develop the *Mental Health and High School Curriculum Guide* to improve mental health knowledge, reduce stigma and encourage help-seeking behaviour in youth. With a length of just six to eight hours, the curriculum can be easily embedded within the existing education system. In Nova Scotia, for example, a pilot project was conducted to train 87 Grade 9 teachers on how to improve their understanding of mental health and confidence in implementing the curriculum. The intervention was highly effective in preparing teachers for addressing students' mental health needs, highlighting the importance of further collaboration between the health and education systems.

ORAL PRESENTATIONS: PERSONAL JOURNEYS

Taking their lives back
A series of speakers told their stories of living with mental illness and how they turned the corner to establish a new sense of personal wellbeing and purpose.

PRESENTERS
Barry Shainbaum, CA
Dan McGann, CA
Andrea M. Zoephel, US
Michelle D. Zoephel, US
Tanya Eng, US

Moving forward, taking responsibility
For renowned photographer **Barry Shainbaum**, losing his business, getting in trouble with the law and hitting rock bottom presented the opportunity to finally take control of his life. Diagnosed with manic depression at 18, his illness left him feeling desperate and suicidal. Shainbaum's turning point came during a stay on a psychiatric ward where patients lost their right to operate a toaster, and he became the advocate for winning back the right. From that day, he began a path of progress, taking calculated risks, writing two books and even appearing on a TV show. Thanks to hope, persistence, self-education and speaking with others, he has faced his challenges head on, today living a balanced and positive life without medication.

Overcoming self-stigma by asking for help
On the surface, **Dan McGann** was the picture of perfection—popular, on the track team and member of his school's student council. Behind the scenes, however, he was dealing with alcoholic parents, his own self-stigma and denial that he too was an alcoholic with depression.

That denial persisted after high school. He became a mental health professional working at Mississauga's Credit Valley Hospital—a situation in which he felt he could not possibly ask for help, believing he knew how to deal with mental illness on his own. In 2010, however, he attended his first Alcoholics Anonymous meeting and has been sober ever since, controlling his anxiety through running. Realizing that marathoning positively transformed him, he established a

running program for youth with depression and anxiety to help them cope and gain self-confidence. In 2011, the Canadian College of Health Leaders presented him with the Quality of Life award for his work. The running program is expanding to a growing number of Ontario schools.

Speaking out: A mother and daughter manifesto
When **Adria Zoephel's** 12-year-old daughter **Michelle** said voices commanded she cut her wrists, she immediately sought medical help for her daughter. Unaware of the Wisconsin law that police must transport any person with a mentally illness to hospital, Zoephel watched helplessly as her daughter was handcuffed and driven in a squad car to a hospital four hours away. Perceiving the state legislation as the product of stigma—and that stigma as the product of fear—Zoephel and her daughter became advocates for change. They lobbied to reform a Wisconsin law that stated a person with a mental illness could determine his or her own fate at the age of 14. The age was raised successfully to 16, and Zoephel and Michelle have since established an advocacy campaign called Eliminate Mental Illness Stigma to raise awareness of mental health issues across the United States, often speaking in high schools.

Learning to accept mental illness
Self-described as ignorant, cruel and untrusting, **Tanya Eng** was a fraud investigator who believed the people with mental illness were "lazy" and "fakers." Despite a horrible childhood of physical, verbal and sexual abuse, she denied she had any signs of depression and became severely withdrawn, unable to function and extremely suicidal. Feeling judged and reclusive and after having tried various medications, she found a psychiatrist who changed her life and attitude. She accepted her illness and turned to God for help. After conquering her own self-stigma, she said she was sharing her personal story for the first time in hopes of educating others.

ORAL PRESENTATIONS: CONCEPTS, MODELS AND BEST PRACTICES

Fostering social inclusion
This session's speakers provided perspectives from the U.K. and Canada on concepts of social inclusion, and presented models and best practices for effective anti-stigma programs.

Misconceptions about social inclusion
Virginie Cobigo from the University of East Anglia in the U.K. kicked off the session with a presentation on social inclusion for persons with disabilities. She spoke about her work with the Multidimensional Assessment of Providers and Systems (MAPS) initiative to inform the assessment of services and supports for adults with intellectual/developmental disabilities in Ontario, which she undertook as part of her post-doctoral studies at Queen's University. A literature review revealed overlaps between the concepts of social inclusion, social integration, social participation, social role valorization and normalization with four particular misconceptions:

PRESENTERS
Virginie Cobigo, GB
Fiona Jean Warner-Gale, GB
Jane Sedgewick, GB
Carmen Charles, CA
Peter Lye, CA
Sarah Clement, GB
Adrienne van Nieuwenhuizen, GB
Aliya Kassam, GB
Ian Norman, GB
Clare Flach, GB
Anisha Lazarus, GB
Paul McCrone, GB
Graham Thornicroft, GB

1. Social inclusion is the opposite of social exclusion.
2. Social inclusion means experiencing valued social roles (as opposed simply to being respectful of individuals' varied needs).
3. Social inclusion is measurable as participation in community-based activities (which overlooks individuals' feelings of and about belonging).
4. Social inclusion is often narrowly defined and measured as productivity and independent living.

Cobigo emphasized social inclusion needs to be considered a dynamic process that evolves over time, when opportunities are presented and as individuals develop the skills to perform social roles in the broader community.

Empowering youth to participate

Through consultations, **Fiona Warner-Gale** and **Jane Sedgewick** have learned that with respect to mental health issues, young people—those with and without lived experience—want to have their voices heard, help lead change, "start conversations" to share their experiences, meet people with lived experience and use digital and social media to help. Engaging young people requires an investment in developing their skills and ensuring they are able to take part appropriately. Therefore, youth engagement programs must: be multifaceted and incorporate multimedia approaches; involve partnerships with key stakeholders; empower service users to reduce self-stigma; include an education component; and take a whole-system-change approach.

Does contact education have to be live?

A taped presentation from **Sarah Clement** reviewed a comparative study of filmed versus live social contact interventions (ironically, as Clement noted in her audio transmission, it was a recorded presentation about the effectiveness of recorded presentations). The filmed contact in the study featured personal stories from four people with lived experience. The live intervention was comprised of two personal stories. The lecture was modelled on an established educational practice, presented by a mental health nurse researcher. Evaluation of the relative effectiveness of the interventions showed no significant differences between live and filmed social contact interventions. While the live intervention was most popular, the DVD was deemed as effective as the live intervention, more effective than the lecture, and the most cost-effective.

Introducing the Dream Team

Toronto's **Peter Lye** wrapped up this session with a presentation on the Dream Team, a group of people with lived experience who advocate for more supportive housing in Ontario for people with mental health problems. Lye drew an analogy between stigma and littering and talked about the Dream Team's "anti-littering" campaign efforts. He also shared his personal story—how in his 20s as a top graduate from the University of Toronto he could not find work and found it more rewarding to hang out with street people. At 50, he was diagnosed with schizoaffective disorder ("and there went all my dinner invites," he joked). According to Lye, society needs rehabilitation. Stigma is universal and politics are inadequate. He cautioned that labels such as "crazy" are dangerous and marginalizing, and emphasized that there is an opportunity to empower individuals through inclusiveness—which is what motivates the Dream Team in its work.

PARALLEL SESSION 2: SYMPOSIA, WORKSHOPS, PANEL DISCUSSIONS AND ORAL PRESENTATIONS

SYMPOSIUM: STIGMA IN PRIMARY CARE

Focusing on the front lines

Researchers at Ontario's Centre for Addiction and Mental Health are developing a comprehensive anti-stigma/anti-discrimination intervention for community health centres. These are health-service organizations that cater to new immigrants, racially diverse communities and those with low

CHAIR
Akwatu Khenti, CA

PRESENTERS
Jamie C. Sapag, CA
Edna Aryee, CA
Sireesha J. Bobbili, CA
Maureen A. Murney, CA
Kaha Ahmed, CA

socio-economic status. The goal is to build capacity and address root causes of stigma in primary care.

Community health centres are good candidates for this kind of program because they address the social determinants of health and work with vulnerable populations close to the community level. Approaching the centres was delicate. The team did not want centre staff to feel criticized or blamed where stigma was concerned. They took great care to demonstrate that the aims of the project were constructive and cultivated a healthy environment.

A complex environment
Quantitative research found no statistical differences in stigma between Community Health Centre staff and other health professionals. In subsequent focus groups and a symposium, participants noted the co-occurrence of health issues such as HIV, diabetes and addiction complicate the treatment of mental illness. Symposium attendees stressed the significance of social determinants, and flagged ways that cultural beliefs can interfere with care; for instance, the myth that Western African men are more likely to drink than to take drugs has resulted in some cases of drug-using men from that group to be overlooked. Symposium participants also noted that the overall structure of the healthcare system assumes a middle-class client, and middle-class "rules" and the mode of operation can be alienating to those outside that mean.

Five intervention components were identified:
1. The need for innovative, ongoing education
2. The need to facilitate contact between service providers and people with lived experience
3. Organizational planning to provide the frameworks to embed anti-stigma efforts into overall ways of working
4. Media engagement
5. Qualitative research with peer workers.

Through the initiative's ongoing work, workshops have been developed, contact education pursued and peer worker research undertaken in response to the above.

SYMPOSIUM: CONTACT-BASED EDUCATION AND HEALTH PROFESSIONALS

Reshaping attitudes
Stigma encountered in the healthcare environment can prevent those with a mental illness from seeking treatment. These presentations looked at the positive role pharmacists can play in the healthcare mix, and at the efficacy of contact-based education in reducing stigma.

PRESENTERS
Claire O'Reilly, AU
Graham Thornicroft, GB
Alan Rosen, AU
Timothy Chen, AU

Stigma at the pharmacy counter
There are more than 5,000 community pharmacies and 25,000 pharmacists in Australia. Eleven percent of all prescriptions are for psychotropic drugs to treat mental illness. Pharmacists are uniquely positioned to support persons with mental illness because they tend to be more accessible than doctors, engage more frequently with their clients, and have critical information about psychotropic drugs, side effects and drug interactions.

Claire O'Reilly described a study of how contact-based education helped reduce stigma among pharmacy students in Australia. Pre, post and follow-up questionnaires showed the approach reduced stigma and that reductions were sustained over a 12-month period. For students, the experience resulted in self-reported behavioural and attitudinal changes regarding persons with mental illnesses. A further study compared the impact of live contact to contact through media such as film. While face-to-face contact had significantly greater impact, both produced positive

results. The study concluded that contact-based education is effective in reducing stigma and that the benefits are largely independent of the medium. The context of the contact is most critical. It must occur in an educational, equitable setting.

Establishing an equal footing

Graham Thornicroft picked up on one of his earlier presentations[4] to revisit the phenomenon of "diagnostic overshadowing" in which the physical complaints of people with mental illness are dismissed as psychological. He said the issue is compounded by the increasing use of electronic medical records, which give emergency room workers a view of a patient's past psychiatric problems, potentially colouring diagnoses and treatment of serious physical issues.

Contact-based education is important because it puts persons with mental illness on an equal footing as opposed to being seen as specimens. The use of recorded contact has the potential to be effective on a wide scale through delivery mechanisms such as YouTube. Psychiatrists can help reduce stigma by recognizing the weight labels carry and striving to minimize negative impacts when they deliver diagnoses. Thornicroft said all healthcare workers should examine the barriers to care for persons with mental illness, pointing to tools such as the Mental Illness Clinicians Attitudes (MICA) scale of knowledge and attitudes, the Barriers to Access to Care Evaluation Scale (BACE), and the ITHICA Toolkit—which evaluates whether an organization is violating basic human rights relating to mental health.

The pharmacist's role on the mental health team

Alan Rosen described the concept of community health teams, in which providers from different disciplines work collaboratively. The University of Sydney undertook a series of studies to examine the effectiveness of community health teams in providing mental health services as well as the potential role of pharmacists as contributors to them. The studies found that including pharmacists had positive results for 77% of those being treated for mental illness, and was well received by other members of the team. Patients saw pharmacists as more accessible and available to give technical advice on medications as well as informal, personal advice. The study concluded that incorporating pharmacists into community health teams has a destigmatizing effect, yet can be prohibited by barriers such as insufficient funding, the absence of vocal advocacy for pharmacist inclusion and the fact that there is little clear economic benefit to private pharmacies of having employees participate. For this to change, pharmacists, persons with mental illnesses, families and clinicians must advocate together.

SYMPOSIUM: ADVOCACY

Giving people the chance to speak for themselves

To protect the vulnerable and bring the patient's perspective to bear on government decisions, the Canadian provinces of Alberta and New Brunswick have both established Mental Health Patient Advocate Offices. While they are not the only provinces to have done so, Alberta and New Brunswick stand out for their legislation around the issue of patient rights.

CHAIRS & PRESENTERS
Gisele Maillet, CA
Fay Anne Orr, CA

The principles and practice of advocacy

Good patient advocacy demands adherence to the humanist principles of respect, listening, emotional support and conveying hope of recovery.

These principles, argued by both of this session's co-chairs—**Gisele Maillet** of New Brunswick and **Fay Anne Orr** of Alberta—are imperative if people with mental illness are to be treated fairly and be heard even though they cannot always rationalize their behaviour. Each province's

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[4] See "Building Better Practices Targeting Healthcare" on page 33.

advocacy office gives recipients of mental health services a voice in how they are treated and served. Orr said stigmatizing attitudes are prevalent among health professionals where people with mental illness are concerned, leading them to ignore clients' stated needs and preferences. In turn, this prevents those with mental illness from seeking or continuing with treatment.

Alberta's Mental Health Patient Advocate's Office is an arm's-length entity that reports to the provincial Minister of Health and is mandated to uphold patient rights and investigate complaints. One of the office's core functions is to ensure people are properly advised of their rights and able to exercise them. Similarly, New Brunswick's advocate office acts in the interests of patients to demystify the treatment process and to assist those held for treatment under the province's *Mental Health Act*. One of its goals is to raise awareness of the Act and dispel ignorance or misconceptions surrounding it. Maillet said her organization is in the process of developing a range of materials including a patient rights brochure for both voluntary and involuntary patients as well as for hospital staff. She also said New Brunswick has made changes to the way involuntary patients are transported so that those who do not pose a risk to themselves or others are no longer handcuffed and taken by law enforcement officials from one facility to another. She acknowledged effecting change is a slow process, requiring extensive communication throughout the field. While stigma persists, progress is being made.

SYMPOSIUM: THE ROLE OF PROFESSIONAL GROUPS

How professional bodies can help combat stigma
The healthcare field is home to many associations and professional bodies that have the potential to serve as effective advocates for change where stigma and discrimination are concerned.

CHAIR
Manon Charbonneau, CA

PRESENTERS
Layla Dabby, CA
Constantin Tranulius, CA
Susan Abbey, CA

The PEC approach
Manon Charbonneau described how a Canadian Psychiatric Association (CPA) working group is striving to reduce stigma and discrimination. In a survey of nearly 400 delegates at the association's 2008 conference, most respondents acknowledged that stigma and discrimination are present in mental healthcare settings and expressed a desire for the CPA to take action. The working group examined outcomes achieved by evidence-based national anti-stigma programs in several countries and adopted a strategy known as PEC:

- **P**rotest against lack of parity in funding for services, discrimination in employment and housing, and stereotyping in mainstream media
- **E**ducate on topics such as discrimination, recovery and treatment
- **C**ontact with individuals with mental illness

Charbonneau shared her own experience with mental and physical illness, and touched on when, how and why people should disclose their mental illness. The issue of disclosure is crucial for mental health practitioners. Research indicates that many psychiatrists with a mental illness self-diagnose and self-medicate. Progress will require changing the culture of the medical profession through active involvement of practitioners and the public. The presenter called on everyone to analyze and adjust their own stigmatizing attitudes and to focus on positive messages of hope and recovery.

Unearthing the attitudes that drive stigma
Layla Dabby and **Constantin Tranulius** are currently surveying Canadian primary care physicians and psychiatrists, medical residents and students—applying an implicit association test that requires participants to classify words into categories. The amount of time taken

theoretically reflects their attitudes toward various concepts. The survey will determine whether physicians' attitudes about mental illness are more negative than to physical illnesses.

Finally, **Susan Abbey** spoke about the Canadian Psychiatric Association's recent position paper on stigma and discrimination, copies of which were distributed during the conference. The paper addresses stigma and discrimination, focusing on education, leadership, advocacy and the promotion of best practices. Specific goals outlined include initiatives to: educate students, residents and professionals about stigma and discrimination; encourage people to label stigmatizing and discriminatory behaviour; and develop and disseminate standards and practices for excellent care in mental health. The paper also calls for greater emphasis of messages of hope and recovery, and advocates that people with a mental illness must be seen as able to participate equally in, and contribute fully to, their communities.

WORKSHOP: OUTREACH

Partners—for life
Organized by the Mental Health Foundation, Partners for Life uses education to prevent teen depression and suicide. Youth Program Director **Catherine Burrows** and facilitators **Bianca Petrilli** and **James Graves** delighted the audience with a demonstration of the workshop they take to high schools across Quebec and Ontario.

PRESENTERS
Catherine Burrows, CA
Bianca Petrilli, CA
James Graves, CA

Delivered in both English and French, the workshops are always led by a pair of youth-friendly facilitators (usually 20 to 30 years old) who are carefully selected for their educational background and capacity to interact with teens. The facilitators, usually about 10 each year, undergo more than 150 hours of training in mental illness, presentation skills, referral resources and frequently asked questions. They then talk to teens about depression, the myths and stereotypes surrounding it, signs and symptoms and how to help a friend who may have depression. What happens after the presentation is just as important as the presentation itself. This is when a teen may choose to approach a facilitator one-on-one with a concern. The facilitator is trained to assess the situation and refer the teen based on his or her specific needs.

Partners for Life promotes healthy lifestyle choices, raises awareness about depression and empowers teens and parents to take action and not succumb to silence. Organizers believe the program has helped reduce youth suicide rates in Quebec, which have dropped by more than 65% since 1998. After 14 years of field experience, organizers are confident the program changes attitudes about mental illness and proves that widespread prevention can be achieved through low-cost, large-scale community initiatives. Partners for Life was included in the Mental Health Strategy for Canada—an important reference point for mental health policy and practice across the country.

WORKSHOP: SCHOOL-BASED PROGRAMMING

Getting kids talking
Talking About Mental Illness, or TAMI, has been operating in southern Ontario's Durham region for over 10 years. During this time, it has been presenting workshops to and holding summits for students of all ages—always incorporating people with lived experience.

PRESENTER
Bob James Heeney, CA

The speakers undergo rigorous training to ensure they are prepared to handle any and all questions or situations that may arise when talking with kids about sensitive subjects such as

depression, suicide and coping mechanisms. According to **Bob Heeney**, the Head of Durham TAMI, the training process itself is often cathartic for speakers who are in the process of dealing with their own mental illness. Heeney quoted one speaker, John Dick, as saying it is important for people with lived experience not to "pull any punches" when describing their encounters with mental illness. Students, including kids who struggle behaviourally, are ready to hear the stories—even when they are difficult.

Over the course of a decade, Heeney has learned how to structure a day-long summit and ensure youth are engaged. "Students don't want to hear a doctor talk about medical symptoms of mental illness," he said. "They want to talk and move around—and eat." With the day typically split into three segments—morning breakout, afternoon breakout and closing sessions—students are given significant contact with TAMI speakers and encouraged to think about mental illness in ways they never have before. Activities such as simulating schizophrenia through role-playing demonstrate the difficulties of living with mental illness. Questionnaires force students to consider hard questions; for example, whether "I would date someone with a mental illness" or "I would sit next to someone with a mental illness in class" On a practical level, Heeney says each TAMI seminar achieves an average 12% decrease in stigma and can be put on for less than $5,000.

ORAL PRESENTATIONS: REDUCING STIGMA IN HEALTH PROFESSIONALS

Changing the power dynamics of care
Contact with health professionals can have serious stigmatizing effects on people with mental illness. This stigmatization is rooted in attitudes and behaviour but also in the power structures that dominate healthcare interactions. The four presentations given in this session highlighted different methods and tools to reduce stigma among health professionals, including self-directed study, presentations by people with lived experience, and film.

PRESENTERS
Rivian Weinerman, CA
Liza Kallstrom, CA
Helena Kadlec, CA
Kwame McKenzie, CA
Sean Kidd, CA
Kelly Anderson, CA

Fighting stigma through education
Rivian Weinerman showcased an adult mental health module developed in British Columbia explaining how it became a tool to combat stigma. A Vancouver Island team had developed accessible tools to enhance general practitioners' abilities to work with mental health clients. The *Cognitive Behavioural Interpersonal Skills* manual is a guideline-based diagnostic and skills tool that emphasizes self-management and client partnership. This was combined with the Bounceback program, which includes a DVD and telephone-based coaching from lay counsellors supervised by PhD psychologists, and the *Antidepressant Skills Workbook*, which physicians give patients to complete. All of these formed the Practice Support Program, which has since been evaluated positively and adopted by more than a third of physicians across the province.

Weinerman also presented a nationally accredited e-learning module she co-developed for a group of partner organizations including the Mood Disorders Society of Canada, the Mental Health Commission of Canada, Bell Canada, Canadian Medical Association, North Bay Regional Health Centre, AstraZeneca and Memorial University to educate healthcare professionals about attitudes and behaviours that can lead to stigma. The online continuing medical-education course combines theory with video testimonials, real-life scenarios and the tools from the *Cognitive Behavioural Interpersonal Skills Manual*. A pre- and post-test evaluation allowed participants to self-assess for changes in their attitudes to mental illness, as well as their satisfaction with the learning tool.

What happens after the ward
Kwame McKenzie presented work on behalf of **Sean Kidd** of the University of Toronto and the Toronto Centre for Addiction and Mental Health that was designed to help healthcare professionals change attitudes and behaviours as they relate to mental health clients. He began by noting the challenge of the sharp power differential between healthcare providers and their clients, especially in inpatient units. Providers often feel they have sufficient experience, that they are unlikely to learn anything new about treatment, especially from their patients.

The Centre for Addictions and Mental Health arranged a series of training sessions by former patients returning to the units to address the power differential. The speakers related their experiences to healthcare professionals in sessions lasting 15–20 minutes. The team took pre- and post-measures of the recovery orientation of the staff who had heard the testimonials, and of their job satisfaction. Anecdotal evidence suggests that the speakers felt empowered by the experience, while the staff were engaged in the topics. Many were unaware of the recovery of their patients after they had left the hospital.

Cracking Up: **A documentary making a difference**
Kelly Anderson presented the work she and colleague **Jehannine Austin** have done on the effects of a documentary film about mental illness. The 45-minute *Cracking Up* details the Stand Up for Mental Health program, which teaches people with a mental illness to do stand-up comedy. Many of the performers find the routines therapeutic and an opportunity to break down taboos about mental illness. *Cracking Up* was screened at the 2010 conferences of the National Society of Genetic Counsellors and the Canadian Association of Genetic Counsellors, with questionnaires administered before, after and one month following the screenings to measure stereotype endorsement and social distance. The study showed distinct drops in both scales immediately after the screening, with the greatest impact among those who had indicated discomfort about asking about a family history of mental illness. However, the score on stereotype endorsement returned almost to its original value after a month.

ORAL PRESENTATIONS: MENTAL HEALTH PROVIDERS

Questions of respect
Coming from different countries and different angles, this session's presenters spoke about some of the detrimental effects of stigma on mental healthcare—how it might affect support for the system of care as a whole, and how it manifests among psychiatric service providers.

PRESENTERS
Steve Lurie, CA
Johanne Bratbo, DK
Anja Kare Vedelsby, DK

How much is mental health worth?
One in five Canadians lives with mental illness, and of those only one in three is able to access the services and support required. **Steve Lurie** attributes this gap to Canada's relatively low spending on mental health services compared to New Zealand, the United Kingdom and Australia—and wonders if the stigma that surrounds mental health is to blame. Annual per capita investment in mental health is $107 in New Zealand, $45 in the United Kingdom and $174 in Australia. In Canada, the amount is just over $5. That said, since the 1988 Graham Report identified the need for a community-based mental health system, Canadian spending on non-clinical, community-based mental health initiatives has increased compared to spending on traditional mental health institutions. Addressing the issue of stigma, Lurie wondered if Canadians would tolerate only one in three cancer patients receiving treatment. To end the financial discrimination that surrounds mental health services, funding strategies must: highlight that mental health is an integral part of overall health; demonstrate the cost of not investing; and frame mental health treatment as a human rights issue.

One of Us
Launched in Denmark in the fall of 2011, One of Us is a national campaign aimed at raising awareness of mental health and eliminating the stigma that surrounds it. As a step toward achieving this goal, the campaign partnered with the Danish Mental Health Fund and, in 2011–12, conducted a pilot study testing the assumption that psychiatric staff are more likely to stigmatize than the population in general. Focusing primarily on attitudes toward schizophrenia, doctors and hospital staff at two psychiatric units in Copenhagen were surveyed, and their responses examined and discussed during four focus group sessions. The study found the most stigmatizing attitudes existed among health staff with short-term education and those who considered schizophrenia a chronic disease. The least stigma was found among staff who had daily contact with people with schizophrenia and those with over 12 years of experience in psychiatry. This study highlights the need for dialogue and increased knowledge, respect and understanding of schizophrenia and mental health. Moving forward, program staff from One of Us are considering extending the survey to the national level to encourage reflection on mental illness and stigmatization.

ORAL PRESENTATIONS: MENTAL HEALTH DIRECTIONS

Anti-stigma and mental health awareness in the digital age
Presenters reviewed digital-media resources and websites from Canada, New Zealand and Scotland that were designed to educate youth and other audiences about mental illness—revealing the power of digital media to engage.

PRESENTERS
Andrea Kirkham, CA
Anil Thapliyal, NZ
Niki Legge, CA
Suzie Vestri, GB

A platform for sharing experience
Andrea Kirkham from the Canadian online mental health program Mind Your Mind began by presenting a youth-created video called *Schizophrenia Film* as an example of the kinds of resources (videos, interactive tools, blogs, dance videos, poetry, webcams, etc.) available at mindyourmind.ca for young people seeking help and information from peers. All Mind Your Mind resources and tools are created in partnership with youth. The website provides a platform for young people with lived experience to tell their stories, and for youth to support themselves and their friends. Eleven comment categories were developed for visitors. Feedback has been overwhelmingly positive, in many cases including personal stories of struggle (for example, of living with a mentally ill parent).

For youth, sharing their personal stories is meaningful and also resonates with other young people. This is a group that is hungry for both formal and informal information. Kirkham acknowledged that online platforms sometimes make educators and clinicians nervous, but emphasized the need to embrace them in order to empower youth.

Making assessment available online
Anil Thapliyal talked about New Zealand's efforts to address mental health issues in a number of areas: awareness-raising, workforce development and involvement of service users in solutions. He focused specifically on the 14-year-old National Depression Initiative, presenting the website *depression.org.nz* as a leading example of outreach to adults. The site is promoted through an advertising/online engagement strategy. It provides information and education about depression and its causes as well as a tool for individuals to assess if they may be living with depression. The site also offers a personalized, automated online treatment program and is supported with a help line. New Zealand's youth program, The Low Down (*thelowdown.org.nz*), follows the same model; per month, it receives 19,300 texts and 465 emails, and makes five to seven suicide rescues.

E-mental health awareness
Canada's **Niki Legge** has worked in consultation with experts in New Zealand, applying that country's best practices in developing an e-mental health and awareness program for Newfoundland and Labrador. The program (which uses funding secured specifically to address stigma) has six directions:

1. Stakeholder engagement and involvement of persons with lived experience
2. Community action
3. Awareness (involving a mass media campaign and the creation of a website)
4. Access (including development of a web-based health service portal for youth and adults)
5. Education (including adoption of the Mental Health First Aid course, and development of a tool kit and webinars)
6. Knowledge exchange (including establishment of communities of practice).

Legge said a central focus is a grassroots initiative to strengthen and support community effort, and noted that as the program rolls ahead there will be important opportunities for collaboration with provincial and national partners.

Standing up against stigma in Scotland
Suzie Vestri described Scotland's "see me" campaign, which is a decade-old initiative supporting Scotland's vision to be a country in which all people with mental health problems are fully equal and included. The campaign has three objectives: changing society through improved public understanding, attitudes and behaviours; changing organizations so they treat all individuals with respect and equality; and empowering and supporting individuals to have greater capacity to take action against stigma and discrimination. Vestri showed an anti-stigma video, *What's on Your Mind?* (viewable at *seemescotland.org/whatsonyourmind*), which re-enacts one youth's negative experience with social media. The video is part of a new national campaign under the "see me" banner that encourages 13- to 15-year-olds to think about their behaviour, tackle stigma and help teachers and students in schools be better informed and more comfortable dealing with mental health issues. Vestri acknowledged the tremendous initial response: 50% of Scotland's 400 schools have already taken up the program—double the projection.

ORAL PRESENTATIONS: PARENT AND YOUTH PERSPECTIVES

Trying to speak the same language about mental health
For it to be effective, any youth-focused anti-stigma intervention needs to take into account parents' perspectives. Likewise, understanding stigma's impact on youth can help influence the development of parenting programs and other public policies.

PRESENTERS
Dave Walker, CA
Lynn McKeague, IE
Eilis Hennessy, IE
Caroline Heary, IE
Claire O'Driscoll, IE
Jane Elizabeth Hamilton Wilson, CA
Sherrill Conroy, CA

How do youth see mental health?
Through online surveys, interviews and focus groups, the Mental Health Commission of Canada engaged 298 youth to help answer this question and generate insights that will contribute to more effective mental health education. **Dave Walker** reported that language played a major role, with youth using a variety of terms, from emotional problems and mentally challenged to crazy and retarded—all of which can perpetuate stigma. There was also confusion between mental illness and disorders such as autism. Language also presents a considerable barrier to accessing information about mental health, most of which is not written for youth. Fear is a barrier: mental illness is still a taboo subject for some and youth worry of being labelled by their peers if they are seen to be interested in mental health. As such, there is a clear need to destigmatize mental illness so youth are less fearful of getting help.

The parents' point of view

Because stigma is such a complex issue, children can have difficulty putting words to their experiences. Parents, however, articulate their perceptions of negative attitudes directed toward their children. **Lynn McKeague** described a qualitative study of 29 Irish parents of children with attention deficit hyperactivity disorder, depression or anxiety from which three themes emerged:

Peer problems: Parents felt their children were being given unfair treatment due to their condition. Arguments also became more frequent as peers grew weary of their children's behaviour.

Selective disclosure: Parents tended to conceal their children's conditions, believing others would not take the diagnosis seriously or that disclosure would make things worse. Parents only disclosed if there was a pressing need to explain their child's behaviour.

Negative perceptions: Parents believed a lack of understanding about mental illness would cause others to think: "There's something going on in that house," and that the whole family would be judged because of the child's condition.

Another qualitative study looked at how nine parent caregivers in Ontario experienced first-episode psychosis in young adult children—a distressing time for everyone. **Jane Elizabeth Hamilton Wilson** noted their experiences revealed four common responses:

Fear: Parents kept the illness a secret and withdrew from social circles, leading to isolation, loneliness and shame.

Protection: Parents had difficulty admitting mental illness is something they could not stop from happening.

Grief: Parents had old-fashioned views of prognoses and believed their child's condition would never improve, even though outcomes have never been better.

Enduring love: Parents were willing to make many personal and financial sacrifices to help their children recover.

Hamilton concluded by saying society needs to be proactive in debunking myths and stereotypes. There is currently a disconnect between what is known and understood, and what is thought of as the norms. "Psychosis is a medical condition. It can happen to anyone. And it can be successfully treated."

DAY 3: THE WORKPLACE/HUMAN RIGHTS

The final day of the conference turned attention to the larger-scale issue of human rights: how those of individuals experiencing mental health problems continue to be compromised by stigma; national and international efforts to remedy the situation; and the ways human rights intersect with practical matters such as employment.

Contributing to society through work is widely recognized as important to an individual's sense of self-worth. Many of the day's workplace-focused sessions looked at barriers to entry for persons with mental illness seeking jobs. They also examined some of the challenging questions facing employers caught by the tension between business demands and social responsibilities. The day's presenters also acknowledged that workplaces vary widely, from social businesses mandated to perform beneficial functions, to the military, which requires a capable, ready and resilient fighting force.

The topic of human rights in the workplace—including entitlements to accommodation and labour unions' responsibility to advocate and overcome stigma—dovetailed with the bigger-picture question of human rights for those with mental illness. Multiple panel discussions tackled human rights-related topics including the rollout of the United Nations' groundbreaking *Convention on the Rights of Persons with Disabilities*. Throughout the day, recurrent themes of youth, the importance of contact-based education and using creative arts as a means of outreach reinforced key messages heard during earlier sessions.

"We have a long way to go for people with disabilities to be respected as persons—not as persons with an asterisk, but simply as people who belong in the community."
~ Michael Stein

WORKPLACE WELLNESS

Fighting stigma on the job
Promoting mental wellness and reducing stigma are key issues for the workplace. Employees living with a mental illness must feel supported in disclosing their condition without fear of losing their job, being passed over for promotion or being discriminated against by co-workers.

CHAIR
Keith S. Dobson, CA

PRESENTERS
Terry Krupa, CA
Bonnie Kirsh, CA
Andrew C. H. Szeto, CA
Andy Smith, CA
Ian Arnold, CA

What workplace stigma looks like
Terry Krupa described a study that found stigma resulted in marginalization in the workplace, reduced productivity and undermined basic rights of Canadian citizenship. Several myths underpinned these findings: that people with mental illness are both socially and professionally incapable; that such people are dangerous; that a mental illness is not a legitimate illness; that mental illness is caused by work; and that employers should not be required to support those with a mental illness, as companies are not charitable organizations.

Contributing to these beliefs were the media, mental health professionals, work structures, limited understanding of the relationship between work and mental illness, competing interests and policy limitations. Researchers developed a model to address them, targeting key members in the workplace to serve as champions.

The need for stronger evaluation
Andrew Szeto and **Keith Dobson** recently reviewed workplace anti-stigma programs in Canada and around the world. Few were found to be quantitatively evaluated. Instead, the focus tended to be participant satisfaction. No long-term evaluation based on useful metrics was found, and there were relatively few pre- and post-evaluations. The study concluded more anti-stigma programs are needed, and that evaluation must be improved—asking not if an employer *would* hire someone with a mental illness, for example, but if they actually do.

The military workplace
In 2007, the Canadian Forces introduced a comprehensive mental health education policy with three goals: to reduce stigma; to help people recognize stress and symptoms in others; and to identify potential mental health problems among Forces members. Rear-Admiral **Andy Smith** said the strategy embeds mental health education from basic training onward throughout members' careers. The Forces have developed a mental health continuum showing that mental health is a dynamic, changing state that can deteriorate or improve based on circumstances. Through its Be the Difference Campaign, all members must learn about mental health so they can identify changes in behaviour in themselves and others. Today the Canadian Forces has a third of the level of stigma as some of its allies; this is attributed to the effectiveness of its approach.

The changing world of workplace health and safety
The Workplace Advisory Committee of the Mental Health Commission of Canada has developed programs, activities and initiatives to improve the mental health of Canadians in the workplace. **Ian Arnold** described several of them, including:

The Aspiring Workforce Project: Aimed at finding ways for persons with mental illness to access employment opportunities and earn a living wage.

The Mental Health Leadership Initiative: Downloadable videos for senior-level managers and executives that present a framework for managing workplace mental health.

The Peer Project: Focused on persons with lived experience and their families, creating a climate of peer support, facilitating skill and knowledge sharing and providing a framework for creating new peer networks to support employees coming forward with mental health problems.

The Psychological Health & Safety Action Guide: 24 actions employers can implement to promote mental health.

Managing Psychological Health and Safety in the Workplace: The Business Case: Outlining the benefits of mental health programs including corporate social responsibility, cost effectiveness, recruitment and retention, and risk management.

The Workplace Advisory Committee of the Mental Health Commission of Canada is currently developing the nationwide Standard for Psychological Health and Safety in the Workplace according to internationally standardized principles. It will give employers the tools and framework to achieve measurable improvement related to workers' psychological health and wellbeing.

PARALLEL SESSION 1: SYMPOSIA, WORKSHOPS, PANEL DISCUSSIONS AND ORAL PRESENTATIONS

SYMPOSIUM: SOCIAL BUSINESSES

Where business and society meet
The presentations in this session focused on social businesses—often referred to as the third sector—and how the employment and training opportunities they provide can combat the stigma associated with mental illness.

CHAIR
Bonnie Kirsh, CA

PRESENTERS
Rosemary Lysaght, CA
Terry Krupa, CA
Judith Sabetti, CA

Bonnie Kirsh, chair of the session, gave an overview of social businesses: organizations that seek to generate revenues and meet a social mission or goal, such as providing employment opportunities to disadvantaged groups. A 2009–10 study identified 100 social businesses in Canada, nearly all of which employed fewer than 100 people and operated in particular sectors, such as retail sales. Social businesses often face stigma themselves, as their "double bottom line" approach leads some people to dismiss them as not "real" businesses.

How social businesses work
Rosemary Lysaght described a case study project involving six social businesses in major Canadian cities, presenting highlights from five of them. The businesses included a discount dollar store, a garment manufacturer, a café in a public library, a commercial cleaner and a furniture maker. Data were collected through on-site observation, document reviews and interviews. The study identified several positive outcomes, such as increased workforce participation for members of marginalized groups, reduced dependency on healthcare and social services systems, contact with the general public and, in some cases, the delivery of highly valued community services. While these outcomes help reduce stigma, many social businesses struggle financially and pay only minimum wage.

The next presentation, given by **Judith Sabetti**, also examined data generated by the six case studies. It focused on three types of relationships maintained by social businesses: commercial (with customers), partnership (with institutions) and employee. The study called for a shift away

from "medicalized" approaches to mental health in work domains toward recognizing social-business employees as workers doing real jobs rather than clients or patients.

This is who we are
The final presentation examined how market type (e.g. public, private, non-profit) influences stigma. Lysaght said a key finding was that social businesses competing in the open market tend to be perceived by the general public as more valuable. Another conclusion was that markets vary considerably, even within a region or sector.

In response to a question, a discussion ensued about the disincentive posed by benefit programs that deduct money earned through employment. The impact is that social businesses often have an unstable workforce. Many workers report a high level of satisfaction and a significant reduction in self-stigma. One presenter summarized this as: "We've got business to do, so let's do it. This is who we are and we don't care about fitting in."

WORKSHOP: *THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES* AS A TOOL TO PROTECT THE RIGHTS OF PEOPLE WITH MENTAL DISORDERS

Breaking global ground
This session looked at the United Nations' (UN's) *Convention on the Rights of Persons with Disabilities* as a tool to protect people with mental illness.

MODERATOR
Harvey Goldberg, CA

PANELLISTS
Celia Brown, US
Michael Stein, US
Eric Mathews, US

Nothing about us without us
Harvey Goldberg from the Canadian Human Rights Commission gave an overview of the UN Convention, highlighting its most pertinent articles. The Convention is the first UN human rights treaty to deal with people with disabilities—who also played a critical role in its development. Such inclusiveness has become part of the change underway: "Nothing about us without us." To date, 153 of 193 countries have signed the treaty (the U.S. among them), and 119 have ratified it (including Canada).

The Convention signals a needed shift in how disabilities are viewed. Persons with disabilities have rights, can claim them, can make decisions for themselves and are entitled to full and equal treatment including autonomy, non-discrimination, participation and inclusion, respect for difference, equality of opportunity, accessibility and gender equality.

Goldberg highlighted Article 12 of the Convention as being particularly important: that whether or not a person has a disability, he or she is a person before the law. Deprivation of legal capacity should not be based on disability but rather on other factors (e.g. safety, protection of the individual). When legal capacity must be deprived, it has to be closely monitored and time-limited.

Panel discussion: Three steps forward
Michael Stein said the Convention has moved the idea of inclusion "three steps forward," though it will take many years for significant change to occur. **Celia Brown** agreed that for those with psychosocial disabilities, implementing provisions around legal capacity will take time. **Eric Mathews** noted one of the Convention's main functions is to reinforce rights that already exist under other binding international laws. The Convention simply brings attention to an often-overlooked population.

Brown said that when individuals are forced into treatment, it is a failure, a violation of rights and, in the opinion of some, a form of torture. People want to be able to make their own choices even

if they experience periods of madness and trauma. Stein said the presumption has been that persons with disabilities are equally human but not necessarily able to exert their rights—that they need protection. The strong language of the Convention requires acknowledgement of individuals' equality and ability to make their own decisions, as well as mechanisms for supported decision-making when needed. Though some work is underway in Sweden and Canada, little is being done around the world to construct supportive decision making devices.

Mathews said institutionalization remains a consistent barrier. Research shows people in institutions may be *de facto* stripped of their rights. For example, even when a person is undergoing voluntary treatment and is not forced to take medications, the ability to effectively exercise legal capacity may be limited by the institutional setting.

In these settings it may not matter if individuals have the legal capacity according to law to make decisions if it is not practically afforded to them. Mathews also said that in some institutions, there is little oversight regarding upholding of law, which may lead to situations in which persons with disabilities are subject to treatment that may approach torture. He cited an example of a special needs school in the U.S. using electric shock treatment (or skin shocks twice as powerful as those from a TASER® stun gun) to allegedly modify inappropriate behaviour.

Brown commented that in 2012, people with psychosocial disabilities are still asking for the right to participate in treatment decision-making, and still facing discrimination when trying to live their lives in the community. A single horrific incident of a person with a mental illness committing a crime can cause governments to impose blanket restrictive legislation. Society should focus on improving services for those with psychosocial disabilities so they can go on with their lives.

WORKSHOP (FRENCH): QUEBEC ANTI-STIGMA PROVINCIAL COMMITTEE: A GUIDE TOWARD BETTER ANTI-STIGMA STRATEGIES

A comprehensive look at stigma in Quebec
The Group provincial sur la stigmatization et la discrimination en santé mentale is Quebec's first provincial organization dedicated to fighting stigma against persons living with a mental illness. The Group currently has 15 member organizations—including founding group l'Association québécoise pour la réadaptation psychosociale—and bases its recommendations and activities on three types of evidence: field data, scientific evidence and experiential knowledge.

PRESENTERS
Esther Samson, CA
Sylvain d'Auteuil, CA
Jean-François Pelletier, CA
Yves Blanchette, CA

The state of stigma in Quebec today
Through extensive literature reviews and its own activities, the Group has identified a number of negative effects of stigma, including limited employment opportunities and diagnostic overshadowing. It has found that nearly two-thirds of patients with mental illness do not seek treatment and 42% do not tell their families of their condition for fear of being ostracized or judged.

The Group has identified three main approaches to addressing stigma described in the literature: protest, which confronts negative attitudes and behaviours but can create a negative backlash; traditional education, which debunks myths and stereotypes with facts and data but has limited effectiveness and duration; and contact-based education, which involves direct interaction with people with lived experience. Combined with traditional education, contact-based education can be highly effective but requires all participants to be on an equal footing, with opportunities for feedback and discussion to build empathy.

The lived experience perspective

In 2011, the minister of Quebec's Sante et des Services sociaux launched the province's 2012–17 Mental Health Action Plan. To support the plan, a study—*La stigmatisation en santé mentale vue par des usagers québécois*—was commissioned to discover how recipients of mental health services feel about stigma, and what can be done to combat it.

Based on interviews with people with lived experience, the community-based survey found a significant number of people with lived experience would prefer to suffer severe social consequences such as unemployment rather than enter a psychiatric facility. The associated negative perception of psychiatric workers and facilities is a significant barrier to treatment. However, the study also found that working directly with a researcher who had previously received mental healthcare helped dispel this stigma and made the participant more open to entering a facility. The study concluded that more needs to be done to demystify psychiatric care for the general public, reduce stigma and encourage persons with mental illness to seek care.

Identifying barriers to care

Another of the Group's fact-finding initiatives involved Porte-voix du Rétablissement, a body of persons with lived experience of mental illness. The Group consulted 205 individuals from a variety of organizations, identifying several barriers to care including the side effects of medications, prejudice and discrimination. Family, the media, police, healthcare workers and co-workers were all cited as sources of stigma. The Group proposed a number of solutions, from media advocacy to ensuring that people with lived experience work in influential positions in key mental health services.

ORAL PRESENTATIONS: STIGMA AND FORENSIC ISSUES

Crime and mental illness

Anne Crocker and **Peter Silverstone** looked at the intersections between the criminal justice system and mental health—how public perceptions of the dangerousness of persons with mental illness are misinformed, and how police agencies are identifying new, more productive ways of engaging with these individuals.

PRESENTERS
Anne G. Crocker, CA
Michael Seto, CA
Tonia Nicholls, CA
Gilles Côté, CA
Peter H. Silverstone, CA
Yasmeen Krameddine, CA
David DeMarco, CA
Robert Hassel, CA

Dispelling myths about forensic psychiatry

Crocker began by detailing the National Trajectory Project, a Canadian study of individuals declared not criminally responsible on account of mental disorder. She gave an overview of the past 15 years of research on forensic mental health clients, and how forensic psychiatry is changing in the face of external pressures—focusing on dispelling six misconceptions of forensic mental health clients:

1. There has been a significant increase in the number of dangerously mentally ill cases
While the numbers of people entering the forensic system has increased, there has been no significant change in the actual population rate. The criminal justice system is becoming a gateway to mental health services, albeit with heavy consequences for those apprehended.

2. Forensic clients are involved in serious violence
More than two-thirds of forensic clients have committed simple assault or nonviolent offences; the 5.8% that are admitted because of homicide or attempted homicide are the cases most often reported by the media.

3 Violence committed by individuals with a mental illness is random

57

As with the general population, most such violence is usually directed toward someone known to the individual.

4. Forensic cases require high security
The range of offences is diverse, requiring a diversity of approaches. Many forensic clients could be safely and effectively managed by non-forensic services.

5. Forensic clients are far more dangerous than civil clients
There are in fact far more commonalities than differences.

6. Being found not criminally responsible is a "get out of jail free" card
For most offenses, individuals are under the purview of review boards for much longer periods of time than they would be if found criminally responsible by the justice system. In these cases, offenders are often also victims of an inadequate mental health system and there is no evidence that increases in jailing and sentencing reduce recidivism, particularly among mentally ill clients.

A novel approach to police training
Silverstone discussed a partnership between the University of Alberta's Department of Psychiatry and the Edmonton Police Force aimed at changing officers' attitudes and behaviours toward people with a mental illness.

Corroborating Crocker's findings, Silverstone said forensic patients often come into contact with the police before they encounter mental health services, and police are not always adequately prepared. In one-day sessions, the University of Alberta team trained 663 officers using professional actors in realistic scenarios such as alcohol withdrawal or schizophrenia. The officers would enter the setting in pairs, and were observed by a senior police officer, a psychologist and another actor—all present to observe the officers' actions and body language. Afterward, the officers were asked questions about relevant cues in the scenario and their evaluation of the training.

While the immediate results suggested success, a follow-up six months later showed there had been no significant change in attitudes, notably on the social-distance scale. Yet officer behaviours had changed. As documented by sergeants, the participating officers became better at communicating with the public and at verbally de-escalating situations. Indirect measures corroborated this. Officers were better able to classify mental health calls correctly and process calls more quickly. In terms of saved time, the training paid for itself within six months.

ORAL PRESENTATIONS: INGREDIENTS FOR SUCCESS

Feeling understood, feeling valued
Two presentations showed how effective anti-stigma campaigns in Australia and Canada share many of the same ingredients—among them the promotion of social inclusion, the creation of spaces to talk about mental health and the demystification of services and supports by making them more accessible and culturally relevant.

PRESENTERS
Pui San Whittaker, AU
Bernadette Wright, AU
Lisa S. Jamieson, CA

Using music to reach at-risk youth
How do you develop a whole-community, socially inclusive approach to reduce stigma and discrimination in a state as vast and diverse as Western Australia? Through the use of recreation, sport, culture and, in particular, music.

Recognizing that music can reflect a range of personal issues specific to the youth experience and that adolescents are exposed to music more frequently than any other age group, **Pui San Whittaker** described how, in 2009, the Western Australia Mental Health Commission launched the Music Feedback program to encourage youth to be more open about discussing mental health. A documentary and accompanying CD featuring popular musicians talking about their experiences with mental health were developed and distributed to schools and mental health services. The program also includes a social media component through which youth are taught how to develop their own video and audio files so they can share their mental health stories.

Making banking more accessible
In Ottawa, the Canadian Mental Health Association launched the Banking Accessibility Project to increase community inclusion related to banking services and, by educating bank staff on how to better accommodate those with mental health problems and reduce the stigma faced by people with mental illness when accessing financial services.

Lisa Jamieson explained the pilot project started with a single branch of Toronto Dominion Canada Trust, which offered no-fee bank accounts to people referred by participating mental health agencies. Participants could have automatic deposits and withdrawals set up to ease their monthly financial responsibilities. They also had increased access to bank staff to ask questions about the types of services available to them. The project's evaluation report, *Creating Change by Saving Change*, found that the program was successful in helping those with mental health problems enhance their financial management skills and their self-confidence. Participants said bank staff made them feel as valued as any other customer. Also, by having a bank account, they felt less on the fringe of society and more integrated into the mainstream. The project has since expanded to 10 additional Toronto Dominion Canada Trust branches in Ottawa. The ultimate goal is to grow the project throughout Ontario and eventually across Canada, helping even more people with mental illness become comfortable doing business with financial institutions.

ORAL PRESENTATIONS: PERSONAL PERSPECTIVES AND PERCEPTIONS

Pathways to recovery
The speakers in this session offered various reflections on recovery ranging from the value of a positive outlook to workplace opportunities and how the language affects perspectives.

PRESENTERS
Maritza Tello, CA
Carol Zoulalian, CA
Judy James, CA
John Roswell, CA

Living beyond the illness
Born in Chile and from a close family, **Maritza Tello** was sexually abused by a schoolteacher when she was a child, an event she told no one about for 19 years. She moved to Moose Jaw, Saskatchewan (Canada) at age 13 where she experienced culture shock related to language, food and clothing. As a teen, Tello began drinking, took LSD and showed symptoms of schizophrenia. When she turned 23, she got involved in a karate club. That experience was motivating and prompted her to attend the University of Saskatchewan as a mature student. Still, she was not sure where she would end up. She still experienced hallucinations and believed she was in communication with people from another dimension. In 1994, Tello took part in a blind study comparing two anti-psychotic drugs. Her symptoms lessened. She got involved with Neil Squire Society and received a Literacy Award of Merit for Learner Achievement from her university. Through her recovery, Tello realized she wanted to be a role model to reduce stigma and help others. Today, Tello is a peer support worker and member of the Family Caregivers Advisory Committee of the Mental Health Commission of Canada. She says there is more to life for people in recovery than tolerating meds and managing symptoms—that it is possible to live beyond illness.

Hiring employees with lived experience

Houselink Community Homes is a non-profit organization that has provided housing support to people living with mental health problems for 34 years. Today it houses some 500 people in 22 buildings in the Toronto area. Fifty percent of Houselink's board members use the organization's housing services. That spirit of inclusion extends to the Houselink workplace, explained **Carol Zoulalian** and **Judy James**. Work is important in fostering recovery, yet it is a question for organizations as to how to go about hiring people with lived experience. Houselink uses targeted advertising in a consumer/survivor information bulletin and has developed a selection process including scenario-based interviews and standard questions to determine how well candidates match Houselink's competency requirements. It does not consider educational credentials, but looks rather at applicants' experience. Houselink has encountered overwhelming internal support for hiring people with lived experience among employees who recognize that encouraging and managing an inclusive workforce is an important challenge and demands special considerations.

Using politically correct language incorrectly

John Roswell concluded the session by reminding participants of the power of words. He suggested that even well-intentioned terms such as "mental health issue" and "person with lived experience" serve as labels that ultimately suggest disability, which is not a fair portrayal of the majority of people with a mental illness. Roswell indicated that he is a person with lived experience, but when he saw the label on badges being worn by others, he had no idea what it meant. He worries it actually makes things less clear to the average Canadian. What's the difference between someone living with a mental illness and someone with lived experience? Ultimately, Roswell believes that terms such as mental health are merely polite ways of saying mental illness—belying a collective prejudice that the phenomenon we are dealing with is inherently negative. While some people with mental health problems do need supports, most are not permanently disabled and many recover completely to lead productive lives.

ORAL PRESENTATIONS: USING CREATIVE ARTS

Art as outreach

Using creative arts in mental health settings is known to promote recovery, but it is also proving to be an effective way of bridging the gap that stigma creates between people living with mental illness and their communities.

PRESENTERS
Tamara Grace Dube, CA
Susan Nakhle, CA
Chris Bovie, CA

Sometimes a picture really is worth a thousand words

In 1992, Caroline Wang created PhotoVoice, which takes a grassroots approach to promoting social change by giving those who would otherwise not be heard the chance to express themselves through photography. **Tamara Grace Dube** described how the North Bay Regional Health Centre used PhotoVoice in a mental health setting, creating five programs around it, each based on a distinct principle that promotes recovery: hope, self-direction, empowerment, respect and holism. Participants in each program meet a few hours once a week for 12 weeks. They learn the basics of camera use, ethical guidelines for picture-taking and set goals and rules to follow. They then embark on community outings to take photographs that relate to their program's underpinning principle, then share them with the group. Powerful discussions begin when participants explain the messages behind their photographs. Each program ends with a photo exhibit to friends, family, facilitators and policy-makers. The exhibits help reduce the stigma that surrounds mental illness by offering a window into participants' views of the world and by allowing each to be seen as a person rather than an illness. North Bay Regional Health Centre's PhotoVoice projects have been recognized by the Ontario Hospital Association as a leading practice in patient experience, and will be used in the Centre's future regional engagement strategy.

Connecting to the community through creativity

In 2006, the Ontario Ministry of Health and Long-Term Care transferred the Whitby Psychiatric Hospital to a community-based board of directors. The new board revitalized the hospital's identity, goals and vision, renaming it the Ontario Shores Centre for Mental Health Sciences.

While this was taking place, the area around Ontario Shores was independently purchased and developed into a suburb. The facility's new neighbours exhibited strong stigma toward it. Ontario Shores took the opportunity to act on its new strategic direction—which includes strengthening community partnerships and raising awareness of mental illness—by developing the Creative Minds arts program. Consisting of four core components—the Imagine Film Festival, the Let's Talk speaker series, a visual art program and the Mindful Music/Community Fun Day—Creative Minds brings together community members and those affected by a mental illness who share an interest in film, art, music and education. Thanks to vigorous promotion and positive media coverage of its events, Creative Minds has raised awareness of mental illness and reduced stigma, attracting more than 8,000 people to its events since launching a few short years ago.

ORAL PRESENTATIONS: REDUCING STIGMA IN HEALTH SETTINGS

Questions of dignity

This presentation echoed others earlier in the conference—examining the seriousness of stigma when encountered among those who work in healthcare settings.

PRESENTERS
Hans-Rudolf Pfeifer, CH
Pablo Garcia-Cubillana de la Cruz, ES
Aguila bono del Trigo, ES
Vincente Ibanez Rojo, ES
Evelyn Huizing, ES
Bettina Friedrich, GB
Sara Evans-Lacko, GB
Graham Thornicroft, GB

Homage to a pioneer

Paul Tournier (1898–1986) was the founder of *Médecine de la Personne* (Medicine of the Person) and a significant contributor to destigmatization among health professionals, laypeople and patients. **Hans-Rudolf Pfeifer** of the International College of Person-Centered Medicine in Switzerland described Tournier's visionary concept of a "person-centered approach" to medicine, which focuses on understanding an individual's needs and experiences, finding one's purpose in life and the practice of "learning to listen." It is, as Pfeifer's presentation acknowledged, a basic attitude rather than a theoretical system. It contains the essential elements of coping, cognitive behavioural therapy, the therapeutic value of forgiveness, narrative therapy, resilience, empowerment and mindfulness. Through *Médecine de la Personne,* Tournier contributed both to a new understanding and acceptance of mental illness.

Mental health and human rights

An anti-stigma strategy in Andalusia, Spain, 1 in 4 addresses the general population, media, health professionals, adolescents and people living with mental illness. Framing the stigma discussion in terms of human rights, **Pablo Garcia-Cubillana de la Cruz** of the Andalusian Health Services suggested the main obstacles to ensuring human rights are: a lack of awareness about the need to respect human rights, lack of knowledge on the international level and a lack of policy at the national and regional levels. Politicians, managers, professionals, families and service users accept decisions, actions and behaviours related to mental health that clearly violate people's human rights, from the loss of privacy to mandatory wearing of pyjamas in acute mental health units. By adopting the *Convention on the Rights of Persons with Disabilities*, Spain has implicitly acknowledged the state must modify its legislation on mental health treatment in cases where it limits rights, Garcia-Cubillana de la Cruz said.

Bringing stigma to an END
Education Not Discrimination (END) was conducted under the auspices of England's country-wide Time to Change campaign. It targeted medical students and involved a lecture, witness testimonies and role play. **Bettina Friedrich** said students were surveyed beforehand, immediately following and six months later. Results showed that short- and long-term attitudes improved for the intervention group (although they also rose for the control group). The study was limited by low follow-up participation, a small number of items on the survey, possible influence of a parallel survey (RETHINK campaign), possible bias on the part of the control group and timing of the survey (during psychiatric rotation). Despite those limitations, researchers felt the intervention was a significant predictor for short- and long-term improvements.

ORAL PRESENTATIONS: WORKPLACE PROGRAMS AND APPROACHES

Two views: The workplace, the system
This session looked at the workplace—the positive work experience provided by social enterprises—and the health system itself—how well equipped it is to deal with people who have a mental illness and an intellectual disability.

PRESENTERS
Patrizia Villotti, IT
Sara Zaniboni, IT
Marc Corbiere, CA
Franco Fraccaroli, IT
Julian Trollor, AU
Vince Ponzio, AU

Finding a sense of purpose
Patrizia Velotti noted work is a major determinant of social inclusion, yet the stigma faced by people with a mental illness hinders their integration. Many people find it hard to get or hold a job, and rates of unemployment among those with a mental illness can reach almost 90%. The major barrier is access to a supportive and non-discriminatory workplace. Italy's social enterprises provide a model of the type of workplace that can be beneficial to people with mental illness. These non-profit organizations are designed to provide disadvantaged people with the skills to work in the open market.

A longitudinal study was conducted by Velotti's University of Trento in partnership with the l'Université de Sherbrooke. They found that motivation to work was key to job tenure among people who had work experience in Type B social enterprises (those with more commercial functions than social functions). Severity of symptoms did not affect capacity to work, but did have an impact on productivity. A path analysis was developed to test the model of how working in social enterprises improves vocational outcomes and social skills in persons living with mental illness. It showed that providing meaningful work experience reduces perceived stigma and discrimination. Social enterprises provide a context within which people with a mental illness experience success and a sense of work-related competence. Velotti acknowledged that social support from supervisors and co-workers also is a significant success factor, and that the model needs refinement to account for the kind of workplace accommodation typically provided by social enterprises.

Dealing with the "doubly disadvantaged"
Australia's **Vince Ponzio** talked about the approach being taken to disability services in New South Wales which deals not only with people with a mental illness but also those with intellectual disabilities and/or addictions. Intellectual disabilities affect just under 2% of the Australian population. Of these, 30% to 40% are likely to have a mental illness. Yet only 10% to 20% of people dually diagnosed with mental and intellectual disorders have access to mental health services, compared to 35% of the general population. Thus, people with dual disorders have double the issues and about half the access. The figures are worse for those from Aboriginal or culturally and linguistically diverse backgrounds. In many cases, the primary diagnosis (e.g. either intellectually disabled or mentally ill) is unhelpful because it ignores the other half of the equation.

One of the challenges is that mental health professionals are less confident working with people who have intellectual disabilities. Nearly half of 222 respondents completing a recent survey said people with intellectual disabilities should not be treated in the mainstream. As a consequence, New South Wales identified three areas of strategic focus:

1. To facilitate better coordination between mental health and disability service providers to increase access and effectiveness.
2. To focus on training and education that involve the clinical and service domains, supported by e-learning and better data links.
3. To develop an integrated service program for people with multiple and complex needs that catches those who would otherwise fall through the gaps by providing accommodation, case management and clinical services.

ORAL PRESENTATIONS: STIGMA STEREOTYPES AND ATTITUDES

Professional approaches

Despite the often noble ideals of medical students and practitioners, recent studies have shown those responsible for diagnosing and treating mental illness can harbour their own stigmas. **Scott Patten** of the University of Calgary and the Mental Health Commission of Canada's Opening Minds initiative and **Sanjai Dayal**, a medical student at Isreal's Ben Gurion University of the Negev, showed that stigma is widespread in both pharmacy and psychiatry.

PRESENTERS
Scott Burton Patten, CA
Alfred Remillard, CA
Leslie Phillips, CA
Geeta Modgill, CA
Aliya Kassam, CA
Andrew C.H. Szeto, CA
David M. Gardner, CA
Sanjai Miika Olavi Dayal, IL
Dana Wang, IL
Sharon Steinberg, IL
Alan Jotkowitz, IL

An absence of exposure

Patten described a study of pharmacy clients that found 26% would not talk to their pharmacist about their mental illness due to stigma. In another study, the majority of pharmacists did not want to talk to patients about their mental illness because they were "uncomfortable" doing so. Such results could be because few pharmacology programs provide contact-based mental illness education as part of their curricula. Opening Minds has made it a goal to increase contact and interactions between students and people with lived experience of mental health problems and illnesses. Analyzing the results of contact-based sessions in pharmacy programs at three Canadian universities, reductions in levels of stigma were found after participation in these sessions. These improvements were significantly greater than those seen in the control group consisting of students randomly assigned to receive the sessions at a later date. These results confirm the efficacy of contact-based education in pharmacy students.

Encouraging interest in psychiatry

The lack of awareness about mental illness and its treatment often leads students to avoid the fields of psychiatry and related pharmacology, said Dayal. There is a widespread perception that "psychiatry is not a practical, results-based field where they can make a difference in terms of global health." He referenced students' assertions that there is stigma against psychiatrists themselves, and family members often convince psychiatry students to pursue "more prestigious fields such as cardiology." One way to change this is to offer early clinical experience in mental health, which is usually not offered until after medical students have narrowed their focus. Volunteer experience also plays a role. The short-term nature of volunteer work (usually in chronic, acute-care units) leads students to disrespect the field, since they tend not to see any improvement in the patients and do not get the benefit of viewing the long-term results of psychiatry.

PARALLEL SESSION 2: SYMPOSIA, WORKSHOPS, PANEL DISCUSSIONS AND ORAL PRESENTATIONS

SYMPOSIUM: METHODS FOR UNDERSTANDING WORKPLACE STIGMA

Three ways of seeing

These three presentations outlined different approaches to understanding workplace stigma. The Chair of the session, **Andrew Szeto,** noted that the authority structures and hierarchies of the workplace make it complex and open to a variety of approaches.

Making the case for the case study

Terry Krupa of the School of Rehabilitation Therapy at Queen's University and a member of the Opening Minds initiative began her presentation by defining case-study research as the study of a "bounded unit" that reflects a specific issue or phenomenon. The unit could be an individual, an event, a program, a decision or an organization. Case-study research applies well to the workplace because it allows researchers to accommodate complexity and nuance while looking for patterns and building interpretations within and across cases. Krupa noted that while the case-study method is often held in low regard in the healthcare field, it is considered one of the highest forms of business research.

The ethnography of the enterprise

Roula Markoulakis and **Cindy Malachowski**, PhD candidates at the University of Toronto, described institutional ethnography as an approach to dealing with stigma in the workplace. Institutional ethnographies examine individuals' experiences as well as the connections between individuals and other elements in a system. They are used to study social relations and systems rather than empirical datasets, shifting the role of the researcher from "expert" to "explorer." Institutional ethnography research can be in the form of interviews, observations, the study of texts and the mapping of interrelationships, with a view to understanding not only the connections, but the reasons behind connections.

Malachowski detailed some of the techniques of institutional ethnographies, which involve beginning at a "disjuncture" or problematic point, and progressing to key informants and texts. The researcher-as-observer might also shadow a worker to understand the processes and activities that have become routine. Eventually, the researcher would map how individuals, texts, procedures and actions interrelate.

The need for better measures

Keith Dobson of the University of Calgary and a member of the Opening Minds initiative described some of the methodological issues associated with using survey tools and quantitative approaches to understanding stigma in the workplace. Survey tools have many benefits, he said, principally because of their adaptability to different populations and attitudes, and the fact that quantitative results can be readily analyzed by a computer. Dobson cautioned that satisfaction surveys have limits. They are done after the fact and cannot map changing attitudes or behaviour. Dobson then detailed several other types of surveys, such as social-distance and workplace-wellness surveys. He stressed the need to use standardized psychometric evaluations (for comparison with other studies) and for internal reliability, so that results are sensitive to

CHAIR
Andrew Szeto, CA

PRESENTERS
Terry Krupa, CA
Roula Markoulakis, CA
Cindy Malachowski, CA
Keith S. Dobson, CA

specific changes. Dobson said no survey tool meets all desirable characteristics. He noted that the Mental Health Commission of Canada's Workplace Attitudes Survey is being refined. The University of Calgary team has validated testing among students, reduced the 27-item survey to 23 and addressed challenges such as anonymization of data by allowing pseudonyms. There is still, however, potential for perceived or real bias, depending on how, when, where and by whom the survey tool is administered.

WORKSHOP: THE LEGAL RIGHT TO BE ACCOMMODATED: A HUMAN RIGHTS APPROACH TO GETTING AND KEEPING A JOB

Challenging stigma in the workplace
Panellists in this session discussed the employment challenges facing people with mental health problems.

MODERATOR
Monette Maillet, CA

PANELLISTS
Barbara Mittleman, CA
Patrick O'Rourke, CA
Susan Jakobson, CA
Margaret Tebbutt, CA

What is workplace accommodation?
As a starting point, moderator **Monette Maillet** raised some of the fundamental questions surrounding the right to accommodation in the workplace: Is stress a disability? Do people with disabilities have the right to be accommodated at work? What does accommodation mean? How much does an employer need to know to accommodate a worker? She then asked the panel what is a greater challenge for someone with a mental illness: To return to work, or to stay at home?

Margaret Tebbutt answered, saying the Canadian Mental Health Association embraces the philosophy that, in the workplace, the individual employee knows what is best for him/herself (to stay home, to return to work), and this should be negotiated in collaboration with their supervisor. One of biggest challenges with returning to work, said **Susan Jakobson**, is damaged relationships from performance issues related to the period of illness.

Barbara Mittleman emphasized how important it is for employers to have practices and policies in place outlining how to deal with these situations so the individual is supported, privacy is respected and accommodation is possible. She noted it can be difficult when an employee does not realize or admit to a problem. If an employee does not realize he or she has an issue, there is only so far an employer can go. **Patrick O'Rourke** said that when an employee is aware, the most important thing an employer can offer is a safe environment in which to come forward and discuss the issue.

Changing policies
Beyond knowledge of policies and practices, Tebbutt said managers and union representatives need to improve their skills and become more comfortable dealing with employees who have a mental illness.

O'Rourke told a story of an employee who was off work to recover from the psychological trauma resulting from two on-the-job assaults. On the day after his return to work, he was fired because the organization's absenteeism policy trumped his need to be accommodated in his recovery.

Tebbutt suggested the need to move further "upstream" and incorporate mental health into discussions of occupational health and safety. British Columbia, she noted, recently expanded workers' compensation to include mental illness directly related to work factors. She asked whether the same coverage is given for psychotherapy as for chiropractic care or massage.

Tools for employers

Jakobson talked about the success of peer support programs such as Simon Fraser University's Guarding Minds at Work, which measures psychosocial factors as a tool for progressive employers. Mittleman acknowledged many employers have strict and rigorous recruitment practices to ensure fairness for candidates with disabilities. One best practice she emphasized was clear guidelines to help managers deal with mental illness and substance abuse.

Tebbutt noted that direct contact helps reduce stigma in the workplace as it does elsewhere. What is needed is to listen to real people with lived experiences who are in the workplace, competent and performing well, and to enable conversation with their peers. As a final comment, Jakobson remarked that workplaces need to start hiring managers as much for their emotional intelligence as for their technical expertise.

SYMPOSIUM: MILITARY MENTAL HEALTH EDUCATION

Awareness-building from boot camp onward

Picking up on previous sessions focused on mental health in the Canadian military, this final set of presentations described approaches being taken to build mental health awareness and education into military careers, from recruitment to retirement, teaching members how to watch for signs or problems, and where to turn for help.

CHAIR
Suzanne Bailey, CA

PRESENTERS
Ross Macdonald, CA
Kim Guest, CA
Marty Lipcsey, CA
Raymond Corby, CA
Dave Blackburn, CA

Equipping members to help themselves

Taking an evidence-based training approach that employs cognitive and behavioural techniques, Canadian Forces not only educates its members, but teaches them what to do with the information being given so they have the skills to help themselves. Each session is co-facilitated by a clinician and a military peer, bringing the credibility of operational experience to the discussion, and focuses intensively on interactive, small-group work.

Co-presenters **Ross Macdonald** and **Kim Guest** revisited the Forces' mental health continuum, which was developed with input from members and their families and provides a practical lexicon for referring to mental states: "I'm in the green today," or "I'm feeling yellowish-orange."[5]

Martin Lipcsey said a key concept for the Forces is the "warrior's ethos," which recognizes that members perform a unique role, one that demands intellectual and physical fitness and mental resilience. While most people follow a typical stress/performance bell curve in which low stress produces low performance and higher stress higher performance, soldiers have to sustain stressed performance for longer periods. Drawing from sports psychology, resilience techniques emphasize coping skills, understanding the normalcy of stress reactions and knowing when to ask for help.

Four core skills (just four, as simplicity was found to be an important success factor in such training) are promoted: goal-setting, mental rehearsal/visualization, self-talk and arousal reduction (e.g. combat breathing). The approach also promotes a buddy model that gives each member a trusted peer to turn to as a first resort and trains to be good buddies in return. The education program focuses equally on all ranks, appreciating that leaders face their own, often extremely intense stresses, many times without resort to immediate peers due to the distribution of the command structure. Troops look to their leaders when things get tough, and leaders who show a reserve of resilience lead people effectively.

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[5] See also "Workplace Wellness" on page 56.

Suzanne Bailey concluded the session by retracing the origins of the Forces' emphasis on mental health and resilience, going back to General Walt Natynczyk's 2009 declaration that mental health was an issue the Forces had to deal with openly. Today, the Forces maintain a national mental health advisory committee with representation from members, their families, researchers, chaplains and others involved in Forces mental health. The aims are many, including to increase mental health literacy, decrease stigma, overcome barriers to mental healthcare, enhance psychological resilience and provide useful tools.

Working with Defence Research and Development Canada in Toronto, Forces researchers looked at best practices to employ in changing attitudes about mental health and adult education. That led to recognition of the recruitment-to-retirement span of training and that the information must be perceived as coming from within the Forces, not imposed externally. Training must also be tailored to the needs of different groups (e.g. basic for those just starting out, advanced for senior leaders). Based on their experience and success, the Canadian Forces is now working with the Royal Canadian Mounted Police and the Mental Health Commission of Canada to adapt the military training program for police and other civilian groups across the country.

SYMPOSIUM: MEASUREMENT

How do you measure stigma?
Fundamental to the success of any strategy to reduce stigma and discrimination is the ability to measure the impact of particular interventions. Yet accurate, credible measurement presents unique and significant challenges. To address these and develop appropriate tools, a partnership known as SAPPHIRE was created by several GB organizations including King's College London's Institute of Psychiatry at the Maudsley and the Mental Health Research Network.

CHAIR
Simone Farrelly, GB

PRESENTERS
Paul McCrone, GB
Steve Wright, GB
Graham Thornicroft, GB
Elaine Brohan, CH
Jheanell Gabbidon, CH
Sarah Clement, GB
Diana Rose, GB
Mike Slade, GB
Norman Sartorius, CH
Debra Jeffery, GB
Claire Henderson, GB
Stephani L. Hatch, GB
Aliya Kassam, CA
Nick Glozier, GB
Morven Leese, GB
Adrienne van Nieuwenhuizen, GB
Ian Norman, GB

CODA, DISC and QUAD
Diane Rose described the development of a model known as the Costs of Discrimination Assessment (CODA). CODA considers both actual costs (those associated with limited access to healthcare services) and opportunity costs (such as those arising from limited access to employment and recreational activities).

Simone Farrelly talked about the Discrimination and Stigma Scale (DISC), which focuses on an individual's actual experiences of stigma and discrimination in healthcare settings. An ongoing effort is underway to improve DISC by making it a more reliable, valid and practical tool for researchers. This effort has already produced DISC 12, the current version of the tool.

A related tool is Questionnaire on Anticipated Discrimination Scale (QUAD). **Jheanell Gabbidon** explained that QUAD measures the extent to which people anticipate discrimination in healthcare settings. This presentation focused on refining QUAD through psychometric testing for reliability, precision, validity and acceptability. Initial results have been positive and a paper will be published soon.

Measuring attitudes and barriers to care
Debra Jeffery focused on the development and psychometric properties of the Barriers to Access to Care Evaluation Scale (BACE). BACE has undergone a four-stage psychometric validation involving a literature review to identify barriers, the revision of a proposed measure by an expert panel, a cross-sectional online survey (completed by 117 people) and the finalization of

the measure. BACE scored well on established measures for reliability, acceptability and readability. The researchers hope to improve the tool by sampling larger and more diverse test groups.

Gabbidon returned to talk about the Mental Illness Clinician's Scale (MICA), which was created to measure clinicians' attitudes toward people with mental illness. The fourth generation of MICA has been developed and distributed worldwide. Although originally developed for doctors, another version was created for nurses and other healthcare professionals.

A short discussion followed about the relationship between "perceived" discrimination and the internalized stigma often felt by users of mental health services. The presenters emphasized that users' experiences are essential to the accurate assessment of discrimination.

ORAL PRESENTATIONS: STIGMA IN HEALTHCARE SETTINGS

Strengthening services, stamping out stigma
This pair of presentations looked at practical approaches to improving healthcare service delivery to persons with mental illness—in one case, through both front-line and management-level training; and in the other, by addressing 'diagnostic overshadowing.'

PRESENTERS
Allison Potts, CA
Claire Henderson, GB
Adrienne van Nieuwenhuizen, GB
Aliya Kassam, GB
Tanya Graham, GB
Joanna Murray, GB
Louise M. Howard, GB
Graham Thornicroft, GB

Training tried and tested
Opening Minds on the Front Lines engages the Lakeridge Health system's frontline emergency staff in reducing stigma and enhancing service provision. **Allison Potts** explained how she used data from a survey of emergency department staff at three acute hospital campuses to develop a contact-based educational session supported by sustained messaging and resources. This includes a session with a person with lived experience who gives a talk and fields questions from participants. It is a chance for front-line workers to see an example of someone in recovery and to draw connections between crisis and wellness. Potts offered recommendations for others wanting to implement the program, which has nationwide applicability: be willing to train small groups, secure the support of the charge nurse, be flexible and follow up with booster sessions.

Potts also presented on the Advanced Leadership Foundations, a mandatory program for Lakeridge Health leadership that was launched to fill a gap in healthcare managers' mental health training. Training individuals who supervise healthcare staff is essential to effecting cultural change related to mental illness treatment. As with Opening Minds on the Front Lines, the Advanced Leadership Foundations program incorporates the personal story of an individual with lived experience. It also includes knowledge transfer through experiential exercises and presentation of data and practical information related to mental health.

Collaboration key to avoiding diagnostic overshadowing
Claire Henderson of King's College London raised the topic of diagnostic overshadowing, which is the misattribution of physical symptoms to a mental illness. In-depth interviews in 25 emergency departments revealed that the physical healthcare of people with mental illness may be adversely affected by this phenomenon and that this is compounded by avoidance among clinical staff, difficulties created by an illness, medication and the emergency department environment. Henderson suggested greater collaboration between psychiatric and emergency department staff as one way to reduce diagnostic overshadowing.

WORKSHOP: FAMILY EXPERIENCES

How caregivers cope

While there have been significant advances in the diagnosis, treatment and understanding of mental illness, the stresses and challenges on those who provide care for patients with a mental illness is an area that is receiving greater attention these days.

PRESENTER
Ella Amir, CA

Caregiving typically involves forming a close, personal, long-term relationship with an individual. When dealing with someone day after day, caregivers often feel a personal stake in whether or not the patient's condition improves and goals are met. When goals are not met, it can be difficult for some caregivers. Those who tend to be most positive and optimistic are likeliest to re-evaluate unsuccessful or unrealistic goals; others may be tempted to blame themselves, which leads to a cycle of stress in their own lives. Compounding the problem is the temptation to subordinate their own lives, goals and dreams to this relationship.

There is also a correlation between the personality of the caregiver and the coping mechanisms he or she will call upon to deal with stress. The ability to cope does depend on how "burdened" the caregiver feels about his or her duty to provide care. Those who can disengage effectively from unattainable goals tend to be able to activate more positive coping behaviours. Finding a way to coach or teach this kind of "dispositional optimism" should become a key component of training and coaching caregivers.

A recent study performed by Quebec's Action on Mental Illness and presented by **Ella Amir** quantified the experiences and difficulties faced by family, friends and caregivers in providing long-term care. Amir asserted a balance of goal re-adjustment skills and positive coping mechanisms can help alleviate the stress-inducing, chronic burdens of mental health caregivers.

ORAL PRESENTATIONS: CONSUMER-BASED INTERVENTIONS

Engaging lived experience

To uncover and counter stigmatizing attitudes and to empower their clients, mental health service providers must gain a greater understanding of mental illness—an understanding that only persons with lived experience can provide.

PRESENTERS
Claude Lurette, CA
David Patrick Clarke, CA
Sue Cathcart, CA
Mike Miller, CA
Edmundo Bejar, MX

Patient council success

Established in 2006, the Client Empowerment Council works in partnership with the Royal Ottawa Healthcare Group to ensure a more client-centred model of care through direct involvement in the Group's policy-making process. Past Chair **Claude Lurette**—an intermittent patient for many years who credits The Royal with saving his life—knew the hospital's client-care policies needed to be reworked and he returned to help improve the treatment and quality of care of its clients. The Council built a collaborative relationship with The Royal, which provided an operating budget and office space within the institution.

As clients are the stakeholders most directly affected by policy, the Council worked to remove stigmatizing and complex language from The Royal's existing client-care policies, making them more accessible to clients. The Council now has access to first drafts of new policies and, through a consultative process, is able to provide client feedback. Future challenges for the Council involve facilitating the current transition in its leadership, providing competencies support

to Council volunteers and managing the time commitments of recovering clients who wish to stay involved with the Council.

Peer-support service delivery
In May 2011, funders mandated Durham Mental Healthcare Services to provide a peer-support program for clients. Peer-support specialist **Sue Cathcart** and volunteer **Mike Miller** described their experiences with stigma in a mental healthcare setting and how the peer-support program has facilitated recovery by eventually reducing it. In fact, the peer-support program initially provoked stigmatizing behaviour from staff toward the program's peer-support specialists. Cathart said that when staff learned of her role, she was given what she calls "the look" as people tried to figure out what her diagnosis might be.

Despite encountering stigma initially, the two presenters shared their enthusiasm for the program. Taking an active role in delivering mental healthcare services has helped Miller—who had been homeless for 14 years and spent time in 10 different mental health facilities—find stability in his life and a stronger, deeper sense of identity. Cathcart reported that, despite the initial transition period, the peer-support program has integrated successfully with Durham Mental Health Services. Looking forward, the peer-support program hopes to increase its service capacity by training new peer-support volunteers, collaborating on a set of standards with other agencies and redefining its role.

What are we really fighting against?
This session closed with a provocative, experiential presentation by **Edmundo Bejar**, who believes it is a tragedy the general public does not understand—indeed, can never fully understand—mental illness. While appreciating that the treatment of mental illness involves treating the brain, Bejar said the physiological approach to mental illness does not give enough consideration to the concept of the mind. He invited attendees to open their minds and souls in an attempt to find calm—a balance between the physical organ of the brain and the metaphysical concept of the mind—to elucidate a better understanding of mental illness.

ORAL PRESENTATIONS: EMPLOYMENT STIGMA

Mental illness on the job
What impact do mental illness and stigma have on a person's job prospects? What obligations do labour unions have to defend the rights of those living with mental health problems? A pair of presentations explored those and other related questions.

PRESENTERS
Elizabeth Ann Corker, GB
Sarah Hamilton, GB
Claire Henderson, GB
Craig Weeks, GB
Vanessa Pinfold, GB
Diana Rose, GB
Graham Thornicroft, GB
Heather Oxman, CA
Karoline Klug, CA

To disclose or not to disclose: Mental health and job prospects
As part of England's national Time to Change campaign, the Viewpoint Survey recorded and measured experiences of stigma and discrimination among those looking for work.
Elizabeth Ann Corker said approximately 20% of the country's employed adult population has a severe mental illness. Using the Discrimination and Stigma Scale 3 (DISC 3), 579 participants were interviewed by phone about their experiences in the previous 12 months. The survey concluded experiences of discrimination increased in 2011 over 2010, although economic circumstances—with many companies laying off employees or folding entirely—may have contributed to the result. Corker said 75% of participants hid their diagnoses from their employers to avoid discrimination. In 2010, legislation was passed prohibiting employers from asking a candidate about their mental health before giving an employment offer and the organization is hoping to reduce the rates of discrimination in the next few years.

Unions and protecting people with mental health problems
When **Heather Oxman** returned to the public service after experiencing a nervous breakdown, she received a less-than-warm welcome from her colleagues. In fact, her supervisor harassed her repeatedly. Undergoing a series of psychiatric assessments, she was diagnosed with bipolar disorder and told to work from home, but was unproductive. Oxman returned to work, only to be harassed again, this time by a different supervisor. Unaware of her rights, she sought the advice of her union, which had been known to represent health and safety from a physical perspective instead of from a mental health standpoint. **Karoline Klug**, a representative from the union, declared that the responsibilities of unions are to protect equity in all forms and ensure every person is treated fairly, including those receiving mental health services. Working with employers to establish accommodations for employees with mental health problems, unions are also educating their own membership to raise awareness and create inclusive work environments. Such regulations include creating a return-to-work plan with the employee as well as preparing the workplace and colleagues for an employee's return.

ORAL PRESENTATIONS: ADVOCACY AND HUMAN RIGHTS

Are we living up to our obligations?
Although Canada's Charter of Rights and Freedoms sets the foundation for the protection of the rights of all citizens, provincial mental health policies are not always grounded in human rights principles. The efficacy of anti-discrimination legislation is often hindered by underlying public assumptions about people with mental illness.

PRESENTERS
Nicole Chammartin, CA
Gayle Restall, CA
Amy Kendry Deyell, CA

In 2010, Canada ratified the *Convention on the Rights for Persons with Disabilities*. Its signing, however, raises a number of questions: Are existing mental health programs meeting Convention obligations? Can compliance be assessed?

Looking at legislation through a human rights lens
Before a framework addressing the rights of people with mental illness can be developed, a review of existing mental health legislation must first take place. In 2010, the Canadian Mental Health Association partnered with the Mental Health Commission of Canada and the Public Interest Law Centre of Legal Aid Manitoba to pilot an instrument to evaluate mental health legislation, regulations, policies and service standards from a human rights perspective.

Central to this project was a consultative group consisting of people with lived experience. Using the PhotoVoice platform, members provided valuable guidance to the project research team by presenting personal stories about how public policies had personally affected them. Those stories often highlighted the unshakeable link between stigma and human rights violations. Group members also shared ideas on how to create environments in which human rights can flourish. Validated by the experiences of the consultative group, the pilot evaluation tool supports Canada's ratification of the Convention by giving the provinces the capacity to assess and report on their own adherence to the Convention's principles and obligations.

Supporting the *Convention on the Rights of Persons with Disabilities* through the social model of disability
Disability can be viewed as either biomedical, which locates disability within the individual, or social, which considers it the result of attitudes and behaviours preventing people from participating in society. The *Convention on the Rights of Persons with Disabilities* outlines various measures to combat stigma. For example, Article 8 imposes obligations on participating nations to undertake immediate, effective and appropriate measures to improve societal attitudes toward

people with disabilities. Article 8 clearly states that for any nation to be compliant with the Convention, the social model of disability must be applied.

With the release of the Mental Health Strategy for Canada, the Mental Health Commission of Canada has indicated its acceptance of the social model. So far, its efforts are on track toward compliance. The Opening Minds initiative, for example, meets the Convention's criteria of immediate, effective and appropriate. It was underway prior to the Convention's ratification, does not employ a generalized, untargeted, nationwide media campaign, and uses the "recovery approach," which says barriers need to be removed, not simply overcome. If Canada's anti-stigma approach aligns with the immediate, effective and appropriate criteria, the country will demonstrate its faithfulness to the principles of the Convention with respect to stigma reduction.

ORAL PRESENTATIONS: WORKPLACE STIGMA

Shaping the workplace through knowledge and law
These two presentations took different tracks—one outlining a program for training supervisors to be more attentive to mental health issues in the workplace, and the other asking what role does the law plays in reducing stigma.

PRESENTERS
Bonnie Kirsh, CA
Terry Krupa, CA
Dorothy Luong, CA
Judy Kerling, CA
Kathy Jurgens, CA
Derek Jones, CA
Colleen Sheppard, CA

Supervising a healthy workplace
Fighting stigma in the workplace requires an arsenal of best practices that can be perfected and replicated throughout the country. **Bonnie Kirsh** from the University of Toronto and a member of the Opening Minds initiative offered the Supervisor Training Program in the Region of Peel as one such example. Its goals are to: raise supervisors' awareness of mental health issues, reduce stigma and give managers the training they need to support mental health in the workplace. Mandatory training components include self-service group training through video modules, workbooks and, critically, management-led discussions. No one with lived mental health experience was required to lead the training sessions. Currently, more than 90% uptake has been achieved and the training continues to be offered to newly hired workers and individuals promoted within the Region.

Of the 500 supervisors who participated, 73 completed all pre, post and follow-up evaluation questionnaires. Results showed that the group began with relatively low levels of stigma, and the general workplace attitudes questionnaire showed little significant improvement. However, some improvement was found in the supervisory attitudes questionnaire. In the months following the training, 16.2% of supervisors reported having faced an employee dealing with a mental illness. Fifty-two of 53 said they used material from the training in their response, and 94.2% felt the program was useful in dealing with the situation. The researchers with the Opening Minds initiative concluded the training resulted in improvements in attitude and behaviour and that supervisors both valued the training and learned useful skills.

Shattering stigma in the workplace
The law can be an effective tool in combating stigma and ensuring persons with mental illness are not discriminated against. **Derek Jones** said the right legislation can advance public perception and opinion through dispute resolution, mandating equality, providing education on standards and discrimination, protecting confidentiality and balancing rights with societal interests.

The law has a particularly significant role to play in combating systemic discrimination, which is critical to resolving the "difference dilemma" in which persons with mental illness are forced to chose between divulging their condition and risking discrimination or and hiding it and risking non-accommodation, isolation and lack of care. The law must review and change institutional

practices, develop proactive policies and ensure reasonable accommodations are made. This is particularly important when it comes to employment. The Canadian Senate reported that one-third to half of all persons with a mental illness have been turned down for a job due to their condition.

The issue of pre-employment mental health questions—asking on an application if the prospective employee has ever been treated for a mental illness, for example—is particularly relevant to the discussion. The invasiveness of such questions and their potential to be used to discriminate against those with mental illness must be balanced with genuine concerns about job performance and injury. Rules and regulations regarding accommodation and return-to-work are also complex. To what extent must a company accommodate an employee with a mental illness through flexible work time and other compromises? The answers must be in accordance with the *Canadian Charter of Rights and Freedoms*.

PANEL DISCUSSION: IT'S A MATTER OF RIGHTS: A HUMAN RIGHTS APPROACH TO ELIMINATING STIGMA AND DISCRIMINATION

Identifying the sources of discrimination
Human rights for people with mental illness may be the final and most challenging civil rights issue of our time. In this panel discussion, experts shared their thoughts on a wide range of issues, including the extent to which society accepts people with mental illness as being entitled to the human rights of dignity, independence and respect; the limitations standing in the way of such acceptance; how the *Convention on the Rights of Persons with Disabilities* will change the way mental health professionals work and how human rights apply to treating the mentally ill within the correctional system.

MODERATOR
David Gollob, CA

PANELLISTS
David Langtry, CA
Celia Brown, US
Michael Stein, CA
Eric Mathews, CA

Increased awareness of discrimination
The Canadian Human Rights Commission's Acting Chief Commissioner **David Langtry** said it is clear there is still a long way to go before people with disabilities—whether physical or psychosocial—feel respected by society. This is evident from the growing number of human rights complaints about discrimination against people with a mental disability received by the Canadian Human Rights Commission. Yet higher numbers of complaints may also mean that people are more aware today of human rights. The actual incidence of discrimination may not be on the rise, but the number of people willing to come forward and challenge the system may be. **Celia Brown** of MindFreedom International expressed the hope that improving society's attitudes toward people with disabilities will allow all to feel respected, have autonomy and live in their communities of choice.

The dangers of institutions
Eric Mathews, an Advocacy Associate with Disability Rights International, said mental institutions are considered "a structural manifestation of discrimination." They create barriers by segregating people and denying them the chance to participate fully in society—in some cases not allowing them to leave. The directors of these institutions often understand how unsatisfactory the situation is, but the system itself does not provide tools or resources to facilitate greater respect of patients' human rights. Systemic change must take place, shifting the paradigm from institutions to community-based alternatives.

Securing legal capacity for all
Michael Stein of the Harvard Project on Disability compared the situation facing people with mental illness today to that of women in the 19th century—that is, society is unsure if they are capable of exerting their "personhood" to actually make decisions on their own. The issue is more severe for those residing in old-style mental institutions where they may be, for all intents and purposes, stripped of their legal capacity and where they may lack the ability to challenge the authority of the institutions from within. People should not be prevented from making their own decisions—but appropriate mechanisms should also be in place when they need assistance in doing so. Mental health professionals should therefore be working in partnership with people with mental illness to facilitate shared decision-making, developing life plans with people instead of for them. Such empowerment can lead to further recovery and societal integration.

CLOSING CEREMONIES

Mike Pietrus of the Mental Health Commission of Canada returned to the podium to conclude the conference. He thanked all the presenters, sponsors and volunteers, and acknowledged the close of the meeting as bittersweet—attendees often make new acquaintances and reunite with old ones, and everyone benefits from spending concentrated time with others who are like minded, so that it can be hard to say goodbye.

PRESENTERS
Mike Pietrus, CA
Heather Stuart, CA
Aileen Lindsay, CA

Much progress was made during and around the event. Just prior to the conference, a number of international anti-stigma groups had met and agreed to create an international association focused on sharing information with groups around the world, and to help smaller groups become more effective and efficient at reducing stigma. Over the course of the conference, it became clear that there are effective programs out there, tools to share and partners with which to join forces.

Heather Stuart thanked the members of the scientific community who reviewed abstracts, the presenters for their incredible work and the performers who brought an added dimension to conference events. She also acknowledged the staff of the Delta City Centre for going above and beyond in accommodating a so-much-larger-than-expected group of delegates.

The conference concluded with a call for all attendees to complete a short email survey and offer a story about their experience of the conference, and with a closing prayer from First Nations representative **Aileen Lindsay**.

Contest and auction results
Graham Hopkins' name won a stay for two at any Delta Resort in Canada—the conclusion of a contest that had run over the course of the conference.

Winners of the poster competition were: Meagan De Jong, University of New Brunswick; Lisa Hawkes, University Health Network, Toronto; and Felicia Meyer, Psychiatry Department at Concordia University and Royal Ottawa Mental Health Centre.

The art auction raised $2,825 for the artists who contributed works.

CONCLUSIONS

Out of the enormous volume of content covered during the conference, a number of observations and key messages repeatedly emerged. Among the most prominent were:

1. **Including people with lived experience** (those with mental health problems and illnesses and their family members) **is critically important** when designing services, developing and delivering solutions and executing programs to combat stigma. "Nothing about us without us" was an oft-recited mantra.

2. **Contact-based education** (facilitating interactions between those with lived experience and groups that might hold stigmatizing attitudes) is highly effective in reducing stigma. Contact-based encounters can be both live and electronic, such as video.

3. **We must go beyond changing attitudes and seek to change behaviour** to effect real change where stigma is concerned. Behavioural changes should be measured.

4. A **need for greater research** into understanding how—and to what degree—stigma affects help-seeking among those with mental health problems.

5. **Working with the media** to raise awareness of mental health issues and establish best practices for reporting and for depicting mental illness is an effective approach with potential to have a positive impact on public perceptions.

6. **Engagement in creative arts** not only facilitates recovery but may also help break down barriers and reduce stigma.

7. **Programs must be tailored to specific audiences** in consideration of culture and context to achieve optimal outcomes. One-size-fits-all approaches are less effective.

8. **Prejudice and discrimination are prevalent within the health system** and must be recognized as such. Programs are needed to address this—from better mental health education at post-secondary institutions to contact-based initiatives in the field.

9. **Youth are an essential audience** to reach through anti-stigma programs, as mental health issues often first present in the teenage years. Dispelling stigma will encourage help-seeking and foster hope and confidence in recovery.

10. **Work plays an important role** in establishing a sense of worth, purpose and social inclusion. Work opportunities for persons with mental illness have to be fostered and the workplace and capitalized on as an environment for anti-stigma intervention.

11. **We must adopt a human rights and social justice framework** to bring about structural changes and support those living with mental illness—ensuring that individuals retain their rights and freedoms, and are able to exercise them (with support during periods when they cannot).

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The conference attracted about 700 delegates from 29 countries, making this the largest anti-stigma congress to date.
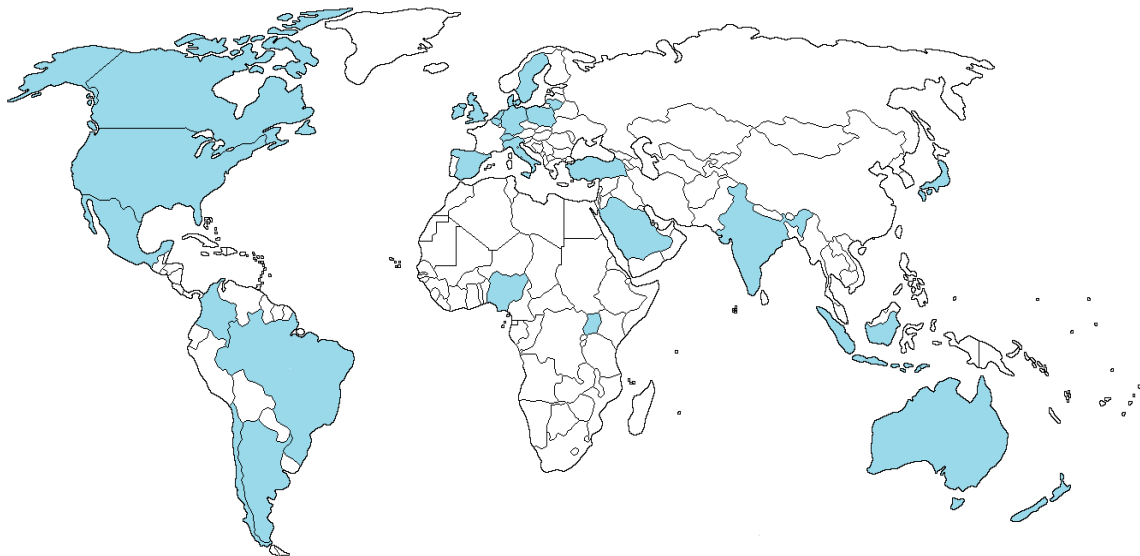
The 5th International Stigma Conference attracted participants from:

Argentina	(AR)	Australia	(AT)
Belgium	(BE)	Brazil	(BR)
Canada	(CA)	Chile	(CL)
Colombia	(CO)	Denmark	(DK)
England	(GB)	Germany	(DE)
India	(IN)	Indonesia	(ID)
Ireland	(IE)	Italy	(IT)
Japan	(JP)	Lithuania	(LT)
Mexico	(MX)	Netherlands	(NL)
New Zealand	(NZ)	Nigeria	(NG)
Poland	(PL)	Saudi Arabia	(SA)
Scotland	(GB)	Spain	(ES)
Sweden	(SE)	Switzerland	(CH)
Turkey	(TR)	Uganda	(UG)
United States	(US)		

APPENDIX A

POSTER SUMMARIES

Poster 1: Most paramedics are victims of violence in the pre-hospital workplace
Authors and organizations: Blair Bigham, St. Michael's Hospital, University of Toronto, CA; Jan Jensen, Humaira Saleem, University of Toronto, Scarborough, CA; Walter Tavares, Centennial College, CA; Glenn Munro, Tema Conter Memorial Trust, CA
Summary: *The results of this study showed that most paramedics are victims of violence in the workplace. Further research is needed to understand the impact on their mental and physical health.*

Poster 2: Opioid peer education network: Empowering consumers to address stigma
Authors and organizations: Luciana Luce Rodrigues, Centre for Addiction and Mental Health, CA; Sylvie Guenther, Centre for Addiction and Mental Health, CA
Summary: *The Opioid Peer Education Network (OPEN) trains consumers to speak publically about their experiences to increase awareness and reduce stigma of prescription opioid addiction and methadone treatment among healthcare providers and other groups such as the media and the public.*

Poster 3: Experiences of nursing students, advanced police students and community mental health professionals who participated in the Hearing Voices simulation
Authors and organizations: Jane Elizabeth Hamilton, Conestoga College Institute of Technology and Advanced Learning, CA; Wendy Azzopardi, Conestoga College Institute of Technology and Advanced Learning, CA; Sherrill Conroy, University of Alberta, Faculty of Nursing, CA
Summary: *In this study, student nurses, advanced police students and community mental health professionals were asked to respond to three open-ended prompts within an electronic text document immediately following a Hearing Voices simulation. The simulation appeared to provide an experience that reshaped participants' attitudes and deepened their sensitivity toward those with mental health challenges.*

Poster 4: A research of recognition about forensic psychiatry of patients with mental disorders
Authors and organizations: Akihiro Shiina, Chiba University Hospital, JP; Yoshit Igarashi, Chiba University, Center for Forensic Mental Health, JP; Masaomi Iyo, Chiba University, Graduate School of Medicine, Department of Psychiatry, JP
Summary: *A study was performed in Japan to investigate how outpatients with mental disorders and their family members felt about the present condition of the forensic mental healthcare system. It concluded that many patients and family members are not strongly self-stigmatized in Japan, and are willing to receive precise information about psychiatry.*

Poster 5: Empowerment, disclosure and group identification
Author and organization: Joan Edwards Karmazyn, National Network for Mental Health (NNMH), CA
Summary: *The NNMH seeks to advocate, educate and provide expertise and resources that benefit the Canadian consumer/survivor community. Consumer-led support plays a contributing role in reducing self- and public stigma, in supporting disclosure and empowering consumers through positive group identification.*

Poster 6: How do stigma perception and coping processes change? Identifying targets for interventions from laboratory, clinical and population-based studies
Authors and organizations: Nicolas Rüsch, Psychiatric University Hospital Zürich, Department of General and Social Psychiatry, CH
Summary: *Researchers in Switzerland are performing a longitudinal study that shows the combination of highly perceived discrimination, self-labelling and the perception of people with mental illness as a separate group in society could increase stigma-associated stress for people at risk for psychosis. Interventions to reduce public and self-stigma associated with this group are needed.*

Poster 7: The impact of stigma on psychological distress and quality of life in people with intellectual disability
Authors and organizations: Afia Khanom Ali, University College London, GB; Angela Hassiotis, University College London, GB; Andre Strydom, University College London, GB
Summary: *This study aims to recruit 200 people with mild to moderate intellectual disability (ID) to examine the association between internalized stigma, psychological distress and quality of life. The preliminary findings suggest that interventions need to be developed to reduce the psychological distress associated with stigma.*

Poster 8: "They are just like us, but …": How positive speech maintains the stigma of mental illness and homelessness
Authors and organizations: Barbara Schneider, University of Calgary, Department of Communication and Culture, CA; Chaseten Remillard, University of Calgary, CA
Summary: *This study of seven focus groups analyzed conversations to determine how statements about mental illness and homelessness perpetuate stigmatizing conceptions. It was concluded that positive statements about mentally ill homeless people reinforce stigmatizing conceptions of mental illness and homelessness and maintain existing social inequalities.*

Poster 9: Hearing (our) voices: Reducing stigma through non-traditional research dissemination
Authors and organizations: Barbara Schneider, University of Calgary, Department of Communication and Culture, CA; Michele Misurelli, Schizophrenia Society of Alberta, Calgary & Area Branch, CA
Summary: *In an eight-year research project, nine co-researchers, all with a diagnosis of schizophrenia, addressed two topics: communication with medical professionals and housing for people with a diagnosis of schizophrenia. They disseminated the results to a wide variety of audiences using a book and non-traditional presentation modes such as theatre performances, a documentary film, a graphic novel (comic book), a travelling poster exhibit and a website.*

Poster 10: Stigma around depression between physicians
Authors and organizations: Silvana Pujol, La Plata University, School of Medicine, AR; Suarez Richards[6]
Summary: *In this study, 167 physicians in La Plata, Argentina, were asked if they thought depression was a disease and happened in weak people. Results revealed that 10.7% think depression is not a disease and 19.1% think it happens in weak people. It was concluded that primary care physicians need training in the diagnoses and management of depressive patients.*

Poster 11: The stigma of passive suicidal ideation
Author and organization: Liana Voia, The Canadian School of Contemplative, Expressive and Imaginative Arts, CA
Summary: *This presentation looked at the hidden meanings and subtle, but deep impact that passive suicidal ideation has on an individual's personal and professional life, as well as on her or his emotional, psychological and physical wellbeing. Findings suggested that passive suicidal ideation was not an indicator of mental illness and did not require medication or long-term therapy.*

Poster 12: The game designed to stamp out stigma with those living with a mental illness
Authors and organizations: Mary Haase, MacEwan University, CA; Debra Scharf, United Nurses of Alberta – Local 183, CA; Deborah Leonard, United Nurses of Alberta – Local 183, CA; Allyson Fukala, United Nurses of Alberta – Local 183, CA; Elaine Gradidge, United Nurses of Alberta – Local 183, CA
Summary: *This poster documented a workshop that invites participants to discover and examine their values and beliefs about stigma using an interactive game. Through conversations, discussions and learning with co-participants, the goal is to change perspectives in understanding many of the issues that challenge those living with mental illness.*

Poster 13: Stigmatizing people with mental and intellectual disabilities in Eastern and Central Europe: Reasons and consequences
Authors and organizations: Egle Sumskiene, Vilnius University, LT; Dainius Puras, Vilnius University, LT
Summary: *This paper aimed to identify the underlying reasons for stigmatizing people with mental and intellectual disabilities in Eastern and Central Europe (EEC). The model of care common to EEC may be characterized as having a negative effect on social and state development, while presenting a combination of remnants of the former Soviet system and selectively chosen components of modern mental health policy and services.*

Poster 14: The gendered nature of stigma: Men's perspectives on mental health and help-seeking
Author and organization: Sandra Lynn Hoy, Wilfred Laurier University, CA
Summary: *This presentation shared the results of a study on men's perspectives on psychological distress and help-seeking. Findings indicated most participants' conceptualizations of psychological distress are socially based and many have difficulty with the term depression. These accounts show notions of how masculinity negatively impact mental health and act as a barrier to help-seeking.*

Poster 15: Educating undergraduate psychology students about stigma and mental illness: From the classroom to the field
Authors and organizations: Greta Winograd, State University of New York (SUNY) New Paltz, US; Amanda Allen, SUNY New Paltz, US; Jennifer Muir-Braunstein, SUNY New Paltz, US; Steve Miccio, PEOPLe, Inc., US
Summary: *This presentation shares the approach of a two-semester sequence of person-centered education about mental illness, stigma, recovery and empowerment for upper-level undergraduate psychology students at SUNY.*

Poster 16: Effects of stigma on the self-determination of young adults with psychosis
Author and organization: Meagan De Jong, University of New Brunswick, CA
Summary: This study explored discrimination experiences of young adults with a mental illness and their impact on individuals' autonomy, competency and relatedness. Findings suggest that the majority of young adults have experienced both public and self-stigma that has affected their self-determination in positive and negative ways.

Poster 17: Using applied theatre to promote mental health and reduce stigma
Authors and organizations: Dushan Ristevski, St. George Mental Health Service, South Eastern Sydney Local Health District, AU; Vince Ponzio, formerly with St. George Mental Health Services, South Eastern Sydney Local Health District, AU
Summary: This presentation outlined the development, staging and evaluation of Fear and Shame, *a Macedonian-language play addressing mental health and stigma. The results of the project demonstrate the value of using applied theatre as a health promotion tool with communities that may be difficult to engage, have low levels of health literacy and/or experience high levels of stigma around particular health issues.*

Poster 18: Changing stigma through a consumer-based stigma reduction program
Authors and organizations: Patrick Joseph Michaels, Illinois Institute of Technology, US; Patrick William Corrigan, Illinois Institute of Technology, US; Blythe Buchholz, Illinois Institute of Technology, US; Jennifer Brown, On Our Own of Maryland, US; Tea Arthur, On Our Own of Maryland, US; Clarissa Netter, On Our Own of Maryland, US; Kim Mcdonald-Wilson, University of Maryland, College Park, US
Summary: This study evaluated the effectiveness of a contact/education intervention, the Anti-Stigma Project workshop (ASP), for people with mental illness and mental health providers. Results showed that taken together, ASP raises awareness, improves affirming attitudes, decreases stigma and fosters a sense of personal recovery.

Poster 19: Modelling the preferences of young adults for information about anxiety and depression: A discrete choice conjoint experiment
Authors and organizations: Charles E. Cunningham, McMaster University & McMaster Children's Hospital, CA; Monica Nunes, York University, CA; John Walker, University of Manitoba, CA; John Eastwood, York University, CA; Henny Westra, York University, CA; Heather Rimas, McMaster University, CA; Yvonne Chen, McMaster University, CA; Madalyn Marcus, York University, CA; Keyna Bracken, McMaster University, CA; Mobilizing Minds Research Group, York University, CA
Summary: In this study, researchers sought to identify preferred methods of knowledge translation (KT)— that is, the process in which scientific evidence is translated into a format useful to end users. The survey indicated that future KT strategies should be comprehensive, offering new media (Internet) and traditional media (books or pamphlets) options, as well as choice in passive and active learning processes.

Poster 20: A strategy for advancing the recovery agenda on schizophrenia inpatient units
Authors and organizations: Kwame McKenzie, Toronto Centre for Addiction and Mental Healthcare, University of Toronto, Department of Psychiatry, CA; Sean Kidd, Toronto Centre for Addiction and Mental Health, University of Toronto, Department of Psychiatry, CA
Summary: This project involved the development and evaluation of an education program in which former inpatient clients provided a one-year series of bi-weekly talks for inpatient staff on units in a large urban care setting. Overall, it was found that service providers interacting with former clients about recovery and helpful and problematic aspects of inpatient care has considerable potential for addressing care quality and stigmatization in inpatient settings.

Poster 21: Identifying the learning needs of organizational leaders in relation to mental health awareness and stigma reduction in the workplace
Authors and organizations: Clare Shann, beyondblue: the national depression initiative, AU; Angela Martin, University of Tasmania, AU; Andrea Chester, RMIT University, AU
Summary: This study revealed that very few health leaders in Australia have been involved in a mental health awareness and stigma reduction program. The results of this study will be used by beyondblue, the national depression initiative in Australia, to develop an online mental health awareness and stigma reduction program for organizational leaders.

Poster 22: Comparing efficacy of a first-person narrative intervention to reduce prejudice toward persons with mental illness vs. persons with AIDS
Authors and organizations: Caroline E. Mann, Meredith College, US; Tiffany Smith, University of Tennessee, US; Michael A. Olson, University of Tennessee, US; Sharika Prioty, B.A. student, Meredith College, US
Summary: In this study, researchers aimed to identify how the "perspective-taking" mechanism of first-person narratives affects stigma toward people with mental illness in comparison to people with AIDS. They found it was

successful in reducing prejudice across multiple outcome variables for both bipolar and AIDS stigma types; however, there was more prejudice towards people with mental illness in all measures.

Poster 23: Factors facilitating self-determination in young adults with psychosis
Authors and organizations: Meagan De Jong, University of New Brunswick, CA
Summary: This study used information from nine young adults (ages 18–25) with psychosis to explore experiences, services and supports that increase an individual's autonomy, competency and relatedness. Findings suggest that having a variety of supports and a determination to recover facilitates high self-determination and thriving behaviour in these individuals.

Poster 24: "He seems a bit weird." Justifications for the exclusion of peers with mental health problems in childhood and adolescence
Authors and organizations: Claire O' Driscoll, National University of Ireland, IE; Lynn McKeague, University College Dublin, IE; Caroline Heary, National University of Ireland, IE; Eilis Hennessy, University College Dublin, IE
Summary: The purpose of this study was to explore children's and adolescents' evaluations of and reasons for exclusion, specifically in the cases of attention deficit hyperactivity disorder (ADHD) and depression. Findings suggested that although excluding peers with mental health problems is often considered wrong, it could be evaluated as legitimate, especially when acceptance violates group norms or functioning. This insight furthers understanding of youth stigmatization.

Poster 25: Decision making about disclosure of a mental disorder at work
Author and organization: Kate Toth, McMaster University, CA
Summary: In this study, 13 employees diagnosed with a mental disorder and employed at a university in southwestern Ontario were interviewed about their perceptions and concerns related to disclosing their illness to co-workers. The findings of this study begin to address a gap in the literature related to the understanding of disclosure decision-making in the workplace, and suggest possible intervention strategies for enhancing the psychological safety of workplaces through reducing stigma of mental illness.

Poster 26: The association between stigmatization and experience of evidence-based practices in psychiatric hospital staff in Japan: A cross-sectional survey
Authors and organizations: Sosei Yamaguchi, Department of Psychiatric Rehabilitation, Institute of Mental Health, National Center of Neurology and Psychiatry, JP; Nobuyuki Niekawa, Social Work Research Institute, Japan College of Social Work, JP; Keiko Maeda, Japan Society for the Promotion of Science, JP; Rie Chiba, Health Science Institute, JP; Maki Umeda, Departments of Psychiatric Nursing Mental Health, Graduate School of Medicine, University of Tokyo, JP; Junichiro Ito, Department of Psychiatric Rehabilitation, Institute of Mental Health, National Center of Neurology and Psychiatry, JP
Summary: Researchers conducted a cross-sectional study to investigate the association between experiences of evidence-based practices (EBPs) and staff levels of stigma in Japan. Findings suggest that implementation of EBPs contributes not only to improving community care, but also to overcoming stigmatization in staff members.

Poster 27: Anti-stigma public awareness campaign in Niagara
Author and organization: Jessica Rathwell, Pathstone Mental Health, CA
Summary: The components of this campaign, aimed at reducing stigma in the community, were designed to encourage the pubic (primarily youth) to visit the campaign's website, www.mendthemind.ca, where they would find information about stigma, mental illness, suicide, bullying, where to get help and how to support someone with a mental illness. This campaign has strong potential for community action research in the future as it has been supported by both community organizations and mental health consumers.

Poster 28: Mental health from a guy's perspective!
Author and organization: Catherine Dion, *Service des communications, Hôpital Louis-H. Lafontaine, Centre de recherche Fernand-Seguin*, CA
Summary: This study sought to raise awareness and combat prejudice against people with mental illness using web technologies that give them a voice and present a realistic portrayal of daily life and their approach to recovery. Methods included producing a web series featuring people with mental illness and stakeholders, and hiring a filmmaker with knowledge of mental health issues to shed more light on the issue.

Poster 29: Psychiatric treatment as an "anti-stigma intervention:" Objective assessment of stigma by families
Authors and organizations: Amresh Shrivastava, University of Western Ontario, Department of Psychiatry, CA, and Mental Health Resource Foundation, IN; Megan Johnston, University of Toronto, Department of Psychology, CA; Nilesh Shah, University of Mumbai, Department of Psychiatry, IN; Shubhangi Parkar, KEM Hospital and Seth GS Medical College, IN

Summary: This study, carried out in Mumbai, India, assessed the perception of stigma in relatives of people with mental disorders. Almost all relatives felt the roots of stigma lay in unawareness, family and social factors. The study highlights the need for better treatment programs and access to care for anti-stigma intervention.

Poster 30: Youth mental health awareness study, a randomized controlled trial (RCT)
Authors and organizations: Robert Milin, The Royal Ottawa Mental Health Centre, Institute of Mental Health Research, University of Ottawa, CA; Natasha Ferrill, The Royal Ottawa Mental Health Centre, Institute of Mental Healthcare Research, University of Ottawa, CA
Summary: A youth mental health awareness (YMHA) study evaluated the effectiveness of a new mental health curriculum titled: Mental Health and High School Curriculum Guide: Understanding Mental Health and Mental Illness. It involved participants from 30 high schools in the Ottawa Region during the 2011–12 school year and included novel aspects such as the use of eLearning education modules and online follow-up.

Poster 31: Beyond silence: Building support for peer education in a healthcare workplace
Authors and organizations: Sandra Moll, School of Rehabilitation Science, McMaster University, CA; Susan Jakobson, MaryAnn Baynton and Associates, CA
Summary: This presentation highlighted findings from the first phase of a project designed to develop a peer-led education program within a large, multi-site healthcare facility. Analysis revealed key issues to consider in addressing stigma and facilitating change in the way a healthcare organization responds to workers with mental health issues.

Poster 32: Changes in attitude toward individuals with mental illness—Changes over 27 years
Authors and organizations: Syuuichi Okuno, Department of Nursing, Faculty of Nursing and Rehabilitation, AINO University, JP; Hiroko Hashimoto, Department of Occupational Therapy, Faculty of Nursing and Rehabilitation, AINO University, JP; Masako Shirai, Department of Occupational Therapy, Faculty of Nursing and Rehabilitation, AINO University, JP; Manabu Ashikaga, Department of Occupational Therapy, Faculty of Nursing and Rehabilitation, AINO University, JP; Eiichi Nakanishi, Department of Occupational Therapy, Faculty of Nursing and Rehabilitation, AINO University, JP; Kiyohisa Takahashi, Japan Foundation for Neuroscience and Mental Health, JP
Summary: An internet survey was used to examine the attitudes of adults in Japan toward mental illness. This was compared to results of the same survey conducted 27 years earlier. In general, the results demonstrated a significant favourable change in attitudes, with the younger generation (age 20–40) showing a more positive attitude than older participants. In consideration of these findings, it may be necessary to design effective educational programs for specific age groups.

Poster 33: Working with the whole picture: Using PhotoVoice to address stigma in the workplace
Author and organization: Lisa S. Jamieson, Canadian Mental Health Association, Ottawa Branch, CA
Summary: This presentation highlighted the Working with the Whole Picture project, a bilingual photo and narrative exhibit created by people with lived experience. The intention was to open a dialogue with the community, policy-makers and employers about work opportunities for people with lived experience.

Poster 34: Adolescents' attitudes and behavioural intentions toward hypothetical peers with psychological problems: Implications for public stigma
Authors and organizations: Felicia A. Meyer, Concordia University, CA; William M. Bukowski, Concordia University, CA; Diana Raufelderï, Freie University, DE; Joseph A. Carpini, Concordia University, CA; Jonathan B. Santo, University of Nebraska at Omaha, US
Summary: This project presented findings of a mixed-method study examining early adolescents' levels of liking and helping towards peers hypothetically exhibiting symptoms of psychopathology. The findings help shed light on youths' tendency to shun peers with deviant behaviour and enhance the understanding of the development of mental illness stigma.

Poster 35: Explicit and implicit stigma towards peers with mental health problems in childhood and adolescence
Authors and organizations: Claire O'Driscoll, National University of Ireland, IE; Caroline Heary, National University of Ireland, IE; Eilis Hennessy, University College Dublin, IE; Lynn McKeague, University College Dublin, IE
Summary: This study explored patterns of explicit and implicit stigmatization of youth peers with depression and attention deficit hyperactivity disorder (ADHD). Data indicated that youth with ADHD were perceived more negatively than those with depression in all dimensions of stigma except perceived dangerousness and fear. The findings advance understanding of stigma and provide avenues for future research on implicit cognition towards peers with mental health problems.

Poster 36: Stigma towards mental illnesses amongst nursing students in India
Authors and organizations: Ranjive Mahajan, Dayanand Medical College and Hospital, IN; Navkiran Mahajan, Dayanand Medical College and Hospital, IN; Suresh Sharma, College of Nursing, IN

Summary: A study conducted in India divided 100 nursing students into two groups: one of entry-level students and one of students who had undergone a rotation posting in psychiatry. The entry-level students showed a significantly higher stigma level in the areas of responsibility for illness, shame, heredity and labelling. This indicates that intervention in terms of proper education and training in nursing students can bring down the stigma towards mental illness.

Poster 37: Work is too hard? Mental disorders and recovery when employment is involved (FRENCH)
Author and organization: Noémie Charles, *Ordre des travailleurs sociaux et des thérapeutes conjuguaux et familiaux du Québec (OTSTCFQ),* CA
Summary: This study sought to prove that people with serious mental disorders can be employed in competitive markets and that employment would help in their recovery.

Poster 38: Software to apply the *GB Equality Act 2010* to people with mental illness
Authors and organizations: Claire Henderson, King's College London, GB; Padmaja Sasidharan, King's College London, GB; Graeme Lockwood, King's College London, GB; Jeroen Keppens; Elaine Brohan; Mike Slade, King's College London, GB; Andre Tylee; Graham Thornicroft; Catherine Marshall; Michael Fairweather; Andrew Jones, King's College London, GB[7]
Summary: The aim of this project was to create and test a computer-based system to inform laypeople about whether a job applicant satisfies the test of disability according to the UK Equality Act*, and the legal implications of disclosing a mental illness based on this act. The goal was to increase access to employment for people with mental illness.*

Poster 39: Correlation between homophobia and racism in medical students in Colombia
Authors and organizations: Edwin Herazo, Human Behavioural Research Institute, CO; Adalberto Campo-Arias, Human Behavioural Research Institute, CO; Heidi C. Oviedo, Human Behavioural Research Institute, CO
Summary: The purpose of this study was to estimate the correlation between homophobia and racism among medical students in Colombia. Results indicated a need for interventions to reduce prejudice in medical students, thus improving the care of patients.*

Poster 40: Experiences of discrimination among Colombian medical students
Authors and organizations: Edwin Herazo, Human Behavioural Research Institute, CO; Heidi C. Oviedo, Human Behavioural Research Institute, CO; Adalberto Campo-Arias, Human Behavioural Research Institute, CO
Summary: The purpose of this study was to estimate the frequency of discrimination among medical students in Bucaramanga, Colombia. Results revealed that almost one-quarter of medical students had experienced discrimination, especially Afro-Colombians and males.*

Poster 41: The Opening Doors project: Strengthening, fostering and cultivating healthier communities in Ontario
Authors and organizations: Renee Ferguson, Canadian Mental Health Association, Toronto Branch, CA; Carolina Berinstein, Canadian Mental Health Association, Toronto Branch, CA
Summary: The Opening Doors project builds capacity within newcomer and host communities by promoting the strengthened participation of immigrants through a group of peer facilitators, by increasing anti-discrimination literacy in host communities and by increasing mental health and anti-discrimination literacy among newcomer communities.*

Poster 42: Parlez! Key messages from children, young people and parents about mental health stigma and help-seeking
Authors and organizations: Fiona Jean Warner-Gale, Associate Development Solutions, University of Northampton, GB; Jane Sedgewick, Associate Development Solutions, University of Northampton, GB
Summary: This presentation explored the literature around mental health stigma and help-seeking in children and young people. Children and parents are clear about their experiences of discrimination and how they are impacted by them in their daily lives.*

Poster 43: Mental illness stigma and its impact on help-seeking: A multidimensional phenomenon?
Authors and organizations: Elise Pattyn, Ghent University, BE; Piet Bracke, Ghent University, BE
Summary: This study revealed that self-stigmatization is associated with reluctance to seek help from a psychiatrist, family or friends. Future research should devote more attention to the measurement of help-seeking intentions, differentiating between professional and lay caregivers.*
Poster 44: Comparison of the prevalence of mood and anxiety disorders in Canada between self-report and administrative data

Authors and organizations: Saskia Vanderloo, Public Health Agency of Canada, CA; Louise McRae, Public Health Agency of Canada, CA; Jay Onysko, Public Health Agency of Canada, CA
Summary: The aim of this study was to compare trends in prevalence of mental disorders identified with self-assessment and administrative data. Findings revealed negative attitudes toward personal disclosure of mental illness, however, the prevalence of this self-stigma decreased over time, suggesting perspectives surrounding mental illness are improving.

Poster 45: Facing Facts: Tackling the stigma of mental illness
Author and organization: Melanie Goroniuk, University of Alberta, CA
Summary: Facing Facts is an initiative launched at the University of Alberta to destigmatize mental illness using information, practical tools and resources. In addition, staff and individuals in leadership roles are trained in the Mental Health First Aid program by way of focused workshops and discussion sessions. This initiative continues to develop strategies to more effectively reach students and staff.

Poster 46: Reducing stigma in individuals with serious mental illnesses: The potential of genetic counselling as an anti-stigma intervention
Authors and organizations: Catriona Lynne Hippman, Department of Psychiatry, University of British Columbia and Women's Health Research Institute, B.C. Women's Hospital and Health Centre, CA; Angela Ingles, Department of Psychiatry, University of British Columbia, CA; Andrea Ring Rose, Department of Psychiatry, University of British Columbia, CA; Joanna Cheek, Department of Psychiatry, University of British Columbia, CA; Arianne Albert, Women's Health Research Institute, B.C. Women's Hospital and Health Centre, CA; Jehannine C Austin, Department of Psychiatry, University of British Columbia and Department of Medical Genetics, CA
Summary: In this study, researchers evaluated the efficacy of generic counselling as an anti-stigma intervention. There was some evidence that providing information on causes of serious mental illness can reduce levels of internalized stigma, but further research on a larger scale is warranted.

Poster 47: Best practices for interventions addressing intergenerational trauma in Aboriginal (Indigenous) youth: A scoping review
Authors and organizations: Amrita Roy, University of Calgary, CA; Raheem Noormohamed, University of Calgary, CA; Wilfreda Thurston, University of Calgary, CA
Summary: This scoping review of peer-reviewed academic literature and "grey" sources examined best practices for addressing mental illness stigma in Aboriginal (Indigenous) youth due to the legacy of residential schools and other consequences of colonization, and concluded it cannot be successfully addressed without attending to racism, exclusion and ignorance. The review suggested that more research is warranted on evidence-based practices, though promising practices were noted.

Poster 48: The impact of news stories on the stigma of mental illness
Authors and organizations: Karina J. Powell, Illinois Institute of Technology, US; Patrick Michaels, Illinois Institute of Technology, US; Patrick W. Corrigan, Illinois Institute of Technology, US
Summary: Efforts to enhance journalistic responsibility surrounding mental health stigma and discontinue use of language that perpetuates prejudice have existed for many years with limited evaluation of the effects of these endeavours. Drawing on results of a demographic questionnaire given to adult participants, this evaluation concluded that recovery-based articles seem to have positive effects but other projects attempting to challenge the status quo of the public mental health system may make stigma worse.

Poster 49: Knowledge of childhood mental illnesses amongst school teachers in India
Authors and organizations: Navkiran Mahajan, Dayanand Medical College and Hospital, IN; Ranjive Mahajan, Dayanand Medical College and Hospital, IN
Summary: To assess knowledge of childhood mental illness and stigma among school teachers in India, this study of 90 teachers revealed the need for increased knowledge and awareness of mental health issues as a first step in tackling stigma.

Poster 50: Experienced stigmatization in children and adolescents treated for psychosis. The TEA trial: Tolerance and effect of antipsychotics in children and adolescents with psychosis
Authors and organizations: Dea Klauber, Mental Health Centre for Child and Adolescent Psychiatry, Copenhagen University Hospital, DK; Anders Fink-Jensen, Mental Health Centre Copenhagen, Copenhagen University Hospital, DK; Karsten Gjessing Jensen, Mental Health Centre for Child and Adolescent Psychiatry, Copenhagen University Hospital, DK; Ditte Rudå, Mental Health Centre for Child and Adolescent Psychiatry, Copenhagen University Hospital, DK; Marie Stentebjerg-Olesen, Mental Health Centre for Child and Adolescent Psychiatry, Copenhagen University Hospital, DK; Pia Jeppesen, Mental Health Centre for Child and Adolescent Psychiatry, Copenhagen University Hospital, DK; Norman Sartorius, Association for the Improvement of Mental Health Programmes, CH; Marianne Kastrup, Mental Health Centre Copenhagen, Copenhagen University Hospital, DK; Christian Gluud,

Copenhagen Trial Unit, Copenhagen University Hospital, DK; Christoph U. Corell, Zucker Hillside Hospital, US; Birgitte Fagerlund, Lundbeck Foundation Centre for Clinical Intervention and Neuropsychiatric Schizophrenia Research, Copenhagen University Hospital, DK; Jens Richardt Möllegaard Jepsen, Lundbeck Foundation Centre for Clinical Intervention and Neuropsychiatric Schizophrenia Research, Copenhagen University Hospital, DK; Katrine Pagsberg, Mental Health Centre for Child and Adolescent Psychiatry, Copenhagen University Hospital, DK
Summary: Part of the Tolerance and Effect of Antipsychotics in Children and Adolescents with Psychosis (TEA) trial, this pilot study conducted in March and April 2012 aimed to explore the perception of stigmatization associated with pharmacologically treated psychosis and the associations to clinical features in children and adolescents aged 12–17 with first-episode psychosis. It is anticipated that the main proportion of probands has experienced stigmatization due to their psychotic illness, and that the pattern and severity of stigma will be related to the severity of illness, the treatment response, stigmatizing side effects of medication, cognitive functioning and the overall quality of life.

Poster 51: Multi-layered approach to addressing and reducing stigma
Author and organization: Darryl C. Mathers, Kinark Child and Family Services, CA
Summary: To address and reduce stigma in children's mental health, the communications team at Kinark Child and Family Services has employed a multi-layered communication strategy—including media campaigns, surveys, online resources and newsletters—aimed at increasing awareness, engagement and advocacy. Results of an evaluation by the research and evaluation department of Kinark Child and Family Services indicate that this strategy is a promising method of visualizing the complex work of the department, evaluating the outcomes of the work and examining gaps in the strategy in order to develop future plans.

Poster 52: Stigma, discrimination and the media: Newspaper coverage of mental illness in England from 2008–2011
Authors and organizations: Amalia Thornicroft, King's College London, Institute of Psychiatry, GB; Robert Goulden, King's College London, Institute of Psychiatry, GB; Guy Shefer, King's College London, Institute of Psychiatry, GB; Danielle Rhydderch, King's College London, Institute of Psychiatry, GB; Diana Rose, King's College London, Institute of Psychiatry, GB; Paul Williams, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB; Claire Henderson, King's College London, Institute of Psychiatry, GB
Summary: This study compared English newspaper coverage of mental health-related topics over the course of the 2009–2011 Time to Change anti-stigma campaign. It found a significant increase in the proportion of anti-stigmatizing articles between the baseline year of 2008 and the conclusion of the campaign, with no proportional significant decrease in stigmatizing articles over the same period—indicating that the combined contribution of mixed and neutral elements decreased.

Poster 53: Individual and neighborhood predictors of stigmatizing attitudes toward mental illness in New York State
Authors and organizations: Lauren Gonzales, John Jay College & the Graduate Center, City University of New York (CUNY), US; Ginny Chan, John Jay College of Criminal Justice and the Graduate Center, CUNY, US; Philip Yanos, John Jay College of Criminal Justice, CUNY, US
Summary: While current literature discusses stigmatizing attitudes in the general public, this study examined demographic and neighbourhood correlations associated with holding stigmatizing opinions, using data from the Pulse of New York State Survey. Results showed that lower stigma rates were related to high education while conservative ideology and a higher neighbourhood disadvantage revealed higher stigma rates.

Poster 54: Time to Challenge: Challenging workplace related mental health stigma and discrimination
Authors and organizations: Estelle Malcolm, King's College London, Institute of Psychiatry, GB; Sara Evans-Lacko, King's College London, Institute of Psychiatry, GB; Claire Henderson, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB
Summary: England's Time to Change campaign website includes a Time to Challenge subpage focused on people's legal right to be treated fairly in the workplace. The website provides information on legal rights and responsibilities for employers in relation to working with employees with mental health problems, tips for managing stress in the workplace and advice on how and when to disclose mental health problems.

Poster 55: Mental Health First Aid training: An examination of two cases—healthcare professionals and corporate workplace employees
Authors and organizations: Nicola Michaud, Mental Health Commission of Canada, Mental Health First Aid (MHFA) Canada, CA; Julia Arndt, Mental Health Commission of Canada, Knowledge Exchange Centre, CA
Summary: To determine the effectiveness of Mental Health First Aid training programs in improving mental health literacy, MHFA Canada undertook an evaluative study that revealed the need for MHFA training to be undertaken in multiple settings beyond healthcare, and to include a greater focus on other settings such as corporate workplaces.

Poster 56: Understanding Stigma: Building organizational capacity and driving sustainable change

Authors and organizations: Sylvia Starosta, Central Local Health Integration Network (LHIN), CA; Lori Kerr, Central LHIN, CA
Summary: *Building on the success of a previous version—identified by the Mental Health Commission of Canada as a promising best practice—the Understanding Stigma project is designed to address stigma and discrimination toward mental illness and addiction among healthcare providers in the LIHN in Ontario. This presentation shared the results of primary and acute healthcare pilot sites where people with lived experience discuss the impact of stigma and what made a difference in their recovery, which fostered less stigmatizing attitudes after training.*

Poster 57: Community psychiatric service users' experiences of discrimination in relation to parenting: A framework analysis
Authors and organizations: Sarah Clement, King's College London, Institute of Psychiatry, GB; Debra Jeffery, King's College London, Institute of Psychiatry, GB; Elizabeth Corker, King's College London, Institute of Psychiatry, GB; Louise M. Howard, King's College London, Institute of Psychiatry, GB; Joanna Murray, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB
Summary: *This secondary analysis of qualitative data collected to evaluate England's national anti-stigma program aimed to generate a typology of community psychiatric service users' reports of experienced discrimination in relation to becoming or being a parent. This research is the first to demonstrate the ways in which community psychiatric service users can feel unfairly treated by professionals and by people in their personal networks regarding becoming or being a parent.*

Poster 58: Measurement of stigmatizing versus affirming attitudes about mental illness: Psychometrics of a brief outcome battery
Authors and organizations: Karina J. Powell, Illinois Institute of Technology, US; Patrick J. Michaels, Illinois Institute of Technology, US; Patrick W. Corrigan, Illinois Institute of Technology, US
Summary: *The goal of this study was to psychometrically evaluate the reliability and validity of a new battery of affirming attitudes measures for use in mental health anti-stigma programs, with results indicating that measures of affirming attitudes have strong psychometrics.*

Poster 59: Development and testing of a decision aid tool regarding disclosure of mental health status to an employer
Authors and organizations: Elaine Brohan, King's College London, Institute of Psychiatry and Department of Epidemiology and Public Health, University College, GB; Claire Henderson, King's College London, Institute of Psychiatry, GB; Sarah Clement, King's College London, Institute of Psychiatry, GB; Paul Williams, King's College London, Institute of Psychiatry, GB; Francesca Lassman, King's College London, Institute of Psychiatry, GB; Rowena Pagdin, King's College London, Institute of Psychiatry, GB; Oliver Schauman, King's College London, Institute of Psychiatry, GB; Joanna Murray, King's College London, Institute of Psychiatry, GB; Paul McCrone, King's College London, Institute of Psychiatry, GB; Caroline Murphy, King's College London, Institute of Psychiatry, GB; Michael Dewey, King's College London, Institute of Psychiatry, GB; Mike Slade, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB
Summary: *This study described the development and testing of a decision aid tool (DAT) to assist mental health service users in deciding whether to disclose a mental health problem to an employer. The study concluded that the DAT shows initial promise as an educational intervention to assist individuals with a mental health problem in making disclosure decisions, and further testing is planned.*

Poster 60: Qualitative research for the development of a mental health stigma reduction intervention for military personnel
Authors and organizations: Suzanne L. Hurtado, Naval Health Research Center, US; Cynthia M. Simon-Arndt, Naval Health Research Center, US; Jenny A. Crain, Naval Health Research Center, US; Kathleen Onofrio, Naval Health Research Center, US
Summary: *This project aimed to develop a targeted, mental health stigma reduction intervention for a military population through focus groups with military personnel representing a range of ranks and backgrounds, both men and women. Focus group interviews indicated that service members wanted practical tools for talking about difficult stress-related issues. The investigators have developed a plan to evaluate a toolkit for senior enlisted leaders to enhance communication and create a climate in which service members can comfortably seek the help required to improve readiness and functioning.*

Poster 61: How do stigma and discrimination contribute to self–harm and suicidality? A qualitative study
Authors and organizations: Debra Jeffery, King's College London, Institute of Psychiatry, GB; Sarah Clement, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB; MIRIAD Study Group, King's College London, Institute of Psychiatry, GB
Summary: *Part of the Mental Illness Related Investigations on Discrimination (MIRIAD) project in the SAPPHIRE Research Programme on Stigma and Discrimination in Mental Health, this exploratory study investigated how stigma*

and discrimination might contribute to self-harm and suicidality through interviews with outpatients diagnosed with depression, bipolar disorder or schizophrenia. From the data collected to date, 61% reported stigma or discrimination had contributed to them harming themselves or to suicidal thoughts or actions.

Poster 62: Does stigma present a barrier to seeking professional care in black and white ethnic groups?

Authors and organizations: Jheanell T. Gabbidon, King's College London, Institute of Psychiatry, GB; Sarah Clement, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB; MIRIAD Study Group, King's College London, Institute of Psychiatry, GB

Summary: Research suggests individuals from black ethnic groups have less desirable pathways into care than those from white ethnic groups, and that some barriers to seeking professional care may be related to ethnicity. This exploratory study sought to investigate whether there are any ethnic differences regarding stigma-related and non-stigma-related barriers to mental health help-seeking by interviewing service users of community mental health teams in South London taking part in the Mental Illness Related Investigations on Discrimination (MIRIAD) study.

Poster 63: Demystifying mental health treatment for military personnel

Authors and organizations: Suzanne L. Hurtado, Naval Health Research Center, US; Cynthia M. Simon-Arndt, Naval Health Research Center, US; Jenny A. Crain, Naval Health Research Center, US; Kathleen Onofrio, Naval Health Research Center, US

Summary: This project is part of a larger effort to develop a targeted mental health stigma reduction toolkit that aims to prevent the potentially harmful consequences of untreated stress injuries on individual service members and overall mission readiness. Investigators developed a video designed to reduce stigma surrounding mental health treatment by humanizing mental health practitioners and demystifying their work. This video will be evaluated as part of the larger evaluation of the complete toolkit.

Poster 64: Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace

Authors and organizations: Elaine Brohan, King's College London, Institute of Psychiatry, GB; Claire Henderson, King's College London, Institute of Psychiatry, GB; Kay Wheat, Nottingham Trent University, Nottingham Law School, GB; Estelle Malcolm, King's College London, Institute of Psychiatry, GB; Sarah Clement, King's College London, Institute of Psychiatry, GB; Elizabeth A. Barley, King's College London, Institute of Psychiatry, GB; Mike Slade, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB

Summary: Drawing from a systematic review of the period 1990–2010, this paper examined evidence on employment-related disclosure beliefs and behaviours of people with mental health problems. By presenting evidence from the perspective of individuals on both sides of the employment interaction, this review gives an integrated perspective on the impact of disclosure of a mental health problem on employment outcomes.

Poster 65: First Episode Discrimination Outcomes Research Assessment (FEDORA): Experience of stigma and discrimination by people with a first episode of schizophrenia or depression; a European collaborative study

Author and organization: Elizabeth Ann Corker, King's College London, Institute of Psychiatry, GB; Graham Thornicroft, King's College London, Institute of Psychiatry, GB; Norman Sartorius, Association for the Improvement of Mental Health Programmes, CH

Summary: This study investigated the extent of stigmatization and discrimination against people experiencing their first episode of depression or schizophrenia using the Discrimination and Stigma Scale (DISC), and involved 375 participants across 11 countries. The first set of FEDORA results focus on the comparisons between countries and diagnoses in terms of experienced discrimination in numerous life areas and anticipated discrimination.

Poster 66: Development and psychometric properties of a questionnaire to measure children's stigmatizing perceptions of peers with emotional and behavioural problems

Authors and organizations: Lynn McKeague, University College Dublin, IE; Eilis Hennessy, University College Dublin, IE; Caroline Heary, National University of Ireland, IE; Claire O'Driscoll, National University of Ireland, IE

Summary: Of major pragmatic importance to researchers working in children's mental health is the availability of developmentally appropriate measures to capture children's attitudes toward others who face mental health problems. This study examined children's awareness of the negative beliefs about youth with mental health problems that are held by members of their society, and their personal endorsement of those negative beliefs.

Poster 67: Promoting mental health awareness and stigma reduction through meaningful youth engagement

Author and organization: Erin Smith, Children's Hospital of Eastern Ontario, Ontario Centre of Excellence for Child and Youth Mental Health, CA

Summary: Available to Ontario schools, community-based child and youth mental health agencies and youth organizations, the Dare to Dream program fosters community and youth engagement by allowing youth to team with

adult members in their schools and communities to raise the profile of mental health issues and reduce stigma. To date, 21,538 youth have participated in the program, over 566 youth have received awards and an estimated 53,500 have been impacted by projects sponsored by the program.

Poster 68: Psychiatric nursing students' attitudes towards people experiencing mental illnesses: Implications for emotional and cultural response
Author and organization: Abeer Abdelhameed Selim, College of Nursing Riyadh, King Saud bin Abdul Aziz University for Health Sciences, SA; Eman Salah Dawood, College of Nursing Riyadh, King Saud bin Abdul Aziz University for Health Sciences, SA
Summary: This study aimed to explore Saudi psychiatric nursing students' attitudes toward mental illness in the context of their feelings and cultural background, collecting data from 52 female students with a mean age of 22.7 years. While the study concluded that students' positive attitudes toward people with mental illness is attributed to the psychiatric nursing educational course, the students reported that current Saudi cultural prejudice fosters stigma of mental illness.

Poster 69: Theatre as an anti-stigma intervention for bipolar disorder: Live or DVD?
Authors and organizations: Lisa D. Hawke, University Health Network, CA; Sagar Parikh, University Health Network & University of Toronto, CA; Erin Michalak, Department of Psychiatry, University of British Columbia, CA
Summary: This pilot study examined a unique narrative, dramatic intervention, which was recorded to DVD and illustrates how internalized and public stigma manifests and its impact in reducing stigma against bipolar disorder. Twenty-one participants with bipolar disorder or family members living with it attended an initial viewing of the DVD; a majority responded with a positive evaluation, confirming the validity of DVDs as a means of disseminating this arts-based stigma reduction intervention.

Poster 70: Stigma in women who use substances during pregnancy
Authors and organizations: Michelle Foulkes, Children's Hospital of Eastern Ontario and University of Ottawa, CA
Summary: There is no other collective of women more stigmatized or thwarted than mothers who use substances during pregnancy (Greaves and Poole, 2007), but research has indicated that as many as two-thirds of women with substance use problems have a concurrent mental health disorder such as depression, post-traumatic stress disorder, panic disorder and/or and eating disorder that they are struggling to manage, often through their addictions (Canadian Association of Mental Health, 2007).

Poster 71: Bridging Minds: Mount Sinai Hospital anti-stigma event
Authors and organizations: Marci Rose, Mount Sinai Hospital, CA; Ellen Bateman, Ryerson University, CA; Allison Hughes, Mount Sinai Hospital, CA; Christopher McEnroe, CA
Summary: Centred on a series of first-person videos that recreate the symptoms and experiences of mental illness, the Bridging Minds event at Ryerson University in February 2012 generated considerable discussion in the public sphere about mental illness, and received tremendous praise and interest from both the medical and mental health communities. Mount Sinai Hospital hopes to build on the success of this event making it the first healthcare organization to host Bridging Minds, and will conduct an evaluation on its impact and reach of this event through a questionnaire.

Poster 72: Wellness through PhotoVoice
Author and organization: Christa Mullaly, The Cleaning Solution Society (TCS), Royal Roads University, CA
Summary: As part of its responsibility to provide access to a supportive niche of services that enable employees to stay healthy and to thrive in a mainstream work environment, The TCS adopted the use of PhotoVoice to promote the self-sufficiency, health and wellbeing of its employees living with mental illness. While data collected from focus groups on the effectiveness of this initiative was not fully interpreted at the time of this presentation, initial feedback indicates the use of PhotoVoice has had a positive impact on the overall holistic health of TCS employees living with mental illness.

Poster 73: The relationship of religiosity to occupational stress, coping resources and psychological strain in academic settings
Authors and organizations: Maria Helena Suprapto, Pelita Harapan University, Faculty of Psychology, ID; Novia Ling, Pelita Harapan University, Faculty of Psychology, ID; Liza Nelloh, Pelita Harapan University, Business School, ID
Summary: Undertaken at the Christian Pelita Harapan University, this study aimed to determine the relationships between religiosity, occupational stress, coping resources and psychological strain among the university's staff. Results supported the hypothesis that high religiosity helps people deal with occupational stressors more effectively, which led to the recommendation that the university maintain a religious climate and recruit employees who have high religiosity.

Poster 74: Adolescent Mental Health Literacy Program
Author and organization: Susan Nakhle, Ontario Shores Centre for Mental Health Sciences, CA
Summary: Adolescents with unidentified mental health disorders are in poorer physical health, engage in higher risk behaviours and are at a higher risk of committing suicide than their peers. Adopted by eight school boards and more than 85 schools to date, the Adolescent Mental Health Literacy Program seeks to address these issues by raising awareness of youth mental illness, facilitating early recognition of adolescents' mental health needs and enhancing capacity for evidence-based mental health interventions in the primary care sector.

Poster 75: Music talks about mental health. So can you.
Authors and organizations: Pui San Whittaker, Mental Health Commission of Western Australia, AU
Summary: Using multimedia strategies that include CD/DVDs, social marketing, documentaries and song competitions, the Mental Health Commission of Western Australia's Music Feedback campaign connects musicians with youth to demystify how mental health services and peer networks support recovery. As a public education strategy, Music Feedback targets at-risk groups and enhances early intervention for better long-term health and social outcomes. On a policy level, this program aligns with national youth mental health reforms, the Commission's Mental Healthcare 2020 strategic policy and the State Suicide Prevention Strategy.

Poster 76: Children's mental healthcare—Making it a priority in sport and recreation
Author and organization: L.J. Bartle, Parks and Recreation Ontario, CA
Summary: Founded by Parks and Recreation Ontario, HIGH FIVE® is Canada's only quality standard for children's sport and recreation. This presentation highlighted HIGH FIVE®'s new leading-edge training, Healthy Minds for Healthy Children, which was designed for coaches and recreation providers seeking sport-based engagement strategies for common mental health distress or disorders in children aged 6–12.

Poster 77: Journey to Promote Mental Health: Anti-stigma training for settlement workers
Authors and organizations: Helen Lai Man Poon, Hong Fook Mental Health Association, CA; Phillip Chan, Hong Fook Mental Health Association, CA; Maria Lo, Hong Fook Mental Health Association, CA
Summary: Supported by Citizenship and Immigration Canada, the Hong Fook Mental Health Association's Journey to Promote Mental Health is a two-day training series that aims to raise awareness and challenge assumptions among immigrant settlement workers who serve individuals living with mental illness. This project has reached over 700 front-line workers from 250 community agencies across Ontario; pre-and post-training questionnaires show increased knowledge of mental health issues, detection methods and coping strategies.

Poster 78: Real Conversations in Mental Wellness – How to reduce stigma in mental illness
Authors and organizations: Cille Harris, University of Waterloo, CA; Maya Bobrowska, University of Toronto, CA
Summary: A community of professional facilitators, consultants and coaches committed to promoting healthier citizens called Real Conversations in Mental Wellness held its first experiential workshop in January 2012 at the Canadian Mental Health Association. This presentation highlights the event's conversations between mental health professionals surrounding stigma reduction, respect for all individuals, awareness of issues among all ages and an integrated approach to developing initiatives.

Poster 79: Challenges facing community psychiatry for people with severe mental illness: Overcoming the stigma
Author and organization: Catia Carina Teixeira, Kings College London, Institute of Psychiatry, GB
Summary: Despite progress in deinstitutionalizing people with severe mental illness, the shift to community-based psychiatry still experiences several barriers to establishing care in the community and integrating these patients into the mainstream—namely stigmatizing attitudes and discrimination. In reviewing a selection of key literature on the stigma of mental illness, this presentation concluded that more interventions are needed to tackle negative attitudes in both healthcare professionals and the public.

Poster 80: Narratives behind the stigma of mental illness
Author and organization: Robert B. Beedle, Illinois Institute of Technology, US
Summary: This presentation argued that a narrative approach to stigma reduction would promote developing culturally sensitive, population-based counter-narratives to effectively alter attributions of blame and responsibility, given that attitudes towards mental health vary drastically across the globe. Focusing on narrative allows researchers to provide insights on developing effective tools to reduce stigmatizing beliefs using details into different perceptions between age cohorts, political affiliations and religion.

Poster 81: Cognitive resources and judgments of pity
Author and organization: Robert B. Beedle, Illinois Institute of Technology, US
Summary: Aiming to examine the effects of cognitive load as well as the disclosure of being diagnosed with autism spectrum disorder, this study expanded on others indicating that disclosure significantly alters public perceptions of

behaviour. After viewing a vignette of an adult male with autism behaving inappropriately, participants completed an attribution questionnaire. Findings suggested that cognitive resources are related to judgments of pity separate from disclosure or other stigma-related attitudes such as blame or anger.

Poster 82: Student mental health and stigma: The teacher perspective

Authors and organizations: Pauline J. Theoret, Canadian Teachers' Federation, CA; Bob A. McGahey, Canadian Teachers' Federation, CA

Summary: The Canadian Teachers' Federation conducted a national survey of teachers to gather their perspectives on mental health and stigma in schools, and found that close to 70% of teachers strongly or somewhat agreed stigma is a barrier to mental health provision in their schools. These statistics—including the fact that most mental illnesses begin in adolescence or early adulthood—highlight the need for continued mental health anti-stigma initiatives in schools.

Poster 83: The impact of stigma on the lived experience of youth with a mental illness taking anti-psychotic medications

Authors and organizations: Jennifer Slater, Dalhousie University, CA; David Gardner, Dalhousie University, CA; Jeannie Hughes, Dalhousie University and IWK Health Centre; CA; Andrea Murphy, Dalhousie University, CA; Stan Kutcher, Dalhousie University and IWK Health Centre, CA; Steve Kisely, University of Queensland, AU

Summary: To explore the concept of stigma and youth on prescribed antipsychotics, a literature review was conducted using PubMed and PsychINFO® databases in addition to the Mental Health Commission of Canada's reference list. After analyzing 76 citations, it was concluded that very little published information describes the actual experiences of youth taking such medications, and findings suggested youth experience stigmatization differently than adults—supporting the need for continued study of youth.

Poster 84: Emergent forms of stigma within the recovery paradigm

Authors and organizations: Doerte Bemme, Douglas Mental Health University Institute, CA; Duncan Pedersen, Douglas Mental Health University Institute, CA

Summary: Part of a larger ongoing epidemiologic catchment area (ECA) study in Montreal-Southwest, this presentation explored how the ongoing de-institutionalization of psychiatric services, the development of community-based structures and the emphasis on recovery in the provision of mental healthcare have significantly changed the ways and settings in which health professionals and mental health clients engage with one another.

Poster 85: Evaluation of the Progress Place anti-stigma training intervention with University Health Network healthcare providers

Authors and organizations: Marion Patricia Olmsted, University Health Network and University of Toronto, CA; Jan Lackstrom, University Health Network and University of Toronto, CA; Dorothy Luong, University of Toronto, CA; Krysia Theriault, University Health Network, CA; Criss Habal-Brosek, Progress Place[8]; Brenda Singer, Progress Place, CA; Chris Whittaker, Progress Place, CA; David Lord, Progress Place, CA; Dimitri Garvis, Progress Place, CA; David Richards, Progress Place, CA; Heather Stuart, Queen's University, CA; Andrew Szeto, Mental Health Commission of Canada and University of Calgary, CA

Summary: This study looked at the effect on healthcare provider attitudes, considering that some have an unintended negative influence on patients with mental illness. Developed by Progress Place staff with stigma and recovery model expertise, measures included the Attitudes about Mental Illness Questionnaire and the Words That Come to Mind Questionnaire, which indicated a decrease in stigmatizing attitudes post-workshop.

Poster 86: Service utilization and barriers to care among high-risk youth in British Columbia

Authors and organizations: Gillian K. Watson, Simon Fraser University, CA; Marlene M. Moretti

Summary: Part of a larger, longitudinal project examining gender and aggression among high-risk youth in British Columbia, this study assessed mental health profiles of participants during adolescence and later in young adulthood. Many youth with mental health concerns reported at least one barrier to accessing services, such as not wanting services, being embarrassed or feeling stigmatized—making a compelling case for improving the system, especially as they transition to young adulthood.

Poster 87: Together against stigma: The essential services of crisis lines

Authors and organizations: Akhila Blaise, Crisis Intervention and Suicide Prevention Centre of British Columbia, CA; Liz Robbins, Crisis Intervention and Suicide Prevention Centre of British Columbia, CA

Summary: Mental health crisis lines, built on the acknowledgment that mental health stigma exists, are not only a crucial point of access for people otherwise unable to start a conversation about mental health and begin receiving the help they require, they also foster healthy attitudes toward mental illness in the communities in which they operate.

Poster 88: The impact of an educational intervention in reducing the stigmatization of attention deficit hyperactivity disorder among Nigerian school teachers
Authors and organizations: Increase Ibukun Adeosun, Federal Neuro-Psychiatric Hospital, NG, Oluwayemi Ogun, Ola Fatiregun, Suraj Adeyemo, Olu Ukenga Owoeye
Summary: To determine the effectiveness of a structured educational intervention in reducing stigma towards children with attention deficit hyperactivity disorder (ADHD) among Nigerian primary school teachers, this study presented 144 such teachers with vignettes, educational leaflets and questionnaires. Baseline assessment revealed high levels of misconceptions about ADHD, with 35.4% of respondents saying they would be unwilling to accept a student with ADHD in their classroom, but negative attitudes were improved when participants were provided with knowledge about the disorder.

Poster 89: Double stigma: Mentally ill offender
Authors and organizations: Malgorzata Opio, Institute of Psychiatry and Neurology, PL; Anna Walczyna-Lesko, Institute of Psychiatry and Neurology, PL; Janusz Heitzman, Institute of Psychiatry and Neurology, PL
Summary: To examine the issue of double stigma caused by both mental illness and being a criminal offender, this presentation analyzed more than 500 forensic psychiatric and psychological opinions on criminal cases. Concluding that psychiatry is a field where subjective assessment still carries error—which may have consequences for offenders with mental illness—it was determined that forensic psychiatrists could not always deliver an opinion or delivered different diagnoses on the same patient.

Poster 90: Attitude to mental illness and HIV/AIDS among Nigerian primary school children: Implications for stigma reduction
Authors and organizations: Increase Ibukun Adeosun, Federal Neuro-Psychiatric Hospital, NG, Oluwayemi Ogun, Ola Fatiregun, Suraj Adeyemo, Olu Ukenga Owoeye
Summary: Since mental illness is inextricably linked to HIV infection as a cause and consequence in Nigeria, many patients experience stigma, especially from youth. To determine youth attitudes towards those with mental illness and those with HIV-AIDS, this study used a comparative survey of Nigerian secondary school students to discover that many were more likely to stigmatize against mental illness, calling for intensive advocacy and anti-stigma campaigns.

Poster 91: Evaluation of a campaign to promote positive attitudes, awareness and help-seeking toward mental health issues among youth and young adults in British Columbia, Canada
Authors and organizations: James Livingston, British Columbia Mental Health and Addiction Services, CA; Andrew Tugwell, British Columbia Mental Health and Addiction Services, CA; Kim Korf-Uzan, British Columbia Mental Health and Addiction Services, CA; Michelle Ciafrone, British Columbia Mental Health and Addiction Services, CA; Connie Coniglio, British Columbia Mental Health and Addiction Services, CA
Summary: Launched in British Columbia in early 2012, the In One Voice campaign aimed to improve knowledge, attitudes and behaviour toward mental health issues among youth and young adults, and to build awareness of mindcheck.ca as a mental health information resource. Evaluated through a survey given to approximately 800 youth aged 13–25 years of age, the campaign's goals were partially achieved: Although exposure to the campaign was not significantly associated with more positive attitudes toward mental health issues, it did significantly increase awareness of mindcheck.ca.

Poster 92: Descriptive epidemiology of stigma against depression in a general population sample in Alberta
Authors and organizations: Trevor Matthew Cook, Faculty of Medicine, Department of Community Health Sciences, University of Calgary, CA; JianLi Wang, Faculty of Medicine, Departments of Community Health Sciences & Psychiatry, University of Calgary, CA
Summary: Using a cross-sectional telephone survey conducted in Alberta in 2006, this study examined stigmatizing attitudes against mental illness that lead to reduced help-seeking behaviour and increased social distance. Results showed that stigmatizing attitudes towards depression differ by demographic characteristics suggesting that men with less education and immigrants should be targets of stigma reduction campaigns[9].

Poster 93: Causation beliefs and stigma against depression: Results from an Alberta general population sample
Authors and organizations: Trevor Matthew Cook, Faculty of Medicine, Department of Community Health Sciences, University of Calgary, CA; JianLi Wang, Faculty of Medicine, Departments of Community Health Sciences & Psychiatry, University of Calgary, CA
Summary: Given that there are no studies examining the relationship between perceived causes and stigma against depression in Canada, this presentation showed results of a cross-sectional telephone survey to study the biological, psychosocial and medical causal beliefs in depression. Conclusive evidence found that 99.1% of respondents

endorsed a psychosocial cause of depression, associated with lower stigma scores, while endorsement of unrelated factors such as allergies led to increased stigma—making the case for the importance of depression literacy in reducing stigma.

Poster 94: Stigmatization, a day-to-day challenge: HMR-ACT model
Authors and organizations: Véronique Wilson, *Hôpital Maisonneuve-Rosemont & Université de Montréal*, CA; Daniel St-Laurent, *Hôpital Maisonneuve-Rosemont & Université de Montréal*, CA; Gabrielle Labrie-Racine, *étudiante à la maîtrise professionnelle en ergothérapie, Université de Montréal*[10], CA

Summary: The Maisonneuve-Rosemont hospital (affiliated with l'Université de Montréal*) has established an assertive community treatment team (ACT) to provide emergency/internal/external continuity of care to mental health patients whose needs cannot be met through regular health services. Illustrating the ACT team's success, this presentation detailed the eight-year progress of a young adult with a dual diagnosis of schizophrenia and addiction who has now improved family and friend relationships and reintegrated socially thanks to psychosocial rehabilitation interventions.*

Poster 95: Working for Recovery
Author and organization: Jacqueline McLay Rankine, Houselink, CA

Summary: Houselink Community Homes—a charitable agency based in Toronto that provides supportive housing to people with mental health issues—helps its members find employment through its Working for Recovery Program. Users of the program say they enjoy their lives more, feel more energetic, are expanding their social networks and are improving their relationships with peers and family.

APPENDIX B

Chairs, Moderators, Presenters, Panellists & Authors

Susan Abbey, University of Toronto; University Health Network; Canadian Psychiatric Association, CA
Tahirah Abdullah, University of Kentucky, US
Increase Ibukun Adeosun, Federal Neuro-Psychiatric Hospital, NG
Suraj Adeyemo
Ravindra Agrawal, Salgaonkar Hospital and Research Centre (SMRC), IN
Sergio Aguilar-Gaxiola, University of California-Davis, US
Kaha Ahmed, CA
Tsuyoshi Akiyama, NTT Medical Center, JP
Arianne Albert, B.C. Women's Hospital and Health Centre, CA
Afia Khanom Ali, University College London, GB
Amanda Allen, SUNY New Paltz, US
Ella Amir, AMI-Quebec Action on Mental Illness, CA
Kelly Anderson, University of British Columbia, CA
Scott Anderson, CA
Erin Anderssen, CA
Trevor Anzai, Ottawa Hospital, On Track, CA
Julio Arboleda-Florez, Queen's University, CA
Julia Arndt, Mental Health Commission of Canada, CA
Ian Arnold, McGill University; Simon Fraser University, CA
Tea Arthur, On Our Own of Maryland, US
Edna Aryee, CA
William Ashdown, Mood Disorders Society of Canada, CA
Manabu Ashikaga, AINO University, JP
Jehannine Austin, University of British Columbia; University of British Columbia, CA
Wendy Azzopardi, Conestoga College Institute of Technology and Advanced Learning, CA
Roger Baggs, Canadian Mental Health Association, CA
Suzanne Bailey, Canadian Forces Health Services Group, CA
Karyn Baker, Family Outreach and Response Program, CA
Catherine Bancroft, Toronto District School Board, CA
Elizabeth Barley, King's College London, GB
L.J. Bartle, Parks and Recreation Ontario, CA
Ellen Bateman, Ryerson University, CA
Nancy Beck, Capital District Health Authority, CA
Edmundo Bejar, Fundación Bipolar Libre, MX
J. Simon Bell, University of Sydney; University of South Australia, AU
Doerte Bemme, Douglas Mental Health University Institute, CA
Carolina Berinstein, Canadian Mental Health Association, CA
Sarah Berry, McGill University, CA
Blair Bigham, St. Michael's Hospital; University of Toronto, CA
Neetesh Biswas, Institute of Mental Health, SG
Dave Blackburn, Canadian Forces Health Services, CA
Akhila Blaise, Crisis Intervention and Suicide Prevention Centre of British Columbia, CA
Yves Blanchette, Regroupement des organismes de base en santé mentale (ROBSM), CA
Maya Bobrowska, CA
Sireesha J. Bobbili, Centre for Addiction and Mental Health, CA
Aguila bono del Trigo, Regional Goverment of Andalusia, ES
Joanne Marie Books, Canadian Mental Health Association, CA
Chris Bovie, Ontario Shores Centre for Mental Health Sciences, CA
Jennifer Boyd, University of California-San Francisco, US
Piet Bracke, Ghent University, BE
Keyna Bracken, McMaster University, CA
Louise Bradley, Mental Health Commission of Canada, CA

Johanne Bratbo, One of Us Campaign, DK
Elaine Brohan, King's College London; University College London, GB
Beth Broussard, George Washington University, US
Celia Brown, MindFreedom International, US
Jennifer Brown, On Our Own of Maryland, US
June Brown, King's College London, GB
Tamara L. Brown, University of Kentucky, US
Blythe Buchholz, Illinois Institute of Technology, US
Florence Budden, Schizophrenia Society of Canada, CA
Catherine Burrows, Fondation Des Maladies Mentales, CA
Peter Byrne, University College London, GB
Elizabeth Cahill, Government of Canada, CA
Adalberto Campo-Arias, Human Behavioral Research Institute, CO
Eugenia Canas, Family Services Thames Valley, CA
Diana Capponi, Centre for Addiction and Mental Health, CA
Dominic J. Carbone, Sussex College, US
Prescilla Carrion, University of British Columbia, CA
Sue Cathcart, Durham Mental Health Services, CA
Shobhana Chakrabarti, MAITRI Mental Health Service, AU
Jennifer Chambers, Empowerment Council, CA
Nicole Chammartin, Canadian Mental Health Association, CA
Ginny Chan, CUNY, US
Phillip Chan, Hong Fook Mental Health Association, CA
Manon Charbonneau, Canadian Psychiatric Association, CA
Carmen Charles, The Dream Team, CA
Noémie Charles, Ordre des travailleurs sociaux et des thérapeutes conjuguaux et familiaux du Québec (OTSTCFQ), CA
Santosh Kumar Chaturvedi, National Institute of Mental Health & Neurosciences, IN
Joanna Cheek, University of British Columbia, CA
Timothy Chen, University of Sydney, AU
Yvonne Chen, McMaster University, CA
Andrea Chester, RMIT University, AU
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Sarah Clement, King's College London, GB
Theresa Claxton, Canadian Mental Health Association, CA
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Jessie Close, Bring Change 2 Mind, US
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Gretchen L. Conrad, Ottawa Hospital, CA
Sherrill Conroy, University of Alberta, CA
Trevor Matthew Cook, University of Calgary, CA
Marc Corbière, Université de Sherbrooke, CA
Raymond Corby, Combat Training Centre, CA
Christoph U. Corell, Zucker Hillside Hospital, US
Elizabeth Ann Corker, Kings College London, GB
Patrick Corrigan, Illinois Institute of Technology, US
Gilles Côté, Institut Philippe Pinel de Montréal, CA

Jenny A. Crain, Naval Health Research Center, US
Anne G. Crocker, McGill University, CA
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Layla Dabby, McGill University; Canadian Psychiatric Association, CA
Tamara Daily, University of Mount Union, US
Marian Dalal, Family Outreach and Response Program, CA
Julie Daly, Ottawa Hospital, CA
Mehdi Damaliamiri, Bu-Ali Sina University, IR
Anders Dannevang, Copenhagen University, DK
Tim David Darvell, Vancouver Coastal Health, CA
Sylvain d'Auteuil, Les Porte-Voix du Rétablissement, CA
Simon Davidson, CA
Eman Salah Dawood, King Saud bin Abdul Aziz University for Health Sciences, SA
Sanjai Miika Olavi Dayal, Ben Gurion University of the Negev, IL
Sheila Deighton, Schizophrenia Society of Ontario, CA
Jane De Jong, Alzheimer Society of Canada, CA
Meagan De Jong, University of Lethbridge, CA
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Michael Dewey, King's College London, GB
Amy Kendry Deyell, Juris Doctor Student, Dalhousie University, CA
John Dick, CA
Catherine Dion, Hôpital Louis-H. Lafontaine, CA
Keith S. Dobson, University of Calgary, CA
Tamara Grace Dube, North Bay Regional Health Centre, CA
John Eastwood, York University, CA
Tanya Eng, US
Esther Enkin, CBC News, CA
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Birgitte Fagerlund, Copenhagen University Hospital, DK
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Harvey Goldberg, Canadian Human Rights Commission, CA

David Gollob, Canadian Human Rights Commission, CA
Lauren Gonzales, CUNY, US
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Robert Goulden, King's College London, GB
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Elaine Gradidge, United Nurses of Alberta, CA
Tanya Graham, GB
James Graves, Mental Illness Foundation, CA
Sylvie Guenther, Centre for Addiction and Mental Health, CA
Kim Guest, Canadian Forces Health Services Group, CA
Mary Haase, MacEwan University, CA
Julie Hagedorn-Moeller, Copenhagen University, DK
Yoko Hamamitsu, JP
Sarah Hamilton, GB
Jane Elizabeth Hamilton Wilson, University of Alberta, CA
Dawnmarie Harriott, CA
Cille Harris, University of Waterloo, CA
Hiroko Hashimoto, AINO University, JP
Robert Hassel, Edmonton Police Service, CA
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Stephani L. Hatch, King's College London, GB
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Caroline Heary, National University of Ireland, IE
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