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Reducing stigma in healthcare providers:

Key ingredients and a model for successful programming

Presented by:
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Background

- Why is stigma important?
  - It is a barrier to accessing care
  - It is a negative experiential dimension of mental illness
  - Diminished clinical engagement -> negative outcomes
  - Diagnostic overshadowing

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Background

- Healthcare providers one of MHCC Opening Minds (OM) initiative's key target groups.
- OM partnered with numerous organizations conducting anti-stigma interventions targeting various healthcare provider groups in Canada, with the purpose of evaluating program outcomes.
- Most partner programs used some form of social contact, although amount and type of contact was varied.
- Evaluation results showed variation in program outcomes – unclear why some programs performed better than others
- Qualitative investigation to gain more theoretical insight

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Outline of the Project

1. Development and validation of a standard metric. Called the OMS-HC.
2. Working with partners to conduct evaluations of their interventions (randomized controlled trials as well as quasi-experimental ones).
3. Qualitative study to identify perceived “key ingredients” & other important elements
4. Data synthesis – quantitative validation of the key ingredients
5. Development of a process model & toolkits

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Step 1.

Development and validation of a standard metric

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Development of the OMS-HC

- Development of an item pool, Likert-like items
- Construct validation with experts/PWLE
- Focus group assessment
- Initial psychometric evaluation (n=800)
- Subsequent psychometric evaluations (n=1200)
- End result – 15 item scale with three components:
    1. Negative attitudes
    2. Social distance
    3. Willingness to disclose

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Development of the OMS-HC

- Kassam A, Papish A, Modgill G, Patten S. The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: The Opening Minds Scale for Health Care Providers (OMS-HC). BMC Psychiatry. 2012; 12 (1): 62.

- Modgill G, Patten SB, Knaak S, Kassam A, Szeto AC. Opening Minds Stigma Scale for Health Care Providers (OMS-HC): examination of psychometric properties and responsiveness. BMC Psychiatry. 2014; 14: 120.

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Step 2.

Working with partners to evaluate their interventions

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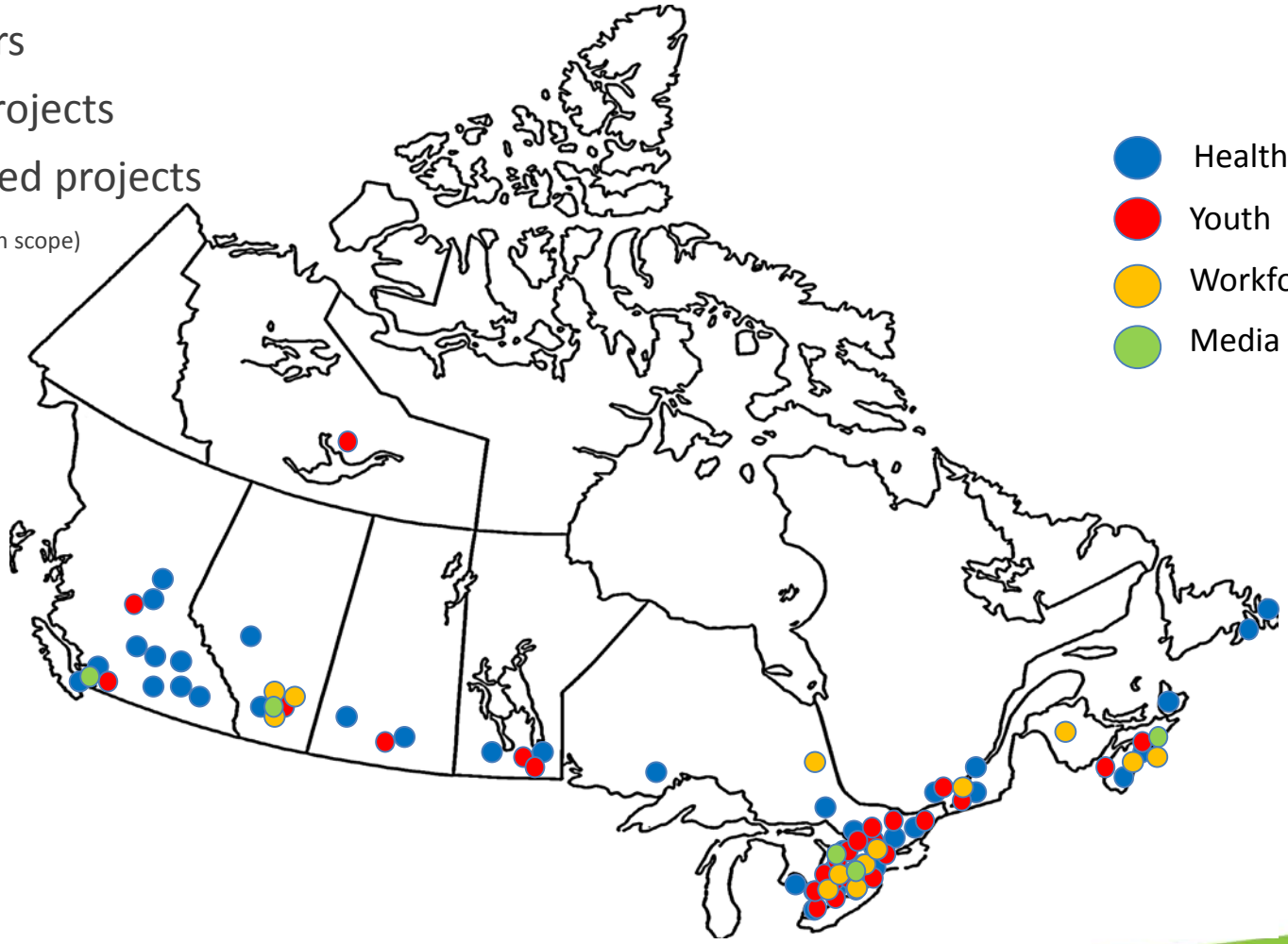
Opening Mind Projects

- 109 partners
- 49 active projects
- 29 completed projects

(Some are national in scope)



Three Program Types

The anti-stigma workshop model

- Good fit for many different healthcare provider groups, esp. practicing hcp
- Recovery-based personal testimony is central programming element, although many programs also include other components
- Programs typically short in duration (e.g., 1-2 hours)
- Programs work best when booster or refresher sessions offered a period of time after initial workshop (strong short term results; positive effects diminish over time without boosters)

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Three Program Types

Intensive social contact / social contact partnership model

- Good fit for university programs; can easily embed program into a larger course
- Students meet with a person with lived experience of a mental illness (e.g., 'client educator') numerous times throughout the term with the purpose of learning their life story. Client educators have a role in co-constructing the assignment and/or grading students' final assignment.
- Evaluation data shows strong short terms results which tend to be sustained over time.

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Cluster-randomized-controlled trials

Patten SB, Remillard A, Phillips L, Modgill G, Szeto AC, Kassam A, et al. Effectiveness of contact-based education for reducing mental illness-related stigma in pharmacy students. BMC Med Educ. 2012; 12: 120.

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Skill-based models

Skills-based programs for working healthcare providers:

- PSP – Practice Support Program for family doctors (this is a longer program which includes CBIS over 3 half days)
- CBIS – Cognitive Behavioural Interpersonal Skills (research shows stigma is reduced even more at 3 and 6 months)

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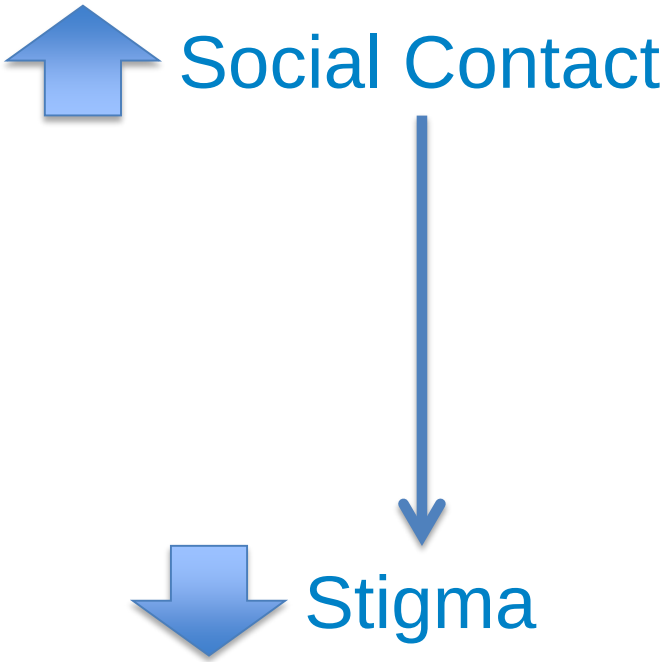
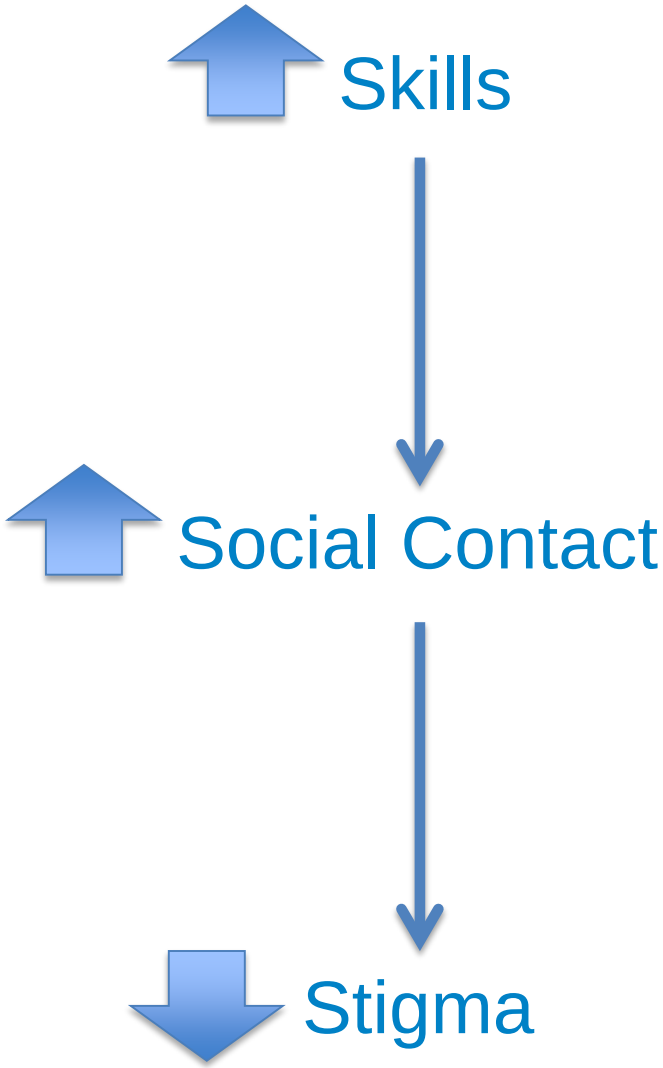
Skill-based models





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Step 3.

Qualitative study to identify perceived “key ingredients” & other important elements

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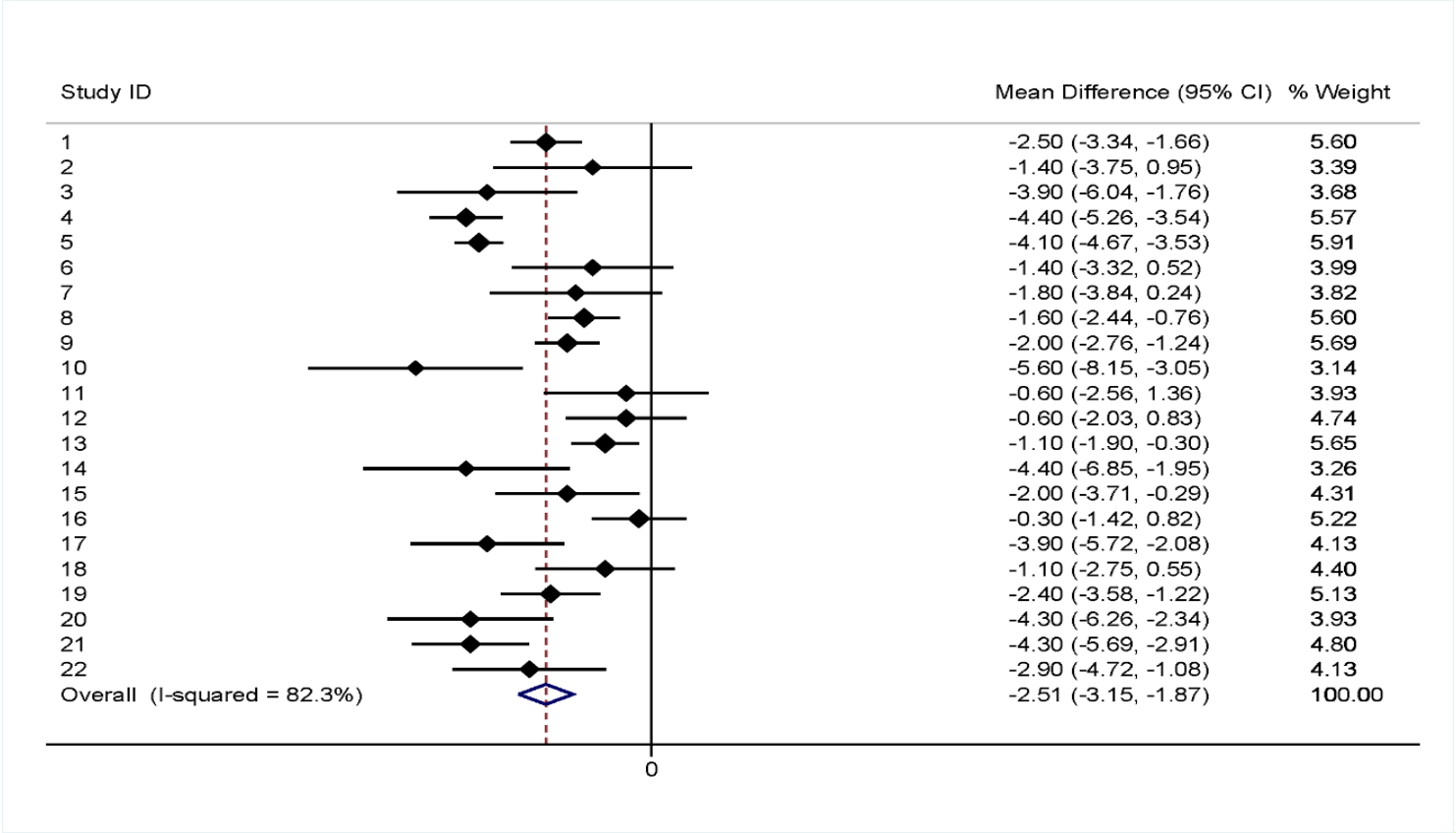
Variation in program outcomes

Forest plot of mean difference in OMS-HC score, all studies



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Qualitative Study

What is the process for designing and delivering successful anti-stigma programs for healthcare providers?

- Key content elements
- Other strategies, practices or processes important for program success
- Methodology: grounded theory
- Data collection: stakeholder interviews (n=23), program observation (n=7), document review (n=48), participant feedback (n=1812), follow-up interviews (n=12)

Result: process model that describes key steps/stages of successful anti-stigma programming, and identifies key strategies/tasks within each of those stages

Model includes identification of 6 'key content ingredients' believed to be important for effective stigma reduction

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Identified Key Ingredients

1. Programs should include social contact in the form of a personal testimony from a trained speaker who has lived experience of a mental illness
2. Programs should employ multiple forms or points of social contact (e.g., live plus video, multiple first-voice speakers, multiple points of social contact between program participants and persons with lived experience of mental illness)
3. Programs should focus on behavior change by teaching skills that help health care providers know ‘what to say’ and ‘what to do’
4. Programs should engage in myth-busting
5. Programs should use an enthusiastic facilitator/instructor who models a ‘person-first’ approach to set the tone and guide program messaging.
6. Programs should emphasize and demonstrate recovery as a key part of its messaging

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Key Learning Needs

- Our research found healthcare providers have specific learning needs that relate to stigma

- These learning needs are what informed the identification of key ingredients

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Pessimism about recovery

feel like what they do doesn't matter

Many[healthcare providers] don't really see recovery as possible, they don't know what it looks like. Because they see people at the height of distress. They don't see people when they are recovered. A lot of stigma comes from frustration in feeling that whatever they are doing doesn't mean anything.

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Small things make a big difference

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Lack of skills / confidence

There is a real lack of knowledge and training among healthcare providers for mental illness. In a lot of cases, they simply don't know what to do or what to say …. If people feel confident that they can help then this will go a long way to reducing stigma.

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Teach skills

"Healthcare providers want practical strategies. That's what they are really asking for. Those practical strategies like 'how can I make someone feel supported versus making them feel stigmatized? What's the right thing to say? ....
By giving them a useful approach and good tools, [healthcare providers] are more welcoming to their mental health patients and less stigmatizing."

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Lack of awareness

Lack of awareness of own prejudices

For [participants in the program] many acknowledged … how they realized they held many prejudices about people with mental illnesses they didn't even realize they had.

Many healthcare providers are unaware that certain terms are considered offensive or stigmatizing.

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Common myth-busting topics

- Relationship between violence and mental illness

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

- Clarification about language use

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

- Belief that interacting with patients in a warm, personal way may encourage them to return more frequently (e.g., to ER)

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

- Correcting misperceptions about prevalence, recovery

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See illness before the person

See the illness before the person

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

Much medical/healthcare education comes predominantly from a pathology perspective instead of a person perspective… We need to help students see the people they will be working with as people, not just diagnoses.

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Include a personal testimony

You absolutely have to have the speaker. Healthcare providers are all over it. They love the speakers and the feedback I get most is, 'we want to hear more personal stories.'

They see it as a reminder. The aspect they get from it is a reminder that these are real people. They see people at their worst and they need a reminder that there is a person's life all around it, around the illness. It's like a refresher to something they knew already so they welcome it.

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Personal Testimony Guidelines

- The overall tone should be hopeful, inspiring. Minimize blaming or negativity
- Stories should be helpful to the audience (i.e., concrete examples of what hcp did well and also what they could do better)
- Tell story as a narrative, be authentic to one's own personal experiences, speak from a place of recovery
  - include background and where they came from (e.g., childhood, family, interests);
  - talk about journey through illness and recovery;
  - include a pivot point or key moment in recovery – what or who made a difference, what stuck with them, what gave them hope;
  - talk about experiences with the healthcare system. Negative experiences should be shared but also emphasize what healthcare providers did right;
  - include a bit about stigma and experiences with stigma
  - end on a positive/inspiring note, emphasize accomplishments, strengths, talk about where they are and what they are doing in their life now.

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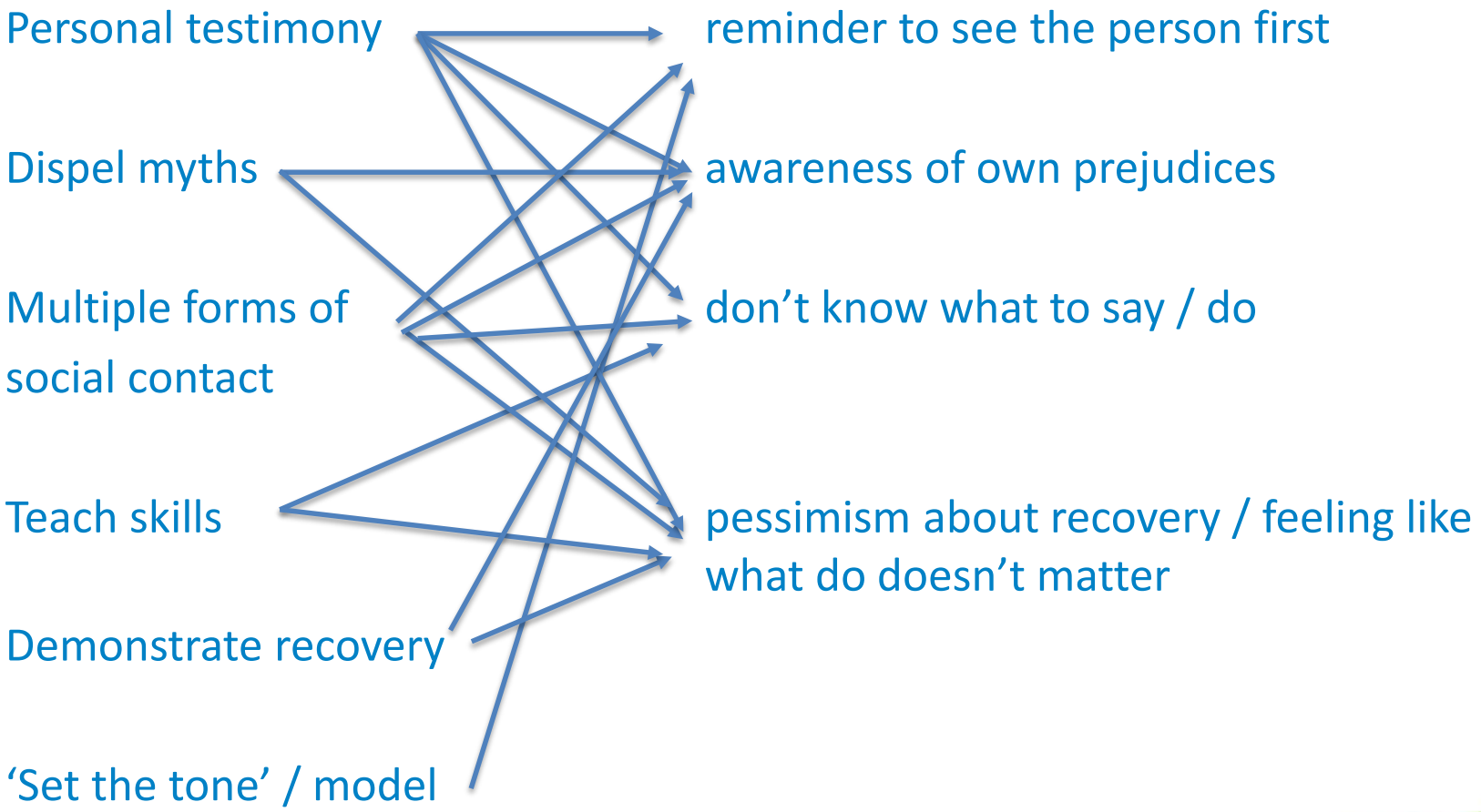
Possible pathways



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More about key ingredients

Why is having multiple modes or points of social contact important?

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

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More about key ingredients

Why is ‘setting the tone’ important?

What I do is I facilitate the first-voice presentation. I set the expectations of what I want the students to focus on and hear, so I set the tone. Then, as the person tells their story, I take notes. So I can expand on things. And then I highlight things I want the student to pick up on. I don’t know if this is priming or if this context matters or not… but I definitely do this. And I do think it’s important …. We are modeling for them, how to interact, what to do and what to say. We model listening, and we model that person-first behaviour.

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Key ingredients of effective programs

Build the Program: Include Key Ingredients for Effective Stigma Reduction

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

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Step 4.

Data synthesis – quantitative validation of the key ingredients

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Data Synthesis Methods

RCTs key – but volume of data from non-randomized studies was greater.

Before-after (quasi-experimental data = the main focus)

Goals: (1) confirm the association of outcome with the identify key ingredients, (2) explore specific ingredients.

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Data Synthesis Methods

We used quantitative data synthesis methods (meta-analysis, meta-regression).

Graphical exploration – Forest Plots

Heterogeneity assessed with I2 and Q-statistics

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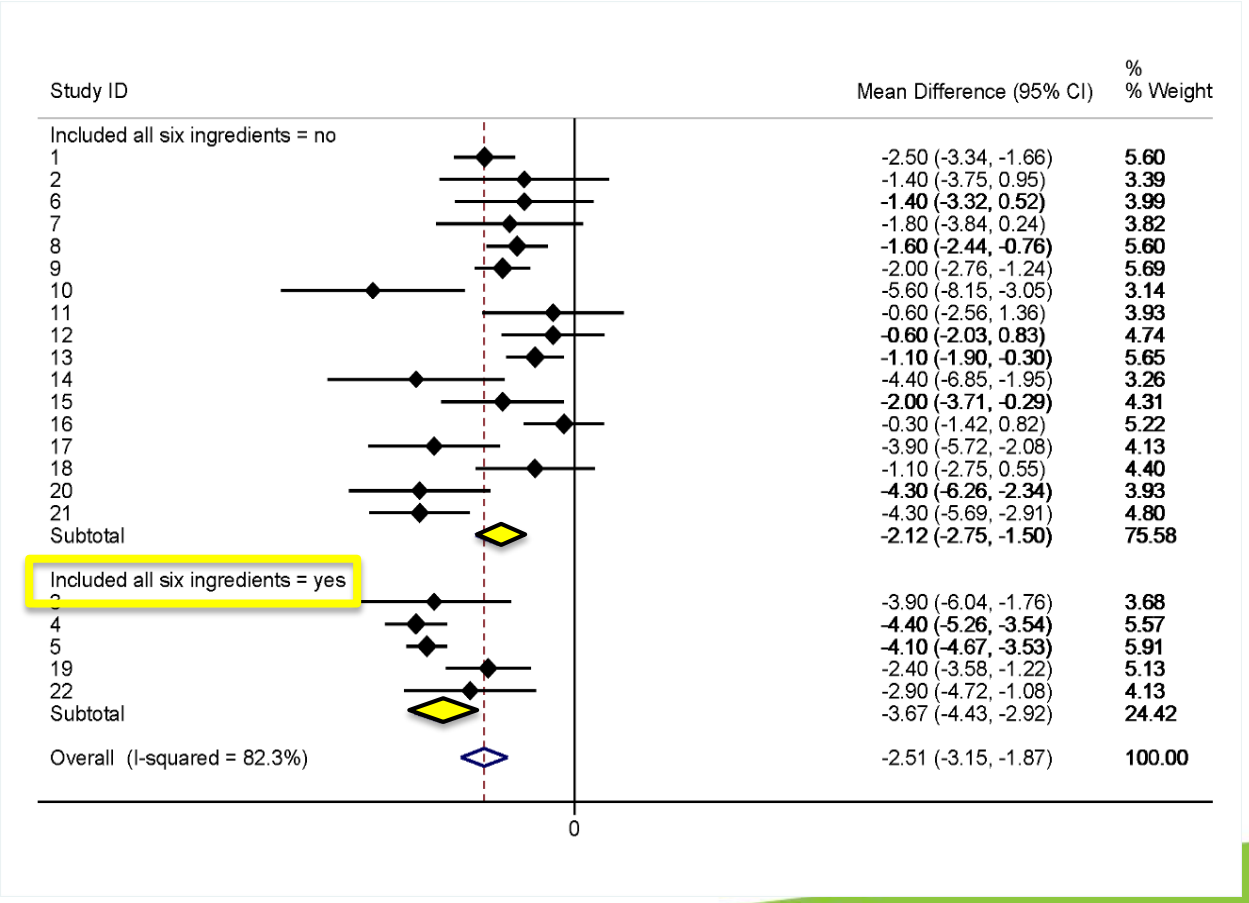
Data Synthesis Methods

Pooling used random-effects models – an *a priori* decision due to diversity of studies.

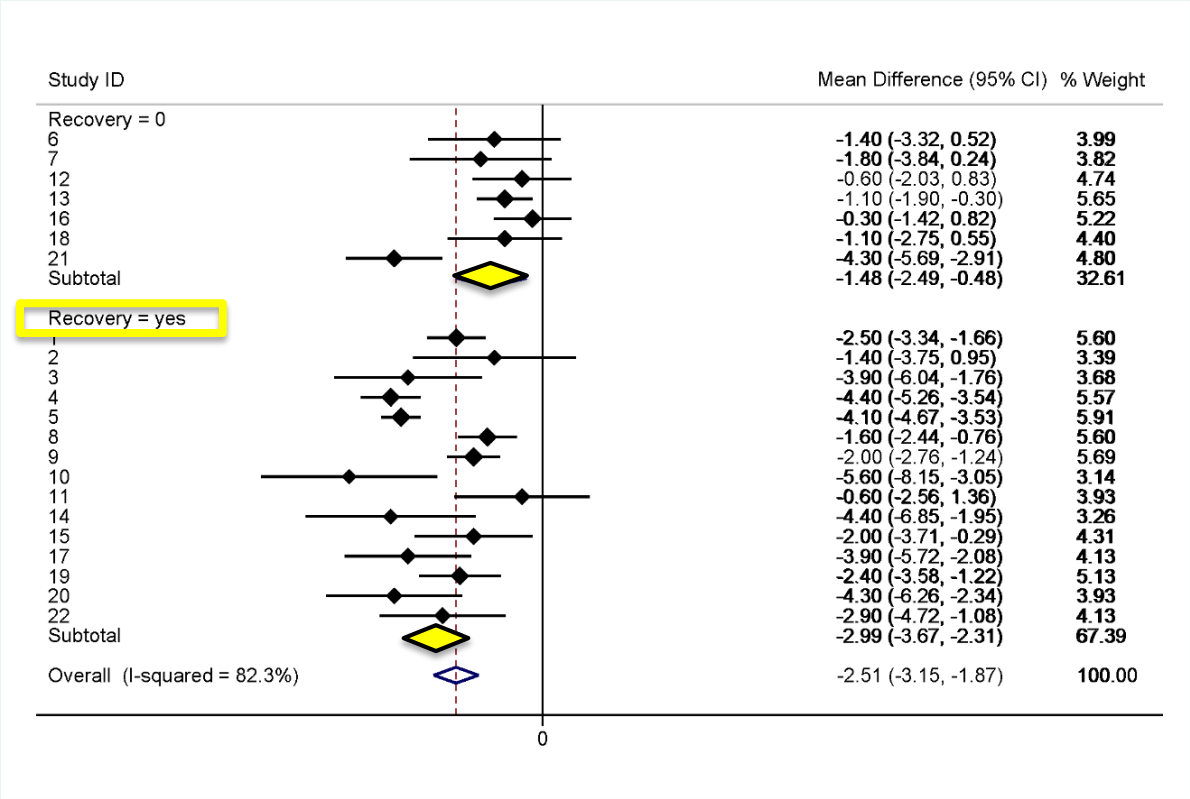
Weights for pooling of studies based in inverse variance of the individual estimates.

Because of the common metric (OMS-HC), mean differences (rather than effect sizes) were the measure of effect.

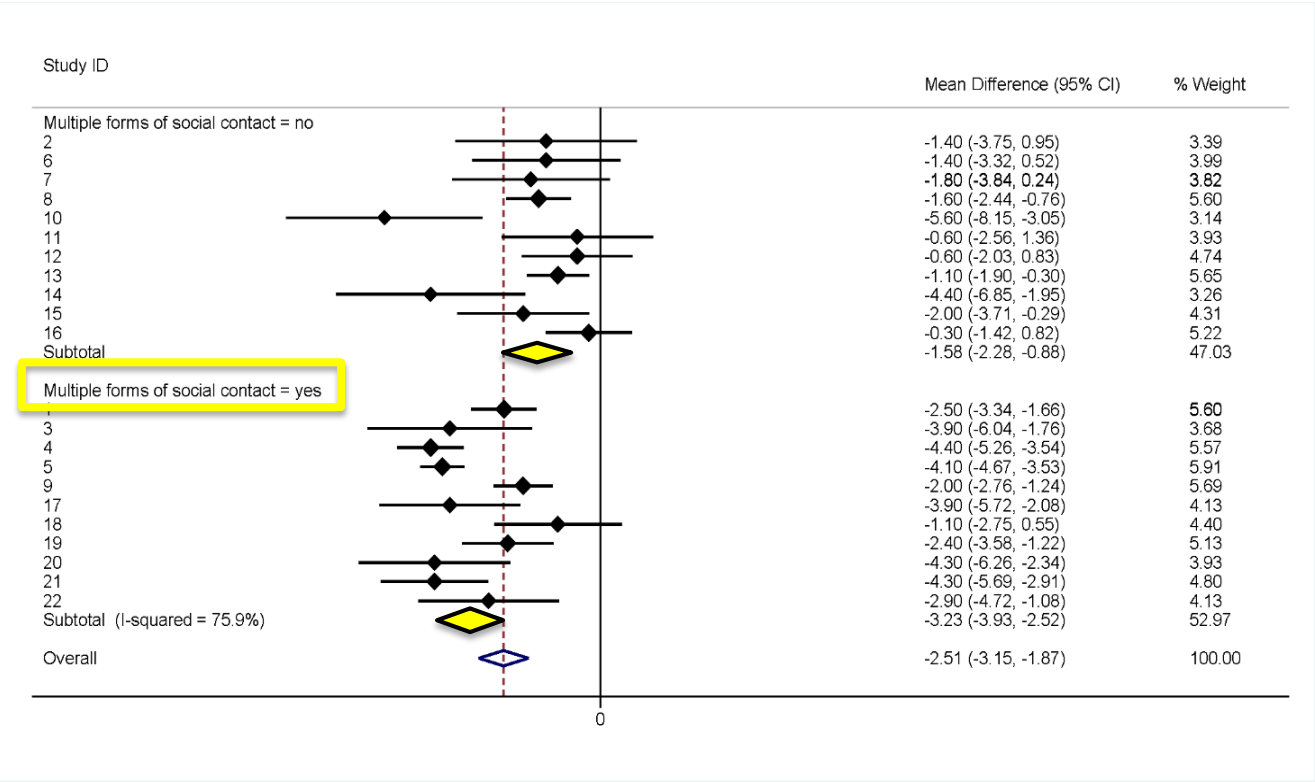
Forest plot of mean difference in OMS-HC score, stratified according to whether studies included all six evaluated ingredients



Forest plot of mean difference in OMS-HC score, stratified according to whether studies emphasized and demonstrated recovery



Forest plot of mean difference in OMS-HC score, stratified according to whether studies included multiple forms or points of social contact



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Step 5.

Development of a process model & toolkits

Process Model for Successful Anti-Stigma Programming for Practicing Healthcare Providers

IDENTIFY KEY LEARNING NEEDS / UNDERSTAND THE ROOTS OF HCP STIGMA

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

SET UP FOR SUCCESS

Plan and Prepare Effectively

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

Get Leadership on Board

Maximize Participation

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

MAXIMIZE OUTCOMES

Build the Program: Include Key Ingredients for Effective Stigma Reduction

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

Maximize Audience Receptivity: Best Practices for Program Delivery

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

MAINTAIN THE MOMENTUM

Sustain Positive Change

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

Continue Moving Forward

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

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

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

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On setting up for success…

"Involve consumers throughout. We had focus groups with consumers and family members which helped to shape the curriculum. One theme that came up a lot was the perception of violence. Consumers feel like [healthcare providers] are afraid of them. So we knew the importance of focussing on this when building the program."

"Work from the top. It's critical to get senior leadership on board. If you don't have that support, it won't fly. At our hospital, they have a leadership forum. We got in there and did a 30 minute abbreviation of the program. That sold them."

"Use all the promotional channels at your disposal. Internal newsletters, posters, emails, you name it. Walk the hospital to get into the staff lounges to hang your poster. Talk to all the people when you are there. Its has to be sometimes 4 or 5 times before it clicks."

You have to think about program length from a participant perspective. Obviously it has to be long enough to cover the content. But too long and it will be difficult for staff to commit."

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On maximizing audience receptivity…

"I like how [first-voice presenter] helps me co-facilitate. I think it's positive for the group to see. But not all first-voice presenters do this. If I had to do it over again, I would set it up as a true co-facilitating workshop."

"It has to be interactive – this is what gets people to reflect"

"The personal testimony has to make that personal connection …. it's about telling a story in a way that resonates and touches people at that personal level."

"The message(s) needs to be communicated over and over again because we are competing with so many negative stereotypes from the media and elsewhere."

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On maintaining the momentum…

"One long day might make us all warm and fuzzy but it might not last. Getting reminders periodically is likely to work much better. We all need to be reminded."

"I definitely think we are going in the right direction with the booster sessions – I don't think you can just have 'level 1' and expect things to change too much."

"One-off things don't change culture. It needs to be, in my mind, a movement ultimately. It needs a lot of champions demonstrating in their individual workplaces a well-mannered intolerance of intolerance. Continuing to raise awareness in ways that are effective … it has to be longitudinal. I think it's about numbers – the numbers of people who are influenced and who are currently unaware."

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On swimming upstream…

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

How do we get all the requirements for training done in this finite period? There is so much learning that has to happen that the more novel ideas – like getting students to understand more about the human experience – keep getting put off. It's not like there's outright opposition. It's more like it gets squeezed out.

This is a culture issue. And the culture of large institutions is very hard to change.

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Looking forward

Healthcare Provider Campaign plans include:

- Business development consultant to help obtain interest and commitment from governments, professional associations and universities
- Ensure all programs are in an easy-to-replicate format
- Start with three provinces, reaching out to all stakeholder groups
- Flexibility and length of programs (university, anti-stigma, skills-based) which can also be complimentary
- Variety of programs allowing for different levels of commitment

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Additional Resources

Scale Development:

Kassam A, Papish A, Modgill G, Patten S. The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: The Opening Minds Scale for Health Care Providers (OMS-HC). BMCPsychiatry. 2012; 12 (1): 62.

Modgill G, Patten SB, Knaak S, Kassam A, Szeto AC. Opening Minds Stigma Scale for Health Care Providers (OMS-HC): examination of psychometric properties and responsiveness. BMC Psychiatry. 2014; 14: 120.

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Validation of key ingredients:

- Knaak S, Modgill G, Patten S. Key ingredients of anti-stigma programs for healthcare providers: A data synthesis of evaluative studies. **CanJ Psychiatry** 2014;59(10 Suppl 1):S19–S26.

Process model:

- Knaak S, Patten S. Building and Delivering Successful Anti Stigma Programs for Health Care Providers: Results of a Qualitative Study. Mental Health Commission of Canada; 2014.

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