Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

The Inquiring Mind Pilot Evaluation Report

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Please note that the format of this report is based on a similar format of The Working Mind and R2MR summary reports

Mental Health Commission of Canada

1. OPENING MINDS: CHANGING HOW WE SEE MENTAL ILLNESS

Stigma is a significant concern for those living with a mental illness. It is one of the primary vehicles for the entrenchment of discriminatory behaviours, and has been identified as a major barrier to timely and accessible care, recovery, and quality of life for persons living with mental illnesses. As such, reducing the stigma and discrimination associated with mental illness is becoming an increasingly important focus.

As part of its initial 10-year mandate, The Mental Health Commission of Canada (MHCC) embarked on an anti-stigma initiative called Opening Minds (OM) to change the attitudes and behaviours of Canadians towards people with mental illnesses. OM is the largest systematic effort undertaken in Canadian history to reduce the stigma and discrimination associated with mental illness in targeted groups that could benefit from these efforts. OM's philosophy is not to reinvent the wheel, but rather to build on the strengths of existing programs from across the county. As such, OM is conducting evaluations of various programs to determine their success at reducing stigma. OM's goal is to replicate effective programs nationally.

For more information, go to: www.mentalhealthcommission.ca.

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2. INTRODUCTION AND PURPOSE

Mental health in post-secondary institutions is an important issue, and one that has recently received considerable media coverage. Much of this coverage has focussed on the increase in help-seeking at post-secondary institutions and subsequent increase in demands on mental health resources at post-secondary institutions that are already over-taxed. Some research from the National College Health Assessment speaks to an increase in students' experiences with mental health problems from 2013 to 2016. For example, the percentage of students who had sought treatment for a mental illness or was diagnosed for a mental illness grew from 19.8% in 2013 to 26.3% in 2016 (American College Health Association, 2013; 2016). Although it is hard to attribute the precise causes of this increase, a portion of it may be a result of increasing rates of mental illnesses in the post-secondary population. It seems appropriate that increasing awareness, increasing help-seeking, and offering skills to manage stressors would benefit the post-secondary population.

3. PROGRAM DESCRIPTION

3a   Background

The Inquiring Mind (TIM) was developed from The Working Mind and the Road to Mental Readiness for First Responders. Both of the latter programs were adapted from the Department of National Defence's Road to Mental Readiness program created to support soldiers and military personnel with their mental health. The development of TIM began in the Summer 2015 after a grant from the University of Calgary Student Enrolment Services provided the resources to create a post-secondary student version of The Working Mind. A program development committee composed of students, faculty, and student service professionals was created to advise on the content and direction of the new program. TIM was initially developed and then presented to students in a focus group format to generate more feedback. Following more revisions, as well as development of student-focused videos during Fall 2015, TIM was launched as a pilot study and evaluation in January 2016 at the University of Calgary and subsequently at Mount Royal University in January 2017.

TIM is a workshop style program that has the aims to reduce stigma associated with mental illness and to promote mental health. The program contains the same core components as The Working Mind, including videos of people with lived experience of mental illnesses, the Mental Health Continuum Model, and the "Big 4 Skills". The program was also developed so that the core components, and all other content, was relevant for students and fit within the post-secondary context. For example, a module was developed to encourage creating a supportive campus environment. Analogous with The Working Mind and the Road to Mental Readiness, TIM ends with the opportunity for participants to work through a set of scenarios to apply what they learned throughout the course of the workshop.

3b   Purpose of Evaluation

The purpose of this evaluation was to examine the effectiveness of TIM in the context of the participating

post-secondary institutions. This report details the results from 6 post-secondary institutions between 2016 and 2018. These institutions include the University of Calgary, Mount Royal University (Calgary), University of Lethbridge, MacEwan University (Edmonton), Memorial University (Newfoundland), and Nova Scotia Community College (Pictou Campus, Strait Area Campus, Truro Campus).

4. EVALUATION METHODS

4a   Survey Design & Procedures

This evaluation of TIM employed a pre, post, and 3 month follow-up design; surveys were administered just before the workshop, just after the workshop, and about 3 months after the workshop. Just before the workshop begun, a TIM facilitator (or a site coordinator) read a recruitment script to workshop attendees. If they agreed to participate, they completed a consent form followed by a paper copy of the pre-questionnaire package. Immediately after the workshop, participants completed a paper copy of the post-questionnaire package. This procedure was followed at all sites. Site coordinators sent the complete questionnaires to the project researchers for processing. Finally, about 3 months after the workshop, the project researchers sent an invitation email to participants to complete the follow-up survey. Participants could access the survey via an embedded link in the invitation email. Those who completed the 3 month follow-up survey received a small gift card for their participation.

The University of Calgary Conjoint Faculties Research Ethics Board approved this evaluation project, including the procedures and processes.

4b   Measures

The surveys were anonymous, as participants were not asked any identifying information. Rather, participants were asked a series of questions at each timepoint that generated the same unique code. These unique codes allowed the researchers to match a participant's responses at each timepoint while protecting their anonymity.

The measures used in the questionnaires were either developed for the project or were pre-existing validated scales. These measures served to assess the efficacy of TIM based on the program outcomes, such as stigma reduction and resiliency. A similar questionnaire package was used in the evaluation of The Working Mind and the Road to Mental Readiness for First Responders.

1) **Reduce stigmatizing attitudes** - The Opening Minds Scale for Workplace Attitudes (OMS-WA; Szeto, Luong, & Dobson, 2013) was used to assess stigmatizing attitudes towards people with mental illnesses. The version used in this evaluation was adapted for a university population; items refer to the post-secondary context rather than the workplace. This measure was completed by participants at all three timepoints. Participants rated each of the 23 items on a 1 to 5 scale, with higher scores indicating higher levels of stigmatizing attitudes. Additionally, this measure has five subscales: social distance, danger/unpredictability, work-related beliefs, perceptions of responsibility, and helping behaviours.

2) **Resiliency** – Changes in resiliency was measure using two scales. The first scale used was a measure of resiliency skills that assessed participant's perception of their abilities and skills to be resilient and recover from traumatic situations. This scale was developed for the evaluation of The Working Mind and the Road to Mental Readiness. Participants completed this measure at all three timepoints and rated each of the 5 items on a 1 to 5 scale with higher scores indicating higher levels of resiliency skills. The other measure used was the Brief Resilience Scale that measured people's tendency to "bounce back" from stress (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008). Conceptually, this measure is an overall or general measure of resiliency compared other measure, which is geared toward participants' perceptions of preparedness. Participants completed this measure at the pre and 3 month follow-up timepoints and rated each of the 6 items on a 1 to 5 scale, with higher scores indicating higher levels of general resiliency.

3) **General mental health** - To assess general mental health, participants were asked to rate their mental health on a scale from 1 (excellent) to 5 (poor). This question was asked at the pre and follow-up timepoints. Participants were also asked at the follow-up timepoint to compare their current mental health with their mental health 3 months ago and rated it as better, about the same, or worse.

4) **Mental health experiences at university -** Participants were asked 4 items to assess possible shifts in mental health culture. These items included participants' understanding of how mental health issues present at their university, their own willingness to seek help and engage in conversations about mental health, and their willingness to support a peer if they are concerned about them. Participants completed these items at the pre and 3-month follow-up timepoints and rated each item on a 1 to 5 scale, wherein higher score indicated increased willingness for each item.

5) **Program perceptions** – Participants' general perceptions of the program were also assessed at post-training and follow-up. To assess this, participants completed 5 open-ended questions, including questions regarding the relevance of the program in their life, what they liked least about the program, and what they liked most.

6) Demographic questions were also included in at the pre and follow-up timepoints that captured age, gender, marital status, program of study, and previous experience with mental illness. A knowledge quiz was included in about 70 post-questionnaires by mistake. This measure was not analysed.

4c   Understanding the Analyses

The paired sample t-test was the primary statistical test used in this evaluation. In this report, the t-test is used to determine if there is a statistically significant difference between participants' scores on a specific measure (e.g., resiliency skills) at two timepoints (e.g., pre vs post). If the test produces a p-value of .05 or less, that means it meet the criteria for being statistically significant. This means that one can say the participants' scores were most likely different at the two timepoints and that this difference is not do to chance.

The t-tests can only indicate that the differences are statistically significant but not if that difference is

meaningful. Effect sizes are used to gauge the magnitude of the difference between participants' scores. This procedure helps to determine whether the changes from the program are useful or impactful for society. Conventionally, effect sizes around .20 are considered small and have minimal impact. Effect sizes around .50 are considered moderately impactful. Effect sizes .80 or greater are considered to have a large impact. The effect size statistic used in the current report is Cohen's d. It was calculated using a pooled standard deviation and accounts for the dependent nature of the pre, post, and follow-up design by adjusting based on the correlation (see https://www.psychometrica.de/effect_size.html#repeated).

5. Results

TIM workshops were held between 2016 and 2018 across 6 sites. A total of 519 participants completed the questionnaire package at one or more timepoints. Of these 519 participants, 289 completed the pre and post questionnaire, while 171 participants completed the questionnaires at all three timepoints. Another 10 had pre and follow-up matched (no post) and the remaining 49 pre-tests were unable to be matched.

5a   Participant Demographics

Of the total sample (i.e., 519), the majority were female (81.5%). The sample had a mean age of 24.19 (SD = 7.14). The breakdown of the demographic variables are summarized in Table 1.

Table 1. Summary of participant demographics (N = 519)	
Demographic Variable	**% (n)**
Gender	
Female	81.5% (423)
Male	16.6% (86)
Age group	
17-20	34.1% (177)
21-25	38.7% (201)
26-30	11.9% (62)
31-35	3.7% (19)
36-40	3.9% (20)
41+	4.6% (24)
Marital Status	
Single	75.9% (394)
Married	9.6% (50)
Divorced or Separated	1.7% (9)
Common Law	11.0% (57)

5b   Testing for Sample Biases

To see if there were differences between those who completed the pre and post only and those who completed all three survey time points, a set of analyses were completed that examined demographic (i.e., gender, marital status, age) and relevant baseline scores (e.g., stigma, resiliency skills). This was done

to see if any differences exist between the two groups, and how this may affect the interpretation of findings. These analyses (i.e., chi-squares for demographic and independent samples t-tests for the baseline scores) failed to find any statistically significant differences between the two groups.

5c   Opening Minds Scale – Workplace Attitudes (OMS-WA)

The average OMS-WA scores for each possible timepoint comparison, along with p-values and effect size, are displayed in Table 2. Please note that average scores for any given timepoint may be slightly different than the same timepoint for another comparison. This is due to the different sample sizes that exist at each timepoint.

Results indicate that there as a significant decrease in scores on the OMS-WA from pre to post ($p < .001$) and from pre to follow up ($p < .001$), indicating that participants had less stigmatizing attitudes towards those with mental illnesses across these timepoints after taking the workshop. This stigma reduction was maintained at follow-up. The effect size for the pre to post change was 0.75, which approaches the large range, and 0.26 for pre to follow-up, which should be considered a small effect size.

Table 2. Average OMS-WA Scores at Pre, Post and Follow-up					
Comparison Period	**N**	**Mean 1 (SD)**	**Mean 2 (SD)**	**p-value**	**Effect size**
Pre – Post	458	1.61 (0.46)	1.40 (0.41)	<.001*	0.76
Pre – Follow-up	181	1.59 (0.44)	1.50 (0.39)	< .001*	0.27
Post – Follow-up	171	1.39 (0.40)	1.50 (0.39)	< .001*	0.36

Note: Mean 1 is always the earlier time-point; SD = Standard Deviation; Mean scores can range from 1 to 5; lower scores indicate less stigma; *Significant at an α = .0167 level. This result is based on a Bonferroni correction to adjust for 3 comparisons (α = .05 divided by 3 analyses).

The t-test that compared the post and follow-up time-points indicated a significant increase in stigmatizing attitudes from post test to follow-up ($p < .001$). This suggests that TIM appears to have reduced stigmatizing attitudes towards those with mental illnesses, but the reduction was significantly greater immediately after the workshop than compared to 3 months after. The effect size for this change was 0.36 (which is approaching the medium range). This finding suggest that some of the initial gains did regress towards baseline after time; however, they did not regress fully. Such a result also implies that some form of ongoing programming, or booster sessions, might be successful to maintain the gains seen from pre test to post test.

OMS-WA Subscales

The OMS-WA contains 5 subscales that examine specific aspects of mental illness stigma: social distance (avoidance), danger/unpredictability, school-related beliefs (competency), helping behaviour, and perceptions of responsibility for their illness. Table 3 displays the results for the comparisons between the various timepoint means on these subscales.

There were significant improvements seen from pre to post test in all five subscales, with danger/unpredictability having a large effect size (0.83) and school-related beliefs and social distance having moderate effect sizes (0.56 and 0.47 respectively). Furthermore, these improvements were sustained at the time of follow-up (pre to follow-up comparisons) for four of the subscales; the exception being helping behaviour, which had a significant increase in stigma from pre to follow-up and post to follow-up (with effect sizes of 0.17 and 0.24 respectively). The subscale of responsibility had no significant change from post to follow-up, however, we did see a significant increase in stigma from post to follow-up for social distance, danger/unpredictability, and school-related beliefs but still lower than pre-workshop.

Table 3. Average OMS-WA Subscale Scores at Pre, Post and Follow-up.						
Subscale	**Comparison**	**N**	**Mean 1 (SD)**	**Mean 2 (SD)**	**p-value**	**Effect size**
Social distance	Pre-post	458	1.45 (0.55)	1.28 (0.45)	<.001*	0.47
	Pre-follow-up	181	1.44 (0.55)	1.34 (0.45)	.002*	0.27
	Post-follow-up	171	1.25 (0.44)	1.35 (0.46)	< .001*	0.29
Danger/ unpredictability	Pre-post	458	1.97 (0.68)	1.56 (0.60)	<.001*	0.83
	Pre-follow-up	178	1.90 (0.62)	1.65 (0.60)	< .001*	0.39
	Post-follow-up	169	1.52 (0.58)	1.64 (0.60)	.004*	0.22
School-related beliefs	Pre-post	458	1.70 (0.59)	1.47 (0.52)	<.001*	0.56
	Pre-follow-up	181	1.68 (0.57)	1.52 (0.52)	<.001*	0.34
	Post-follow-up	171	1.45 (0.52)	1.52 (0.53)	.033	0.16
Helping Behaviour	Pre-post	456	1.69 (0.67)	1.54 (0.67)	<.001*	0.22
	Pre-follow-up	177	1.68 (0.64)	1.84 (0.96)	.031	0.17
	Post-follow-up	168	1.57 (0.78)	1.84 (0.97)	.002*	0.24
Responsibility	Pre-post	458	1.35 (0.56)	1.24 (0.45)	< .001*	0.30
	Pre-follow-up	181	1.33 (0.51)	1.23 (0.40)	.001*	0.25
	Post-follow-up	171	1.22 (0.43)	1.23 (0.40)	.619	0.04

Note: Mean 1 is always the earlier time-point; SD = Standard Deviation; Mean scores can range from 1 to 5; lower scores indicates less stigma; *Significant at an α = .0167 level. This is based on a Bonferroni correction to adjust for 3 comparisons (α = .05 divided by 3 analyses per subscale).

5d   Resiliency Skills

Resiliency skills scores increased significantly from pre to post and from pre to follow-up ($p < .001$; see Table 4). Participants perceived that they were better equipped to deal with stress and trauma from before to after the workshop, and this result was maintained 3 months later. Both of these results were

in the medium range of effect sizes. There was also a significant decrease in resiliency skills from post to follow-up (*p* < .001), indicating some loss in participants' perceptions of resiliency from post to follow-up.

Table 4. Resiliency Skills Pre and Post Training					
Comparison	**n**	**Mean 1 (SD)**	**Mean 2 (SD)**	**p-value**	**Effect size**
Pre – Post	456	3.35 (0.67)	3.71 (0.67)	<.001*	0.60
Pre – Follow-up	174	3.31 (0.69)	3.61 (0.73)	<.001*	0.46
Post – Follow-up	166	3.78 (0.64)	3.60 (0.73)	<.001*	0.29

Note: Mean 1 is always the earlier time-point; SD = Standard Deviation; Means scores can range from 1 to 5; higher scores indicate higher levels of resiliency; *Significant at an α = .0167 level. This is based on a Bonferroni correction to adjust for 3 comparisons (α = .05 divided by 3 analyses).

5e   Brief Resilience Scale

For the Brief Resilience Scale, there was a significant different from pretest to follow-up (*p* < .001), indicating that there was an increase in general perceptions of resilience after participants took the workshop. The effect size for this change was small.

Table 5. Brief Resiliency Scale at Pre-training and Follow Up by Group.					
Comparison	**n**	**Mean 1 (SD)**	**Mean 2 (SD)**	**p-value**	**Effect size**
Pre – Follow-up	176	3.00 (0.77)	3.19 (0.79)	< .001*	0.27

Note: Mean 1 is always the earlier time-point; SD = Standard Deviation; Means scores can range from 1 to 5; higher scores indicate higher levels of resiliency

5f   Mental Health Experiences at Post Secondary and General Mental Health

Participants completed several items at pre-training and at follow-up that assessed their self-rated mental health, as well as items related to help-seeking and the mental health culture at their post-secondary institution (Table 6). Participants had similar ratings of self-rated current mental health at pre test and follow-up. However, participants had higher self-rated general mental health 3 months after the training than just before (*p* = .011). Finally, the 4 questions that assessed mental health perceptions at their post-secondary institution revealed significantly higher scores at follow-up compared to pre training for 3 out of the 4 questions, indicating a positive shift in supporting others and seek help, and understanding and willingness to speak about mental health at their post-secondary institution. These three improvement had a medium effect sizes. The question that did not increase significantly (i.e., "When I am concerned, I ask my peers how they are doing.") already had a mean of 4.18 at pre testing (highest possible score is 5); therefore a ceiling effect could explain the lack of significance seen here.

Table 6. General Mental Health and Mental Health Perceptions at Work: Pre-training and Follow Up					
Item	**n**	**Pre-training M (SD)**	**Follow-up M (SD)**	**p-value**	**Effect size**
Self-rated current mental health	174	3.10 (0.96)	3.18 (0.94)	.214	0.10
Self-rated general mental health (last month or so)	169	2.76 (1.09)	2.98 (0.99)	.011*	0.20
"I understand how mental health problems present on campus."	172	3.42 (0.85)	4.03 (0.68)	< .001*	0.66
"I plan to seek help for my mental health problems, when needed."	172	3.76 (0.91)	4.12 (0.83)	< .001*	0.40
"When I am concerned, I ask my peers how they are doing."	172	4.18 (0.75)	4.25 (0.78)	.275	0.08
"I talk about mental health issues as freely as physical health issues."	171	3.51 (1.07)	3.99 (1.03)	< .001*	0.41

Note: M = Mean; SD = Standard Deviation; scores can range from 1 to 5; higher scores indicate more positive mental health/more positive perceptions

Participants were also asked at follow-up whether their mental health had changed for the past 3 months after the training. Over half of the participants (55.7%) thought their mental health was either somewhat or much better than three months prior. Almost one-third (31.6%) felt it was about the same and only 11.5% felt it was somewhat worse. This finding generally supports the change in the self-rated general mental health item discussed above.

5i   Qualitative analyses

Participants were asked several open-ended questions about their perceptions and experiences of TIM at the end of the workshop. In general, participants reported positive experiences with TIM and enjoyed the content and facilitation.

One main theme from the open-ended comments was the relevance and applicability of the program to the participants' lives. Many participants indicated that the evidence-based Big 4 Skills and the Mental Health Continuum Model were particularly useful. Participants believed the program was relevant because the content addressed stigma reduction and raised awareness of mental health in the post-secondary context and in their overall lives. Similarly, they found that the practical approach and the use of relevant post-secondary examples throughout the workshop were important aspects of the program.

Many participants indicated that they appreciated how open, safe, and comfortable the workshop felt and how engaging, friendly, and well-educated/informed the facilitators were. Participants also believed

the program structure (i.e., a mixture of slides, videos, discussion, exercises, etc.) made it more engaging. The format also was reported to encourage a sense of openness and dialogue among participants, which was highly appreciated. Many participants commented that the videos (i.e., personal experiences of mental illness in post-secondary) resonated with them significantly, especially because they depicted student experiences that participants could relate to.

Many of the participants believed TIM would lead them to act more openly towards others who have the lived experience of mental illnesses, and to be both more aware and more understanding. Many participants indicated that they now had the resources, skills, and knowledge to help others' or their own mental health. These participants indicated that they would be more open-minded, more approachable, less judgemental, and that they would try to be better listeners. However, other participants stated that their behaviours would not change very much after the workshop because they were quite empathetic and knowledgeable already. Some participants indicated that they had received similar information in their program of study (e.g., psychology, nursing, social work). Many of these particular participants, however, suggested that TIM still provided a good reminder of the principles they already knew, and that this program would be of most benefit for students who are new to their post-secondary institutions. In fact, numerous participants stated that this course should be mandatory for all students. Furthermore, many participants said that this program inspired them to work on their own mental health (e.g., seek treatment, utilize coping skills) and said that the program's skills will be very important or useful in their student life and future careers.

Participants were also asked what they enjoyed the least about TIM and what aspects could be improved. Some participants believed the program was too long and some found that some of the content was repetitive. Contrary to this, many others thought that it should be longer and that they wanted more in-depth material and more time for discussion. Some participants indicated that the program could be more interactive, more applicable to post-secondary situations, and less static. An alternative classroom set up (e.g., circle, u-shape) was suggested to help with these issues. Several students suggested the need for better promotion or advertising for the workshop as well as a certificate of completion for those who attended (note that certificates are available if facilitators send the class list to the MHCC). Another common suggestion was providing handouts or copies of the information from the workshop to be referred to in the future. Some participants suggested having materials sent to them prior to the workshop so that they could write notes on them during the presentation. Finally, many participants stated that there was nothing they would change about the program.

To demonstrate the participants' responses to TIM, a sample of participant comments is provided below:

Liked Most about the Program:

a. *I loved the positive energy in the room both from the coordinators and the participants. It made it a very comfortable and genuine atmosphere to be a part of.*

b. *I really enjoyed the mental health continuum model - I think it is a fantastic and innovative way to approach mental health and I appreciate that it is flexible and dynamic.*

c. *It was concise and engaging, focusing on mental health in the context of university.*

d. *The little mental health pamphlets handed out; the perfect size for keeping in your pocket and checking how you're doing throughout the day.*

e. *Honestly I was so inspired by the speakers and in particular the school counsellor who spoke so openly about her own mental health and seeing her own therapist. That was the first time I had seen someone be so open, and it was revolutionary for me to know that as someone who wants to get involved in mental health counselling, it's okay to also seek the same supports. It gave me a lot of hope for myself.*

f. *I liked how interactive the workshop was, it engaged the students in a lot of discussion. People had a lot to share, and a lot to say.*

g. *The videos of people who actually dealt with all we talked about! Again, they really help build empathy.*

h. *It was enjoyable and informative, probably the best workshop I have attended and very inclusive. Thank you guys so much for coming in!*

Program Relevance/Usefulness:
i. *I have a greater respect for all types of mental health and mental illness. I believe more conversations need to be had concerning these topics*

j. *Mental illness affects everyone. It is important to know how to recognize and help those who are experiencing mental illness. This is a transferable skill to all areas of my life.*

k. *I believe it's relevant to every student, as stress, anxiety, depression and more is something we encounter, or feel, on a frequent basis. Having the skills to cope with these feelings and address the impacts is an invaluable skill.*

l. *It inspired me to go seek help from a counselling service. It gave me clear indicators that I can watch for in myself and others. It reminded me of the importance of settings goals*

m. *It is relevant for me as I have struggled with mental illness and have close friends and relatives who have also struggled. I am can learn the skills that I used during the program to help myself and to recognize that others may also need help.*

n. *Very relevant in providing a model for changing perceptions around mental health (mental health continuum model)*

o. *Sometimes I need a reminder that it is okay to not be okay.*

p. *It will reaffirm working on positive coping skills in a meaningful way and make it a priority.*

q. *It gave me greater confidence to speak about mental health with my peers. Additionally, it equipped me with tools that I can use if I know someone who is dealing with mental health issues.*

Suggestions for Improvement:

r. *The first 2 modules had a lot of info that requires conscious processing - discussion and debrief would have been beneficial*

s. *The pacing was a little too fast, given that the material is a sensitive topic. More time delegated would help*

t. *I think there could be more interaction, but besides that, it was informative and well done*

u. *Having notes or sheets that had a general overview of the content that we cold take home for future reference*

v. *The thing I didn't like in the program is the silence that happens when people don't participate. It just feels awkward for the presenter and the audience*

w. *I wish that more examples of vocabulary had been given. For examples, instead of just saying we can talk to someone about it, how can we broach the subject? Is it ok to say, "I've noticed" or "It seem like" or is it better just to say "I'm here for you"?*

x. *The material was quite introductory, more in depth training and more practical knowledge would have made the program better*

y. *That seeking "support" isn't scary. I feel like people can be afraid while still understanding that it was likely be okay (it isn't always a positive experience AT FIRST but once you find the right help it becomes positive). Emphasize that getting help isn't easy (I like that they say you may have to keep trying)*

z. *Lacked more diverse scenarios in conjunction with daily life at university*

Additional Comments:

aa. *Should be available to all discipline, during field placement time, and mandatory - address students in faculty who may have little awareness about mental health*

bb. *This program should be reoccurring and continuous*

cc. *Very informative and really made me assess my own assumptions and stigmas associated with mental health and illness*

dd. *I am so thrilled that this program is being offered and that it is helping to reduce stigma surrounding mental health and mental illness*

6. Summary

TIM is a mental health literacy, skills training, and stigma reduction program targeted directly at Canadian post-secondary students. This pilot project was successful in that there were multiple post-secondary institutions that participated in both the implementation and evaluation of TIM. The pilot project also appears to be successful with regard to the positive results from the quantitative analyses and qualitative feedback from participants.

One of the main outcomes of the program is stigma reduction. Participants reported reduced stigmatizing attitudes from pre to post and from pre to follow-up on the OMS-WA. This result was corroborated by the open-ended feedback from participants. That said, although much of the initial gains were still present at the follow-up timepoint, there was some regression towards baseline. This result suggests that continued refreshers to maintain the initial changes in stigmatizing attitudes are needed after the workshop. It is important to note that the pre-post change approached a large effect size, with the pre to follow-up change being a medium effect. This result shows that TIM had a meaningful impact on its participants, despite being a relatively short program. These effect sizes are larger than those found in The Working Mind and the Road to Mental Readiness (see Dobson et al., 2018).

The other main outcome of increasing resiliency was also achieved by the program. Results showed that participants reported that they were better equipped to deal with stress and potential traumatic experiences (i.e., resiliency skills) after the workshop. This increase was partially maintained at the 3 month follow-up timepoint, although as with stigma reduction, there were some loss of the original pre-post gains, suggesting the need to reinforce the skills learned after the initial program. The effect sizes found for the resiliency skills measure were generally medium and comparable to The Working Mind and the Road to Mental Readiness (see Dobson et al., 2018). Participants also reported increases on the Brief Resilience Scale from pre to follow-up. Although this change had only a small effect size, it is interesting to note that a relatively broad program of short duration managed to increase general resilience 3 months after the program. This result potentially speaks to the impactful nature of TIM.

The qualitative responses also paint TIM as an effective program. Participants generally found the program both relevant and useful, and as well helpful in both reducing mental illness stigma and creating a supportive campus environment. The program itself was well-received. Participants generally found it engaging and believed the structure and the components of the program were well developed. Some participants did perceive the program to be a bit lengthy and repetitive; however, as some of the commenters suggested, this program is a good refresher and may be good for participants who are just entering post-secondary.

This evaluation had several limitations. It would have been optimal to conduct a randomized control trial instead of a pre-post-follow-up open trial, as in the current case. As well, the participant response drop-off in the follow-up period is concerning. The results involving this timepoint should be interpreted with caution. Despite these limitations, the quantitative results suggest that program was largely successful, as the responses were predominantly positive and supported the quantitative findings. Overall, TIM appears to be effective and useful for students in a post-secondary setting. Future research with this program should address the regression towards baseline levels for both stigma reduction and resilience seen at the

follow-up period. As well, a more rigorous design (e.g., randomized control trial) should be incorporated in future evaluations, if at all possible.

7. References

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