Like many of you, I was recently contacted by some people from the Movember Organization to discuss the possibility of funding research in men’s mental health and for general advice on data sources in this field. Seems the organization is interested in expanding their campaign to include men’s mental health, in addition to their highly successful fall raising awareness program, which encourages the growing of outrageous upper lip facial hair in support of prostrate and testicular cancer. My conversations with them led me to think again about the important role that gender and biological sex plays in our research. We know, for example, there are sex differences in the prevalence of major mental disorders (depression and illicit drug use), and in the rates of use of services for mental health. Perhaps the ubiquitousness of sex differences in our field, at least in Canada, has led to some complacency in relation to tackling the big question related to these differences: Why do men and women differ in the first place? (A question Jane Murphy and Dan Rasic also raised in an article in the last edition of the Chronicle). Several years ago, Terry Wade and I conducted a series of studies with the NPHS and other data sources to explore sex differences in the emergence of depression in adolescence, and the pattern of sex differences over the life course. At the time, the most common explanations for such differences pitted social factors (social roles) against biological differences (hormonal changes) as competing mechanisms. The Canadian data, then, were limited largely to cross-sectional survey research, and biological data were absent entirely. Seems to me, we have the opportunity now to explore sex patterns in disorders such as depression and alcohol abuse, using data sources like the NPHS, which follow different age cohorts over 10 or more years (perhaps some of you are already working on this?). British cohort data too, including a number of birth cohort studies (e.g., ALSPAC), also offer some interesting possibilities for tackling the sex differences questions (and there are biological data in many of these studies). My point is simply that more often than not, we take sex differences as a given – we report sex (and age) adjusted rates. The burning question, though, remains why? Psychiatric epidemiology has an important role to play in sorting this particular puzzle out.

John Cairney, Ph.D.
CAPE President
Professor, McMaster University
The 2013 Leighton Lecture

Research informing policy: Selected hits and misses

Angus Thompson, PhD
Institute of Health Economics and the University of Alberta

Translating research findings into health and social policy is an important focus for both researchers and policy makers. There are many sources that provide good advice on presentation style, the quality and relevance of the information, consideration of your audience, and not making extravagant claims about your data. However, when given an opportunity to provide observations on knowledge translation, rather than data, I found that my own experiences took me to a slightly different model that could be sorted into three themes as follows, with examples:

A. RESEARCH CAN SUCCESSFULLY INFLUENCE POLICY

a1. Mental Health Patients in the ER: A Translation Process That Worked. In 1996, the World Psychiatric Association organized a pilot project in Calgary, Alberta, for their World-wide anti-stigma endeavour. I chaired a project sub-committee that focussed on stigmatization among health workers. A consumer member of the project, Michelle Misurelli, made the case that the treatment of people with schizophrenia at hospital emergency departments needed to be addressed. The other members produced ideas, energy, and a questionnaire written on a napkin by Roger Bland. The questionnaire was completed by participating hospital ERs in Calgary and Drumheller. The project report was well received and acted on locally. Furthermore, the Canadian Council on Health Facilities Accreditation (CCHFA) was engaged, and all recommendations, except one, were addressed in their revised accreditation survey.3,4 Thus, local efforts initiated by a world-wide body resulted in the perspective of a person with a mental illness being heard with consequent alterations in standards affecting all Canadian emergency departments. Also contributing were the synergy generated in the community, direct access to an effective policy maker (the CCHFA), timing (the CCHFA and the community were ready).

a2. The Response to a Child’s Suicide: Eventual Good Policy. In 1984 a 17 year-old Aboriginal boy in the care of the child welfare system took his own life. The massive public/official response featured many media reports and a major investigation. With the focus on the child protective services, child welfare policies were upgraded, additional social workers were recruited, their training levels increased, and some heads rolled. Subsequently, however, our study of “death by misadventure” among a child welfare cohort indicated that mortality of this nature differed from the general population only for those who were just above or just below the age of 18 years—the age when the protection provided by child welfare precipitously ends. Deputy Minister Don Fleming quietly used these research findings to support an initiative that increased transitional support for those “graduating” from child welfare at age 18.

a3. Creative Sentencing: Research to Action on Workplace Mental Health. An Alberta firm was fined for an environmental offence reportedly involving mental health issues. The presiding
judge invoked a “creative sentencing” approach. Three-quarters of the fine was awarded to the Institute of Health Economics to undertake a health promotion project relevant to the improvement of mental health conditions in the Alberta workplace.  

Mental Health Works was commissioned to present a workshop for key staff from a range of Alberta workplaces. Sessions dealt with the recognition of mental health problems, connecting with troubled employees, the management role, and suggested worksite policy and procedures.

The findings showed (1) strong evidence for workshop quality, (2) good evidence that learning took place, and (3) indications that some positive developments were initiated in attendee workplaces (albeit not extensively). Thus, a more widespread use of these, or similar, workshops is recommended, with built-in evaluation and provisions for continuous improvement.

B. CRISES CAN LEAD TO RESPONSES THAT ARE NOT GUIDED BY EVIDENCE

b1. A Therapist’s Murder: Tragedy Followed by a Questionable Response. In the early 1990s a patient in Alberta’s community mental health system took the life of a therapist. The system reacted quickly — its investigating committee recommended the use of employee badges, bullet-proof plexiglass in the waiting area, and safety procedures for therapists. Although the Committee Chair acknowledged that none of these measures would have prevented the therapist’s death, they were implemented.

This community system had served well over half a million patients over its 60-year history. The tragedy in question was the only such death during those six decades. It is highly unlikely that such a rare event could successfully be prevented. But there is a cost to such initiatives; services cancelled because of budgetary and attentional diversion and whatever consequences the fortress mentality might have on patient care.

The issue here appears to be the ever-present need to be seen to be doing something about a crisis even when there is limited evidence to guide action.

b2. Out of Control Health Expenditures: Manufactured Crisis? In the early 1990s, the Alberta Government announced that the steep upward trend in its health care expenditures was unsustainable. This was followed by legislation and policy changes addressing this issue. However, my findings on Provincial expenditures from 1975-2001 showed a very small and very manageable change after adjusting for population growth, inflation, and the aging of the population. Furthermore, other studies indicated that most Albertans were willing to pay even higher taxes for more good quality health care. Overall, this showed that public policy explanations do not necessarily follow research evidence or public sentiment.

C. RESEARCH IS STILL EVOLVING FOR MANY LARGE POLICY INITIATIVES

c1. A National Anti-Stigma Campaign. Stigma associated with mental illness is currently a major priority in Canada. Public education programs seem to be the most popular in spite of the fact that such approaches have generally not been shown to be effective. It is my opinion that the research data indicate that perceived dangerousness coupled with faulty thinking are the keys to stigma, and that our inborn self-protective mechanisms are not very amenable to logical arguments. Thus, showing that those afflicted by schizophrenia are good and talented people who have rights is not relevant to the matter at hand, no matter how important and true such assertions are.

c2. National Suicide Prevention Strategy. For some time, the Canadian Association For Suicide Prevention has made a call for a suicide prevention strategy for Canada. They were effective — in October of 2011 the House of Commons passed a motion in support. The issue here is that there is no evidence showing that we know how to prevent suicide. The proposed strategy quite rightfully calls for research and the
development of knowledge, but the main thrust is in support of interventions that are not supported by evidence of their efficacy.

**Conclusion**

While the conduct and dissemination of good research is crucial, my experiences have also pointed to a simple checklist: Spend time clarifying your purpose, and then check for opportune moments, untapped synergy, and access to policy makers with agency. Further, warily address others’ vested interests, unclear policy (particularly about purpose), paradigms that undervalue research evidence, and the pressure to “do something” It is perhaps presumptuous of me to present these simple suggestions, but they are often missing in contemporary issues management. I wish that I had learned them much earlier.

**Notes**


**Connecting Workplace Mental Health and Population Health: A call to action for epidemiologists**

Martin Shain S.J.D.

Principal, Neighbour at Work Centre, Caledon, ON; Adjunct Lecturer, Dalla Lana School of Public Health; and Adjunct Professor, Faculty of Health Sciences, Simon Fraser University.

Ontario has now joined BC and Alberta in acknowledging that work can induce or exacerbate mental distress to the point of compensable disability. Indeed, excluding such disability from the compensation regime has been ruled unconstitutional in BC and Ontario.¹

In reaching its decision, the Ontario Workplace Safety and Insurance Appeals Tribunal (the WSIAT) heard expert testimony for and against the view that certain conditions of
work can cause or contribute to mental disability. After carefully reviewing this testimony the Tribunal ruled that while some people may be more prone to mental injury than others when exposed to identical or near identical conditions of work, this in itself cannot be a reason for disallowing claims for compensation if the disability occurred in the normal course of the job.

This decision invites us to revisit questions about the prevalence of mental injuries that occur in the workplace and about the extent to which they can be prevented. It also revisits questions about particular individual vulnerabilities and the so called “eggshell psyche” cases.

In reality we have only the most rudimentary idea about how widespread the phenomenon of workplace mental injury actually is and we have even less idea about how the particular vulnerabilities of eggshell psyche workers play into this picture.

Current crude estimates of prevalence suggest that between 25% and 33% of all formal mental disability claims seen in the workplace are attributable to actual or perceived mental injuries. One of the problems confronting this area of research is the typically unsurfaced disagreement among investigators regarding the very definition of mental injury. In the context of the new National Standard on Psychological Health and Safety in the Workplace, mental injury is the result of acts or omissions by workplace actors that lead or contribute to short or long term debilitating mental harm. However, this harm may or may not amount to one or other of the mental illnesses defined in the DSM V. In fact, the legal concept of mental harm is quite different from the medical concept. It is increasingly easy for employers to run afoul of the law in this area where the legal threshold for harm is often lower than in the DSM V. An exception to this is in Workers Compensation law where evidence of a DSM V disability must be adduced.

While it is perhaps an obvious point, it is important to keep in mind that mental injury has to be treated differently in the workplace than mental illness although in some instances the two may be one and the same. Mental injury, however, is by definition a result of things that are done or not done by actors in the workplace, whereas mental illness can be imported into the workplace and have little or nothing to do with workplace dynamics. For this reason it is essential that we have a workplace strategy in place that deals with both mental injury and mental illness from different angles. The above-mentioned National Standard on Psychological Health and Safety is Canada’s best effort so far at providing such a strategic framework.

Few attempts have been made to estimate at a population level the prevalence of risk factors related to mental injury. Two Ipsos Reid surveys have sampled the Canadian working population regarding their level of concern about working conditions either known or suspected to be implicated in the genesis or precipitation of mental injuries. These surveys used the instrument found in "Guarding Minds at Work" called the PF 13. The level of concern exhibited by respondents can be seen as roughly corresponding to levels of risk to psychological wellbeing, assuming there is some reasonable relationship between perception and reality. However, in this area particularly, perception often is reality since the experience of mental injury can be quite subjective and unascertainable from an objective point of view. With this caveat in mind, Ipsos Reid reported that approximately 22% of the Canadian working population sees their employment environments as psychologically unsafe, meaning that they are characterized as allowing - or at least not preventing - negligent, reckless or intentional harm to employee mental health.

Taken all together, this suggests that research of the kind traditionally undertaken by epidemiologists (documenting the prevalence, development, and impact of psychological injury) is sorely needed. This is not enough, however. Another important reason for epidemiologists to take the phenomenon of mental injury seriously is that harm created or catalyzed in the workplace does not stay there but rather migrates into
relationships, families, communities and society at large in the form of economic and social costs.

For example, when a person becomes permanently disabled as a result of mental injury they can no longer earn income, support their dependents or participate fully in the world at large. Even when they are not permanently damaged they often carry a burden of mental anguish that keeps them unbalanced and disengaged with those in their circles of influence. These people in turn may exhibit signs and symptoms of distress as a result of the strain of living with a person who is not whole or fully present any more.

Preliminary steps have been made toward conceptualizing this transfer of health or harm from the workplace to society in the form of either social capital or social exhaust but more work needs to be done and done soon in this area.

To ignore this source of health or harm is to ignore the workplace as a significant influence on mental health in its own right.

Workplace mental health is really a population health issue and as such deserves the attention of epidemiologists who have the wit and the will to breach the conceptual and methodological barriers that confront serious research in this area.

Editor’s Note
Billy Crystal and I have something in common; we both believe that a mistake often provides an opportunity. In his case, it often leads to a pithy and funny observation. In mine, it is more mixed. During my talk at CAPE 2013, I mentioned that public education programs have not proven to be effective — at least that is what I meant to say. Furthermore, in that context, I purposely implicated the stigma program of the Mental Health Commission of Canada. Word got back to Heather Stuart, a significant player in the Commission’s work, who, as a long-time friend and colleague, provided me with opportunity to explain myself! While self-defence might have been interesting to me, I thought it might be more useful to all if Heather were to prepare a description of her approach for CAPE Chronicle readers. She agreed and has prepared a concise and masterful exposition on the topic.

Can Education Reduce Stigma?
Heather Stuart, PhD

Heather Stuart is Professor and Bell Canada Mental Health and Anti-stigma Research Chair, Queen’s University and Senior Consultant, Opening Minds Anti-stigma Initiative, Mental Health Commission of Canada.

At the September 25th CAPE meeting Gus Thompson made some interesting points about policy setting in spite of the evidence, giving numerous examples of how this plays out. In one of the examples, he identified the national

1. Plesner v. British Columbia Hydro and Power Authority, 2009 BCCA 188 (CanLII), http://canlii.ca/t/23c21; WSIAT Decision 2157/09
2. CSA Z1003-13, BNQ 9700-803/2013
3. www.guardingmindsatwork.ca
consensus that mental health stigma is significant
and should be addressed. He provided the
example that education-based anti-stigma
programs have not been effective and suggested
that the pressure to "do something" may have led
groups such as the Mental Health Commission of
Canada to adopt such approaches in spite of the
evidence.

Gus's statement that education-based anti-
stigma programs have not been effective is both
right and wrong, depending on how you define
education, and depending on how you define
stigma. In order not to leave the wrong
impression about the Mental Health Commission's
anti-stigma activities, I wanted to
take this opportunity to elaborate.

Stigma is enacted at three levels. Self-
stigma occurs when individuals who have a
mental illness accept and agree with negative
cultural stereotypes. They feel ashamed,
blameworthy, and try to conceal their illness from
others. Although still in the pilot phase, my
colleagues at Queen's University and I have
found that our newly developed Overcoming
Stigma Program, which is based on psycho-
educational principles, is helping some people
overcome self-stigma and better manage
society's response to their illness. We will know
more as we continue to evaluate this intervention
more carefully, but there is strong evidence to
support psycho-educational approaches in illness
management (e.g.: (1)) so this is one area where
education may help.

Public stigma encompasses the prejudicial
attitudes and discriminatory behaviours
expressed toward people with a mental illness by
members of the public. Public stigma is based on
deeply held prejudices that are, by definition,
resistant to change. Prejudices do not respond to
traditional educational and awareness raising
approaches that are designed to convey facts
about mental illnesses in order to improve
understanding and literacy. Indeed, there is a
growing body of evidence to show that those with
the highest levels of literacy (such as health
providers) are among those who are experienced
as most stigmatizing. In addition, we know from
social psychological theory that people who hold
prejudices particularly those rooted in fear of
may selectively attend to information that supports
their perspective and ignore or explain away
information that doesn't. Even in the face of
considerable contradictory evidence, people are
able of maintaining their prejudices. For those
who are old enough to remember Archie Bunker's
confuse me with the facts defense, you will
get a sense of how this process works. (2)

Contact-based education occurs when
someone who has had a mental illness tells their
recovery story and allows for interaction and
experiential learning. There is strong social
psychological theory promoting social contact to
reduce prejudice between groups. Though
originally introduced by Allport in 1954 to reduce
prejudices between racial groups (3), social
contact has since been used extensively to
improve public attitudes towards people with a
mental illness. In a meta-analysis of outcome
studies, personal contact with a person with a
mental illness significantly decreased stigmatizing
attitudes. (4) So, contact-based education also
seems to work.

Structural stigma occurs at the level of
institutions, policies, and laws. It creates
situations in which people with a mental illness
are treated inequitably and unfairly. It is possible
that awareness raising educational efforts (such as
policy briefings) could encourage funders and
decision-makers to improve structural supports
for people with a mental illness. However, it is
more likely that active advocacy and legal protest
will be needed to ensure that people with a
mental illness can take advantage of the rights
and privileges they have been afforded through
constitutional law and equity legislation. (2) In
this scenario, education plays a role, but, by itself,
may be insufficient to instigate change.

The Opening Minds anti-stigma initiative of
the Mental Health Commission of Canada is
using contact-based education in four target
groups: youth, workplaces, health care providers,
and media (through journalism schools).
Researchers from five universities (The University of Calgary, The University of Toronto, Queen’s University, McGill University, and Dalhousie University) are working with over 100 community programs and partners who have implemented contact-based educational strategies. Supported by the Opening Minds initiative (which is funded through Health Canada), they are working together to systematically evaluate program effects and distill out the most critical ingredients. The approach is deliberately grass roots and based on community development theory. It avoids large public education campaigns (which are inefficient and ineffective), in favour of potent, local interventions, delivered by networks and coalitions of community partners. (5)

In the team that I lead, which targets youth, we are finding up to a 30% improvement in our general measure of stereotypic attitudes and up to 15% improvement in feelings of social acceptance (a measure of behavioural intent) in high school youth who have received contact based education. Using qualitative research, we have also identified what we think are the critical (or active) ingredients in contact-based intervention. We are in the process of validating these quantitatively and on the road to developing formal fidelity criteria to help programs maximize their chances for success. Our conclusion is that educational approaches that empower through interaction and contact have tremendous potential to unseat prejudices and eliminate discriminatory behaviours. Those that purvey nuggets of knowledge, or sell social acceptance like soap, are destined, as Gus says, to be searching for something to do in spite of the evidence.

**Works Cited**


---

**Important Conference Dates**

  Contact: Prof. Arnstein Mykletun
  [arnstein.mykletun@uib.no](mailto:arnstein.mykletun@uib.no)

- International Association for Suicide Prevention (IASP)
  28th IASP World Congress
  New Discoveries and Technologies in Suicide Prevention
  June 16 -20, 2015
  Montréal, Québec, Canada
  Contact : Prof. Brian Mishara

- **CAPE 2014** - Annual Scientific Symposium
  September 10th, 2014
  Toronto, ON
  Coordinators:
  Paul Kurdyak: [paul_kurdyak@camh.net](mailto:paul_kurdyak@camh.net)
  Karen Urbanoski: [karen_urbanoski@camh.net](mailto:karen_urbanoski@camh.net)
You are invited to Ontario for CAPE’s 2014 Annual Scientific Symposium. Keynote speaker, Dr. Ben Druss of the Rollins School of Public Health, Emory University, will highlight his work on psychiatric and medical outcomes among people with serious mental illnesses featuring the evaluation of policy and interventions using administrative data.

The day will also include oral and poster presentations from researchers and students across the country plus an expert panel on policy and prevention. Another highlight of the day will be the presentation of the Alexander Leighton Prize and the winner's address.

More information on the CAPE Website. http://www.psychiatricepidemiology.ca/

Conference Conveners:
Drs. Karen Urbanoski & Paul Kurdyak, CAMH

Information:
Stacey Penaloza  Tél. 613-746-4621
Stacey.Penaloza@camh.ca

CAPE / ACEP was organized in 1984 by a multi-disciplinary group to: (1) facilitate communication among those involved in psychiatric epidemiology in Canada, (2) provide information and advice to policy makers, clinicians and scientists in the mental health field, and (3) support improvements in the quality of training for students of psychiatric epidemiology in Canadian centres.

More information is available at the CAPE/ACEP website: http://people.ucalgary.ca/~patten/CAPE.html

CAPE Chronicle
Send Newsletter submissions and announcements to:
Gus Thompson, Editor
gthompson@ihe.ca