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An Evaluability Assessment of a Program to Combat Stigma to Mental Illness in the Workplace

by

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Abstract

This study is an evaluability assessment (EA) of "What's Up with Biff?", a program developed by the Calgary Canadian Mental Health Association to combat stigma to mental illness (MI) in the workplace. MI is associated with staggering social and financial costs in Canada. Stigma to MI can be worse than the disease itself and is widespread in our society. "What's Up with Biff?" is one of few programs that combat stigma to MI in the workplace, but it has not been evaluated. Qualitative methods of data collection and data analysis were used to describe the program and derive a program logic model. This EA determines if the program is evaluable and provides recommendations to prepare it for an evaluation. Recommendations to adopt more realistic program outcomes are made. With these recommendations, the program will be ready for a process and outcome evaluation. The Context Input Process and Product (CIPP) evaluation model is recommended.

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Dedication

To Alison Lall, my late friend and co-worker, and to her loving family who, tragically, were all victims of mental illness.

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Chapter 1: Stigma to Mental Illness in the Workplace

Introduction

The workplace, where most adults spend many hours of their lives, is an ideal setting for health promotion (Stuart, 2004). Being engaged in productive employment is an important mental health (MH) determinant. However, people affected by MI often feel stigmatized in the workplace (Stuart, 2004), which leads to worsening mental health and decreased productivity. Considering that 20% of Canadians are expected to develop MI at some point in their lives (Health Canada, 2002), one can see the importance of combating stigma to MI in the workplace.

The Calgary branch of the Canadian Mental Health Association (CMHA-Calgary Region) developed The Copernicus Project™: Risk Management for Workplace Mental Health, which currently includes two programs, the "Copernican Shifts" and the "What's Up with Biff?" programs. According to the CMHA-Calgary Region, both programs have been delivered with positive results to a wide workplace audience in Calgary, including oil and gas corporations, municipal and provincial agencies, and construction companies. However, neither the "Copernican Shifts", nor the "What's Up with Biff?" program has been formally evaluated (J. Whitworth, personal communication, April 5, 2009).

This project is evaluation research, more specifically an evaluability assessment (EA) of the "What is Up with Biff?" program. An EA is a set of procedures that prepares a program for an evaluation, and it will be further described in Chapter 2.

Literature Review

This section starts by defining some important terms used in this paper. The definitions are followed by discussions on: MI and its incidence and costs in Canada; stigma to MI, its consequences and contributing factors; the workplace as a setting to combat stigma to MI; and gaps in knowledge about stigma to MI in the workplace and on interventions to combat stigma to MI in the workplace. It concludes with a brief discussion on population health intervention research and evaluation research.

Definitions.

According to the Health Canada's Report on MI in Canada (2002), "mental illness is characterized by alterations in thinking, moods or behaviours (or some combination thereof) associated with significant distress and impaired functioning over an extended period of time" (p.16).

Mental health (MH) is defined as not just the absence of MI. According to the World Health Organization (WHO), MH is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2007, p. 1).

Wellness is defined using many dimensions of human well-being. Smith, Tang, and Nutbeam (2004, p. 344) state that wellness encompasses "the realization of the fullest potential of an individual physically, psychologically, socially, spiritually, and the fulfillment of one's role expectations in the family, community, place of worship, workplace and other settings." This definition illustrates two things: the reality that health and wellness are created in the social contexts and settings within which we live,

including the workplace; and the fact that work itself is a dimension of wellness. Other definitions include intellectual, emotional, occupational and environmental dimensions (North Dakota State University Wellness Center, 2011).

Stigma is a combination of stereotyped beliefs, prejudiced attitudes and discriminatory behaviours towards a specific group (Hinshaw & Stier, 2008). For the purposes of this paper, MH issues is a broad term that encompasses any problems related to MH, including all problems experienced by those afflicted and affected by MI, and problems arising from stigma to MI. In this paper the term *afflicted* refers to people that are suffering from MI themselves. The term *affected* refers to people that are associated with someone afflicted by MI.

Incidence of MI in Canada.

According to Health Canada (2002), one in five Canadians will suffer from MI at some point in their lives. Two percent of the population will suffer from severe MI such as psychosis, schizophrenia, severe bipolar disease or severe depression. The remaining 18% will suffer from less severe MI such as depression and anxiety (Health Canada, 2002). In Alberta, 25% of physicians' claims for visits from 2004 to 2006 were related to MI (Alberta Health and Wellness, 2007).

Although MI is more prevalent in disadvantaged or vulnerable groups, such as the elderly, adolescents, gays and lesbians, women, marginalized groups and people with low social status, people of all ages, educational levels, cultures and socio-economic status may be affected by MI (Health Canada, 2002). Thus, it is an issue that affects all Canadians; those afflicted by MI and those that are affected by a family member's or friend's illness.

Cost of MI in Canada.

The financial and social costs of MI can be felt in all sectors of our society. Costs to industry and governments due to absenteeism, presenteeism (i.e., decreased productivity at work), and disability days caused by MI are estimated to cost at least $16 billion a year in Canada (Great-West Life Centre for Mental Health in the Workplace, 2008). Governments experience a loss of revenue from decreased income tax revenue and an increase in the costs of services such as welfare programs and unemployment benefits (Dewa, McDaid, & Ettner, 2007). At the community level, there are costs borne by families and friends that provide financial support and give up work to assume the role of caregivers. Families suffer from overburden, guilt and shame (Dewa et al., 2007). In the workplace, co-workers often have to take on the extra work not completed by people affected by MI (Dewa et al., 2007). Finally, at the individual level, mental disability can lead to loss of work and income. Many of these costs are reinforced or caused by stigma to MI, rather than by the mental illness itself (Stuart, 2004).

Stigma to MI and its consequences.

Stigma is a pervasive and complex social phenomenon (Hinshaw & Stier, 2008). It occurs in a social context when an attribute is perceived to be negative. The person or groups that possess this negative attribute are stereotyped and treated with an attitude of prejudice and discriminatory behaviours (Corrigan, Watson, & Ottati, 2003; Couture & Penn, 2003).

Stigma can be found in all levels of society (Penn & Wykes, 2003; Stuart, 2004). Governments are unwilling to provide funds to MI programs (Mental Health Commission of Canada & Hotchkiss Brain Institute, 2008). Services and research directed at MI go

underfunded and are the first to be cut in times of financial restraint (Stuart, 2004). At the community level, stigma to MI is found everywhere, including the general public, employers, co-workers, and even from health care providers and family members (Penn & Wykes, 2003; Stuart, 2004; Heijnders & Van Der Meij, 2006).

Stigma of all sorts has a detrimental effect on mental health. It affects people not only after MI has developed, but is one of the factors that precipitate the onset of the disease itself (Boydell et al., 2001; Penn & Wykes, 2003). There is a complex bidirectional relationship between stigma and MI; as described by Davidson (2002), the more a person is stigmatized, the more likely this person is to develop MI and the more likely he or she will be further stigmatized. Thus, the social environment, including the workplace, is an important factor in the development and course of MI. The social environment in the workplace is clearly a concern for population health, public health, health practitioners, researchers and policy makers.

Many scholars and researchers agree that stigma is one of the biggest challenges for people suffering from MI (Britt et al., 2008; Penn & Wykes, 2003; Service, 2004; Stuart, 2004). Stigma adds another dimension of stress and suffering to people that are already ill, and it can be more devastating than the disease itself, seriously compromising the coping abilities of people suffering from MI (Holmes & River, 1998; Penn & Wykes, 2003; Stuart, 2004). Stigma limits opportunities for education, jobs, housing, and access to health care. It interferes with social activities, thereby limiting opportunities for a healthy and productive life (Holmes & River, 1998; Penn & Wykes, 2003; Stuart, 2004).

Stuart (2004) summarizes the impact of stigma on people suffering from MI as follows "... stigmatizing attitudes can impede recovery and promote disability. Stigma

hinders social integration, the performance of social roles, timely access to treatment, and quality of life" (p. 101). Stuart adds that self-stigma, the acceptance of stigma as a personal failure, causes low self-esteem and low confidence, which may hinder performance in all aspects of life, including in job interviews (Stuart, 2004). Stigma and fear of stigma act as barriers to treatment, to adherence to treatment programs, and to successful treatment in people suffering from MI (Britt et al., 2008). There is fear of disclosure of any type of MI due to stigma and its consequences, especially in the workplace (Heijnders & Van Der Meij, 2006; Stuart, 2004).

Contributing factors to stigma to MI.

There are a number of factors in our society that contribute to stigma towards people suffering from MI. These contributing factors will be presented as predisposing, enabling and reinforcing factors.

Predisposing factors are those that motivate the behaviour (Green & Kreuter, 2005). They include fear of facing a disease that can affect oneself; misconceptions about people with mental illness as being crazy, incompetent, unreliable, irrational, violent and/or weak in character; and discomfort in interacting with people that are dealing with MI (Penn & Wykes, 2003; Stuart, 2006).

Enabling factors are those that facilitate the behaviour (Green & Kreuter, 2005). They include lack of positive role models and lack of knowledge of how to interact with people afflicted or affected by MI (P. Hawe, MDSC 651.03 Community Interventions: Theory, Research and Practice, June 2008).

Reinforcing factors are those that reward the behaviour (Green & Kreuter, 2005). They include a sense of protection ("if I don't think about it, it will not happen to me"),

media with sensational negative stories that mislead people's perceptions (Penn & Wykes, 2003), inadequate policies, and some generally-accepted negative attitudes or prejudices (Stuart, 2006).

The workplace as a setting to combat stigma.

There are three main reasons why the workplace is an appropriate setting for combating stigma: the importance of settings for health promotion as identified by the Ottawa Charter (WHO, 1986); the increased stress seen in the workplace lately and its association with MI; and the importance of work to mental wellness. Further, as per its definition, an important dimension of wellness is the realization of one's potential in an occupation.

The workplace is one of the settings identified for health promotion. The setting approach has its roots in the Ottawa Charter for Health Promotion: "Health is created and lived by people within the settings of everyday life, where they learn, work, play and love" (WHO, 1986, p.2). The setting defines the frame for the intervention and identifies the subjects that would benefit from the intervention. It also facilitates the understanding of the social structure, the social context and the characteristics and living circumstances of the target population, all of which facilitate research and health promotion (Green, Poland, & Rootman, 2000).

There is increased stress reported in the workplace lately, which increases the risk for MI (Britt et al., 2008). In the last few decades, we have experienced a technological revolution that has changed the way we work and the demands of work (Dewa, 2007). The workplace has shifted from physical labour to more knowledge-based work practices with increased use of the mind, and an associated increase in mental stress and mental

challenges, all of which increase the risks of MI (Britt et al., 2008). Therefore, it should not be surprising that there is an increase in the prevalence of MI and costs associated with MI in the workplace (Institute of Health Economics [IHE], 2008). Low job quality and increased work demands, especially when coupled with feelings of low control, increase stress at work and are risk factors to depression and anxiety (Sanderson & Andrews, 2006). Unsupportive organizational practices towards employees are also important risk factors for MI (IHE, 2008). The increase of stress in the workplace reinforces the workplace as an ideal setting for health promotions aimed at improving the social environment, such as programs to combat stigma.

Work is an important activity for adults and an important determinant of health. Adults spend much of their life at work, and careers are strongly associated with a person's self-identity. Work should be a healthy part of life; it can provide financial independence, satisfaction and self-worth. "Work is a major determinant of mental health and a socially integrating force that is highly valued. No single social activity conveys more of a sense of self-worth and social identity than work" (Stuart, 2006, p.522). If stigma limits the opportunities for people to obtain or maintain meaningful jobs, and work is an important MH determinant, it follows that the workplace is an ideal place for an anti-stigma intervention.

In conclusion, the workplace is a natural target setting and a place with great potential for health promotion interventions that contribute to the development and maintenance of a healthy workplace environment, including combating stigma to MI.

Gaps in knowledge and interventions in the workplace.

There is much in the literature about mental wellness initiatives in the workplace (Vezina, Bourbonnais, Brisson, & Trudel, 2004). These initiatives promote mental wellness and are also intended to prevent mental illness caused by circumstances in the workplace. However, little is known about stigma in the workplace in Canada, particularly stigma towards less severe or less disabling mental health problems that are more likely to be found in the workplace (Stuart, 2004). In a survey in Germany, Angermeyer (2004) found that more than 80% of patients suffering from depression anticipated some degree of discrimination when applying for a job and 67% of these patients were advised by others not to disclose their condition when applying for a job. According to Angermeyer, even though such research results cannot be generalized to other countries due to differences in laws and employment rates, one would probably find similar results in Canada in an equivalent study with the Canadian population (Angermeyer, 2004).

Stuart (2004) identified three gaps related to MI in the workplace in Canada. One of these gaps is the lack of anti-stigma programs. She suggested three priorities as part of a national research agenda on mental health in the workplace: to increase targeted research on mental health, stigma and work; to collect population data on stigma and work; and to create business/research alliances to defeat stigma in the workplace (Stuart, 2004).

Combating stigma to MI in the workplace has the potential to decrease employees' risk factors to MI in two ways: first, by directly decreasing the consequences caused by stigma when a person is afflicted or affected by MI; and second, by decreasing

the general stress level in the workplace, which is in itself a risk factor to MI. A stressful workplace can lead to anxiety and feelings of inadequacy, leading to MI; therefore, reduced stress in the workplace should reduce the risk factors to MI (IHE, 2008).

Population health intervention research and evaluation research.

The Institute of Population and Public Health defines population health intervention research as "the use of scientific methods to produce knowledge about policy and program interventions that operate within or outside of the health sector and have the potential to impact health at the population level" (Canadian Institute of Health Research, 2006). Population health intervention research includes all evaluation research in population health (Hawe & Potvin, 2009).

Evaluation research is an essential part of best practices in population health interventions. It addresses important aspects about the effectiveness of an intervention, such as whether it is delivered as intended (i.e., the fidelity of the program), whether it is reaching the target population, and whether the effects of the intervention are positive and not causing harm. Evaluation also points out the strengths and weaknesses of a program. A formal evaluation can detect problems early in an intervention, thereby avoiding failures. It can clarify if an intervention is intrinsically faulty (e.g., in its theory or development) or if there are problems in the delivery of the program (Hawe & Potvin, 2009). However, these advantages are realized only when evaluation research is done correctly. Thurston, Vollman, et al. (2003), in their project to develop and test a framework for assessing the effectiveness of health promotion, found few health promotion programs in Alberta that met their criteria for inclusion in their project. From 180 health promotion programs with a written evaluation, only 35 met criteria such as

appropriate research design, appropriate data collection methods and appropriate interpretation (Thurston, Vollman, et al., 2003).

Rationale/Relevance

There is a strong and clear case supporting the value of the proposed evaluation research. MI is widespread in Canada and there are large associated economic and social costs. Stigma to MI is a serious problem, and there is a strong bidirectional relationship between MI and stigma. The workplace, where people spend many hours of their lives, is an ideal setting for health promotion, and there is a lack of programs to combat stigma to MI.

We know that health promotion interventions can do harm and therefore it is very important to evaluate them (Hawe & Potvin, 2009). Since some interventions against stigma to MI have been administered without a formal evaluation, it is essential to evaluate how they affect the workers and the workplace in which they are delivered.

"What's Up with Biff?" is one program that has been commercialized and administered to thousands of workers in the Calgary region (P. Lebtika, personal communication, August, 2009). It has not been, however, the subject of any type of formal evaluation to date. The "What's Up with Biff?" program is the focus of this evaluation research.

In the next chapter the design of this project and the research methods are described. The study design and the research questions are presented, and the methods of data collection and data analysis are described in detail.

Chapter 2: Design and Method

In this chapter the design of this research project is described, the research questions are introduced, and the methods used to answer the research questions are detailed. The description of methods will include sampling and sample size, data collection, data analysis, methodological rigour, and a discussion of the ethical issues related to conducting research with human subjects. This study received ethics approval from the Conjoint Health Research Ethics Board (CHREB) on May 20th 2010, ethics ID# E-23133.

Study Design

This research project is an EA of the "What's Up with Biff?" program. The goals, objectives and activities of this program are unclear and further attention is needed in better understanding it before proceeding with a full evaluation. EA is a set of procedures that determine "whether the program is ready to be managed to achieve desired performance and outcomes, what changes are needed to allow results-oriented management, and whether the evaluation is likely to contribute to improved program performance" (Strosberg & Wholey, 1983, p.66). In fact, improvement in program performance may be one of the main benefits of an EA (Thurston, Graham, & Hatfield, 2003).

According to Wholey (1987), an EA provides a program description that includes: i) a definition of the problems addressed by the program; ii) a description of the program's activities; iii) the expected outcomes or impacts of the program; iv) a logic model that links all of the above; and v) an agreement on evaluation priorities and intended uses of evaluation by key stakeholders. An EA clarifies and improves the

ability and willingness of key stakeholders to take action on the evaluation results, thereby increasing the utility of the evaluation.

EA clarifies the program from the point of view of key stakeholders and helps them obtain a consensus on the goals and desired objectives of the program. It also clarifies the plausibility and measurability of these objectives. In so doing, EA can identify opportunities to change program resources, activities and objectives in order to improve a program's performance (Wholey, 1987).

A logic model is provided when an EA is conducted (Wholey, 1987). A logic model is a diagrammatic representation of a program. It depicts and links the goals, target population, objectives, indicators, resources and activities of a program (Dwyer & Makin, 1997; Thurston et al., 2003). Logic models are used to present a program, and they aid in understanding the connections amongst the various aspects of the program.

Primary Research Question

What modifications to goals, objectives and activities would strengthen the evaluability and performance of the "What's up with Biff?" program?

Secondary Research Question

What type of evaluation is most appropriate at this point in time for the "What's up with Biff?" program?

Study Methods

To conduct an EA, a full description of the program is required (Wholey, 1987). Qualitative methods are most appropriate when rich in-depth information is needed (Patton, 1987). Therefore, qualitative methods consisting of interviews, observation, and document review were used to collect the data in this study.

To provide better understanding of the "What's Up with Biff?" program, the program needed to be explored through the perspective of different stakeholders. Rossi (1999) says that "the evaluator must interact with the program stakeholders to draw out their implicit program theory" (p. 162). Qualitative methods such as interviews allow for this interaction, and allow for flexibility to adapt the discussion and explore an issue in depth (Rossi, Freeman, & Lipsey, 1999).

Sampling and Sample Size

Sampling was purposive. Purposive sampling is a deliberate, non-random, method of sampling that aims at selecting people that have specific characteristics or knowledge (Bowling, 2007). The advantage of purposive sampling is that one can focus on recruiting individuals that can provide rich information (Patton, 1987). In this project, participants were recruited that were connected with the program in different capacities, including program development, management, delivery, purchase and participation. All research participants were asked to recommend others that could be invited to take part in this project (snowball sampling). Using a snowballing sampling technique normally helps to uncover prospective participants that might otherwise be missed.

As a result of a meeting with the CMHA-Calgary Region, their participation in this project was secured. One of their managers agreed to share the documents available about the program, and a binder with the train-the-trainer material. The complete package, including the video clips that are part of the "What's Up with Biff?" program, was not made available due to the commercial nature of the program. The videos were watched on one of the computers at the CMHA-Calgary Region and again during program observation.

The CMHA-Calgary Region approved the participation of internal stakeholders to take part in the project during work hours and provided a signed letter to this purpose. This approval included two current employees, one of whom was actively involved in promoting, maintaining and delivering the program, and the other who was the direct supervisor. Other participants recruited were the developer of the program (no longer working for the CMHA-Calgary Region) and three managers of organizations responsible for purchasing the program from the CMHA-Calgary Region. One person that participated in a workshop that was delivered during the course of this project was also recruited. The total sample size for the interviews was seven people.

Recruitment of participants was done with help from the CMHA-Calgary Region. The CMHA-Calgary Region was asked to identify a client that had used the "What's Up with Biff?" program for more than six months and one that had used it for less than three months in order to obtain variability in client exposure to the program, which could affect their perspective and assessment. The CMHA-Calgary Region approached their clients to obtain their permission to be contacted. This permission was required because the CMHA-Calgary Region felt unable to disclose the identity of their clients without their consent. Once permission was received, these clients were sent an invitation letter (Appendix A). These clients were managers that had purchased the "What's Up with Biff?" program on behalf of their organizations. Once the purchasers were recruited, authorization was requested to directly contact and recruit program participants for interviews during work hours, at a venue and time of mutual convenience.

Data Collection

Prior to gathering data, the researcher wrote a reflection on her knowledge, assumptions and pre-understanding about MI in the workplace and programs to combat MI in the workplace. These notes were discussed interactively with her supervisor at different stages of the research project. The aim of this reflection was to improve awareness of her beliefs and pre-conceptions and to question them. This reflection is done in order to open or prepare one's mind to receive new information, and to help avoid searching for or dwelling on one's own perspectives during data gathering and analysis (van Manen, 1997).

Key documents produced by the CMHA-Calgary Region were reviewed, including those describing the program, those promoting the program, and other documents and materials used to deliver the program, such as handouts. When possible, the documents were imported into the software QSR-NVivo 7™ to be analysed. A written description and synopsis of documents that could not be imported into the software was prepared. Those descriptions and synopses were then imported into QSR-NVivo 7™ for analysis. All interviewees were asked to identify and share any additional documents they believed to be relevant. Copies of the documents were obtained and assessed for relevance in this project and, if relevant, they were added to documents reviewed.

The documents were used to help obtain a preliminary understanding of the program. The document reviews helped to determine and guide questions that were asked during the interviews.

Semi-structured interviews were scheduled with all research participants, either face to face or by telephone, depending on each participant's choice. The aim of the interviews was to understand the program from the point of view of the interviewees. Questions varied somewhat depending on the person's connection with the program. For the developer and the person currently responsible for the program, the aim of the interview was to clarify the issues addressed by the program, the goals and objectives of the program, intended activities, resources used, and the intended and actual delivery of the program. For the purchasers of the program, the aim of the interview was to clarify the resources that they would or had used, their expected goals, objectives and anticipated impacts when purchasing and using the program. For the program participant, the aim of the interview was to clarify goals, objectives and expected impacts when participating in the program and to find out more about the experience during the workshop and after. All interviewees were asked about their general impression of the program and about the program's strengths and weaknesses.

A small number of open-ended questions were developed to help guide the interviews and gather intended information so that interviewees would "express their own understanding in their own terms" (Patton, 1987, p. 115). An interview guide was developed to serve as a basic checklist (Appendix B). This interview guide provided a framework from which further questions could be developed. The researcher was free to elaborate, in a conversational style, on the subject areas described in the guide (Patton, 1987) and on any new subject introduced by the interviewees. Interviews lasted up to 60 minutes, depending on the participant's willingness, time and availability. Interviews were done during work hours. All participants were asked to take part in one interview,

with the possibility of a follow-up for clarification and confirmation of the information obtained.

Follow-up was done by sending clarifying questions through e-mails and asking interviewees for their preference for further contact. They were offered a choice between a telephone call, an e-mail or another face to face meeting. Five of the seven interviewees answered follow-up questions by e-mails, one person by telephone, and one did not respond to the first e-mail or a second reminder e-mail.

The CMHA-Calgary Region staff member responsible for the promotion and delivery of the program was requested to be available for consultations at key checkpoints during the project, and this person accommodated the request. Periodic consultations continued until this person's position was terminated in December 2010. These consultations were aimed at discussing any gaps and/or contradictions uncovered during data collection and analysis.

Interviews were digitally recorded and transcribed verbatim by the researcher. This process helped in gaining more familiarity and better awareness of the data. Meaningful tones, hesitations and pauses during the interview were easily recalled when the interviews were transcribed, helping with a preliminary analysis and with reflecting on any clarifying questions to be asked of the interviewee. Further, it helped to identify early developing themes in the data, and to formulate new questions related to these themes for the next interviewee. As the researcher was a novice in this technique, transcribing the interviews also helped in reflecting on the quality of the interviews.

Post-interview field notes were written to help the researcher reflect on the interview, and to capture immediate impressions and reactions about the interview, the

interviewee and the context of the interview. These notes were reviewed during different phases of data analysis to maximize recall and context of the interviews.

In qualitative research it is very important to keep data in their context. Describing the context allows the reader to better understand the situation in which data were collected and analysed (Patton, 1987). This understanding has great implications in transferability. Transferability refers to how reasonable it might be to apply the research results to another group of people in another setting and time (Lincoln & Guba, 1985).

Direct observations were included in the research to gain firsthand experience with some of the program activities. Two observations were conducted in this study: one of the delivery of the "What's up with Biff?" program itself, and another of the delivery of the business case presentation used by the CMHA-Calgary Region to promote and justify the use of their Copernicus Project™ programs. The observational method used was semi-structured with the researcher as an independent observer and non-participant in the meeting.

Although observations may be more subject to interpretation by the researcher than interviews, observations capture important information that broaden data obtained by other methods such as the document reviews and interviews (Mulhall, 2003). Observations help determine if people actually do what they say they will do, help capture context, confirm processes, determine influences of the physical environment and provide insight into interactions (Mulhall, 2003).

After discussion with the thesis supervisor, formal consent from each participant in these observations was deemed unnecessary. The researcher did not know the participants, and would not identify any of them because the program and the setting

were the objects of research interest, not the people taking part in the program. At the beginning of the presentation of the business case, the researcher was introduced to the group and informal group consent was obtained. A short explanation of the research project and the purpose of the observation had been prepared, but was not required at the time of the observation.

Prior to the observation of the delivery of the "What's up with Biff?" program, the researcher reviewed the data obtained through the interviews and through the document reviews. An observation guideline was written to help confirm the expected processes. For each element of the program, prompts were prepared to help capture interactions, context and the researcher's own impressions (Appendix C). An observation document was created from these field notes. A similar guideline was prepared for the observation of the business case presentation.

To summarize, this research used reflective notes, document reviews, semi-structured interviews and observations as methods of data collection. Using different sources of information assisted in the understanding of the program from different points of view and helped improve the validity of the study through methodological triangulation (Patton, 1987). Triangulation will be further described in methodological rigour.

Data Analysis

As the analysis was conducted, memos were written to capture the researcher's thought process and decisions. This practice ensured that interpretations were open and transparent (Schreiber, 2001). The researcher reviewed these memos and reassessed

decisions/interpretations throughout the analysis process as new information was obtained.

Data analysis was inductive, which means that the analytic process was based on the data and not guided by pre-conceived theories. Inductive analysis uncovers and makes explicit the information that is embedded in the data (Lincoln & Guba, 1985; van Manen 1997). Further, the processes of data collection, data analysis and report writing are not distinct steps and do not occur in a fixed linear approach. These processes often happen in an interactive analytic movement that is interrelated and simultaneous (Creswell, 2001).

All data collected were in the form of text, and comprised notes from document reviews, transcripts of the interviews, field notes, reflective notes and memos. Content analysis was done on all the texts and comparative methods were used when analysing these texts throughout the project. As new data became available, they were analysed in light of what had been already learned. All the data were then reanalyzed and reintegrated as the research project advanced (Lincoln & Guba, 1985). This means that the data were reduced into themes through the process of coding (or unitizing) and categorization (Creswell, 2001).

Coding is a process of systematically transforming the data into units of meaning. These units are bits of information that have a meaning of their own, without the need for any additional information (Lincoln & Guba, 1985).

Categorization is the process of gathering these units of meaning into categories based on similar characteristics. As more units of meaning were uncovered from new data, they were tested against the categories already formed. If they did not fit into any

of them, new categories were created or criteria were modified for inclusion in the categories. These categories were eventually gathered into themes. These themes were compared and relationships among them were identified and detailed. This process helped ensure that there were no missing links, gaps and/or ambiguities among the emerging themes (Creswell, 2001; Lincoln & Guba, 1985).

The general themes adopted in this research project were themes that represented the program's logic model components, such as goals, target population or program objectives. The final conclusions for each theme were compared with information from the literature review, and contradictions and concordances were identified.

This analytic process ensured rigour, helped identify information needs and possible gaps and/or contradictions, and provided guidance on sampling and interview questions (Creswell, 2001). Analysis was done with the help of QSR-NVivo 7™ software.

Methodological Rigour

Rigour refers to the robustness and integrity of a research project (Tobin & Begley, 2004). This research project relied on qualitative analysis. In qualitative analysis decisions and conclusions rely on the researcher's interpretations and personal interactions (Akkerman, Admiraal, Brekelmans, & Oost, 2008), and rigour is assessed by trustworthiness criteria (Tobin & Begley, 2004). Trustworthiness criteria in qualitative research include credibility, transferability, dependability and confirmability of the research results (Lincoln and Guba, 1985). Establishing trustworthiness was an important part of this project and, as explained below, steps were taken to conform to the above criteria.

Credibility refers to whether the results are credible or believable from the point of view of the research participants (Lincoln and Guba, 1985). Credibility was ensured by:

i) An adequate period of engagement with stakeholders to build trust and understand the context;

ii) Persistent attentiveness with the aim of identifying and assessing any salient factors;

iii) Triangulation[1] through the use of different sources (comparing findings from documents, observations and from people involved in the program in different capacities), through the use of different methods (collecting data from document reviews, observations and interviews) and through the use of different perspectives and theories when interpreting the data (theory triangulation) (Patton, 1987);

iv) Reflection on pre-understandings to keep the researcher from pursuing pre-conceptions on the topic;

v) Debriefings with the supervisory committee (consisting of experts in the field of evaluation) for guidance, to help the researcher work on ideas, and to detect possible mistakes in a timely manner;

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[1]Triangulation is the use of multiple data collection and analysis strategies to build checks and balances into the research project (Patton, 1987). Triangulation increases the validity of the project (Lincoln & Guba, 1985).

vi) A certain degree of member checking[2] by testing/confirming data from the source where the data originated; and

vii) The use of direct quotes from the raw data (such as interview transcripts) to enable the reader to make her or his own judgments (Fleming, Gaidys, & Robb, 2003).

There was no opportunity to present the results and confirm the interpretation of the data with the research participants. However, some member checking was performed by contacting the interviewees to clarify and confirm the interview data they had provided, and through the periodic consultations with the key contact person at the CMHA-Calgary Region. These periodic consultations were performed when any gaps and/or contradictions were uncovered during data collection and analysis.

Transferability refers to how reasonable it might be to apply the research results to another group of people in another setting and time (Lincoln & Guba, 1985). Transferability was achieved by providing in-depth, rich descriptions, including that of time and context, to enable someone else to reach the conclusion as to whether or not transferability is possible (Lincoln and Guba, 1985).

Dependability and confirmability refers to how well the researcher accounts for the context within which the research occurs, and the degree to which the results can be corroborated by others (Lincoln and Guba, 1985). Dependability and confirmability were assured by building an audit trail. The audit trail consisted of documentation of the

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[2] Member checking consists of presenting the results of the study to the providers of the data to obtain confirmation about the interpretation of the data (Lincoln & Guba, 1985).

whole procedure of data collection and analysis, including the raw and categorized data material (Akkerman et al., 2008). When creating an audit trail, the researcher kept scrupulous, accurate and comprehensive notes "related to the contextual background of data, the impetus and rationale for all methodological decisions, the evolution of the findings, and the researcher's particular orientation to the data" (Rodgers & Cowles, 1993, p. 219). These included: i) contextual documents such as post-interview field notes; ii) methodological documentation, including all methodological decisions made throughout the research project; iii) analytic documentation, which captured the researcher's thought processes when analysing the data; and iv) personal response documentation which included reflection on the researcher's pre-understandings (Rodgers & Cowles, 1993). Although these materials can be compiled for a research auditor for formal review, they were used as a tool to increase the trustworthiness of this research project. An audit trail can be used, with much value, simply as a means of tracking the evolving analysis and monitoring the researcher's personal responses to the data without having a formal audit done (Lincoln & Guba, 1985).

Lastly, attention was given to congruence amongst the research question, methodology and methods. This congruence was accomplished by using the research questions as a point of reference and guide during planning and execution of this project.

Ethics

Participation was voluntary and there were no incentives provided for participation. Interviews were performed at the participants' workplace during their working hours.

During recruitment, all potential participants were provided by e-mail a written document containing a brief explanation of the aims of this project, an explanation of what was expected of them, and an explanation of the potential risks and benefits of participating in the study, along with a consent form (Appendix D). This approach was taken to give potential participants enough information and time to make an informed decision as to whether they were willing to accept the invitation to take part in the research project. Just prior to participation, these risks and benefits were reviewed and participants were asked to sign the consent form. Participants were made aware of their right to withdraw from the research at any time and to refuse to answer any of the questions asked.

Participants' privacy was assured by assigning a code to each participant. This code was stored in a secure location separated from all other information about the participants. Participants' identities were known only to the researcher and supervisor. During transcription of interviews, any information that identified the participant was not transcribed. All recordings of interviews were downloaded to a password-protected laptop and kept in a password-protected file for the duration of this project. As per the "Integrity in Scholarly Activity Policy"[3] of the Faculty of Medicine of the University of Calgary, all records from this project were archived in a CD-ROM and will be stored in a secure location for seven years by the supervisor, after which they will be destroyed.

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[3] http://www.medicine.ucalgary.ca/files/med/Integrity_in_Scholarly_Activity.pdf (retrieved on January 16, 2010)

In conclusion, this study is an EA of the "What's Up with Biff" program using qualitative research methods. The use of qualitative methods is the most appropriate approach for this study because rich detail on the program is required in order to properly conduct the EA and prepare it for an evaluation. A number of techniques were used throughout the study to enhance credibility, most notably triangulation in both the collection and analysis of the data. To ensure the credibility of the study, the approaches used are supported by the literature on qualitative research.

The next chapter presents the results of the data analysis. The two main sections of the chapter are a presentation of the historical context of the "What's Up with Biff?" program, and a presentation of the results based on the themes that form the components of the program logic model.

Chapter 3: Results

Introduction

This chapter begins with a brief description of the two programs included in The Copernicus Project™, followed by a description of the data sources. Next, the results of the data analysis are presented. The results start with a section on context, including a description of the historical development of the "What's Up with Biff?" program. Understanding the history of the program's development is important to understanding the program as it is today. The section on context will be followed by the presentation of the themes that compose the logic model.

The Copernicus Project™

The Copernicus Project™: Risk Management for Workplace Mental Health is a program that was initiated by the Calgary branch of the Canadian Mental Health Association. It includes two programs, the "Copernican Shifts" and the "What's Up with Biff?" programs.

The "Copernican Shifts" is a more in-depth program than the "What's Up with Biff?" program. It consists of a series of four two-hour workshops and is delivered normally over a period of weeks with the same group of participants, consisting usually of managers and supervisors.

The "What's up with Biff?" program can be presented in 60 to 90 minutes as a stand-alone workshop. It is in the form of an animated story, based on a real life story. The focus is on a major depressive episode from the point of view of the affected person, Biff, a construction worker, and his co-worker Spike. Biff's manager is also depicted in the story as the person that has "the authority and the responsibility to intervene in the

situation" and help solve the problem (Workshop Synopsis, p. 3, ¶8). It is normally delivered to groups of 20 or 25 people in the workplace, including managers and front-line workers.

Both programs of The Copernicus Project™ can be purchased separately from the CMHA-Calgary Region as a train-the-trainer package or as an in-person workshop delivered by its staff. The train-the-trainer package contains all the materials and instructions required to deliver the program. According to the instructions in the package, no previous knowledge or training in mental health is needed. However, it is firmly recommended that the person delivering the program has experience and knowledge in training or in facilitating workshops, and has effective presentation skills.

Data Sources

The documents.

Four documents were reviewed and coded.

1. A synopsis of the train-the-trainer manual for the "What's Up with Biff?" program

The next three documents are located on the CMHA-Calgary Region's web site under the tabs labelled Programs, Workplace MH, and The Copernicus Project™ or "What's Up with Biff?".

2. What's Up with Biff? The Prickly Question of Mental Health – Workshop Synopsis and Outline of the Train the Trainer Materials;
3. The Copernicus Project™: Risk Management for Workplace Mental Health; and
4. A Business Case for Conversations on Mental Health.

The participants.

Seven adults were interviewed for this study, including three program providers from the CMHA-Calgary Region, three purchasers and one participant in the program. Two of the organizations that participated in this research project had previous connections with the CMHA-Calgary Region, and had approached the CMHA-Calgary Region for assistance prior to the development of the Copernicus Project™. They participated in the early phases of the development of The Copernicus Project™ and had both subsequently used the two programs with their employees.

Table 1. Participants

Interviewees			
Role	Number		Sex
Providers (CMHA-Calgary Region)	3		2 females 1 male
Purchasers	2 Previous use of Copernicus	1 No previous use of Copernicus	2 females 1 male
Participant in the workshop	1		1 female

Introduction to the Results

In this section the results are organized and presented under themes. The first theme is the context, which evolved from the data, and was deemed to be an important theme that deserved more in-depth consideration when presenting the results. All subsequent themes represent the program's logic model components, such as the target population and program goal. Each of these themes will be defined and will contain data from three sources: documents, CMHA-Calgary Region and purchasers.

Context

Context is defined as a set of facts or circumstances within which an event or phenomenon happens or exists, and that are relevant to the event. These facts or circumstances, such as time, social structures, economic resources, background or environment, influence the event and help to ascertain, specify or clarify the meaning of the event (Lincoln & Guba, 1985; Patton, 1987; Scott & Thurston, 2004; Scott & Hofmeyer, 2007).

The description of context is very important in qualitative research (Lincoln & Guba, 1985; Patton, 1987; Schegloff, 1997). In fact, Patton writes that "Keeping things in context is a cardinal principle of qualitative analysis" (1987, p. 162). Context can influence the design, implementation and the outcomes of a program (Stufflebeam & Shinkfield, 2007). Further, the reader needs to have a description of the context to fully understand the findings and to be able to make decisions related to transferability (Lincoln & Guba, 1985).

Deciding on the context that needs to be described in a project can be, however, a difficult decision (Patton, 1987). A researcher runs the risk of including too much information in a report: "Even a comprehensive report will have to omit a great deal of data collected by the evaluator." (Patton, 1987, p. 163). To avoid the risk of arbitrary choices of context, Schegloff (1997) suggests considering the context that is raised and made relevant by the participants. Van den Berg (2008) considers Schegloff's rule narrow and suggests that context outside of the participants' discourse could be an important addition to understand the discourse itself (van den Berg, 2008). Directionally, Van den Berg's point is important as the overall context can influence participants'

perspectives. The context described in this report will be kept close to the themes related to the research questions, what was salient in the interviews, and the circumstances surrounding the development of the "What's Up with Biff?" program.

The results related to context are organized and presented in three subsections; first, the historical development of the "What's Up with Biff?" program, which is critical to the understanding of how and why the program is delivered as it is today; second, the reasons for purchasing the program; and third, a brief note on the Mental Health Commission of Canada. Context related to the themes is not presented here; rather it is presented and discussed as an integral part of each theme.

Historical progression of The Copernicus Project™.

Initial steps.

In 2000, board members at the CMHA-Calgary Region began to discuss the need for a workplace education program on MH issues. At that time the CMHA-Calgary Region had only a youth education program. Staff members were receiving increasing numbers of requests from the corporate community for a program that addressed MH issues in the workplace, but the CMHA-Calgary Region could provide only an adapted version of its youth program, which was deemed inadequate.

In 2001, one of the CMHA-Calgary Region staff members and a volunteer from the youth program developed a proposal for a project addressing MH issues in the workplace. Soon after, the volunteer presented the proposal to the CMHA-Calgary Region board and, once the proposal was approved, this person was hired and began working on the project.

This new staff member was the only person working on the project at the time; the CMHA-Calgary Region board members helped program development by facilitating contacts with the corporate community. The staff member worked more closely with the corporate community than with other staff members of the CMHA-Calgary Region, resulting in a situation whereby the other staff members were not very aware of the developing CMHA-Calgary Region workplace MH program. Because lack of awareness of the program still exists internally, the CMHA-Calgary Region staff person responsible for promoting the workplace MH program must promote it both internally and externally.

Consultations were done with dozens of people from different industries in the corporate community in Calgary, from chief executive officers (CEOs) to front line workers. Face to face and telephone interviews, as well as e-mail exchanges, were used for these consultations. The intent of the consultations was to find out what specific information people were seeking in an educational program about MH in the workplace; to find out what programs were available in the community and in the workplace; to explore possible partnerships; and to look for financial support. Literature was collected on the topic of MH issues.

Based on the consultations, the program developer determined that there were two themes that were important: first, that it was essential to address stigma to MI in the workplace, and second, that silence was the most "damaging and obstructive workplace behaviour" resulting from stigma. No other program addressing stigma to MI in the workplace was found either in the literature collected or through professional connections.

Developing the program.

In 2002, The Copernicus Project™: Risk Management for Workplace Mental Health program was developed and pilot-tested. Five different organizations based in Calgary participated in the pilot project. The Copernicus Project™ program was composed of eight two-hour workshops delivered to the same group of people over weeks or a few months. The program targeted managers and supervisors in the organization. For the next five years, The Copernicus Project™ was revised many times based on feedback from participating organizations and consultation with the literature.

Documents were written to introduce and promote the program. Unlike other programs from the CMHA-Calgary Region, The Copernicus Project™ was delivered to interested organizations for a fee, and there was an expectation of deriving revenue from it.

The demand for a shorter program.

During the time The Copernicus Project™ program was being pilot-tested, a growing demand emerged from the corporate community for a shorter program that could be delivered to a wider audience in a workplace. The eight-workshop series was delivered mainly to managers and supervisors and a shorter program was needed for delivery to the rest of the people in the workplace. By about 2004, a two-hour workshop was developed, titled "Vehicle Maintenance and Mental Health: Pay Me Now or Pay Me Later". This program depicted male blue collar workers and it was the precursor of the "What's Up with Biff?" program. The concept and real-life stories used to develop this first workshop were often adapted for other purchasing organizations and presented under

different names. Some organizations started to purchase only the two-hour workshop rather than the larger Copernicus Project™.

The "gold standard".

The CMHA-Calgary Region's recommendation was to use the longer program with managers and supervisors, and to use the shorter program more widely with other employees. This combination was considered to be the "gold standard"[4] for delivering the program by the CMHA-Calgary Region.

Train-the-trainer material.

The demand for the program both in Calgary and outside of Calgary grew quickly, and the CMHA-Calgary Region staff could not meet the demand. This unmet demand resulted in a client asking for a program that could be delivered by its own staff members with no experience or knowledge of MH issues. This demand led to the development of the train-the-trainer material.

In April 2008 the "What's Up with Biff?" train-the-trainer material was completed. The real-life story used in the previous two-hour workshop was adapted into an animated story and the program was shortened to a 60 to 90 minute workshop. The characters in the story depicted male blue collar workers to reflect the type of workers that composed most of the workforce in the organization that had requested the train-the-trainer format. The train-the-trainer package provided all the materials and guidelines necessary to deliver the program, including the videos, Power Point™ presentation,

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[4] The term "gold standard" is used by the CMHA-Calgary Region to denote the best combination of programs under the umbrella of The Copernicus Project™. It is different from the common usage of the term as a clinical gold standard which means any standardized method, procedure or intervention of known validity and reliability, against which new methods, procedures, or interventions are compared (Porta, 2008).

discussion questions, frequently asked questions and answers, and a list of reading resources for the presenter. There is no training offered by the CMHA-Calgary Region for the facilitator. It is expected that the facilitator will be an experienced presenter with good facilitation skills.

In 2009, another train-the-trainer package was completed: The "Copernican Shifts". The "Copernican Shifts" train-the-trainer material included only the four first two-hour workshops of the original Copernicus Project™ eight-workshop program. The main reasons for this approach were lack of time and resources at the CMHA-Calgary Region, and feedback from potential clients asking for a shorter workshop series.

In 2007 a Canadian trademark for the Copernicus project was obtained by the CMHA-Calgary Region. By 2009 the title The Copernicus Project™: Risk Management for Workplace Mental Health had become the overall brand, and it included all other MH workplace workshops that had been created and delivered by the CMHA-Calgary Region since 2002.

Documents used to explain or promote the programs.

All the documents about The Copernicus Project™ programs, including the "What's Up with Biff?" program, were written by staff members at the CMHA-Calgary Region. These documents were intended to explain and promote the original Copernicus Project™, and are still being used today. For example, a document that was written as a business case to present the problems addressed by The Copernicus Project™, and the importance of addressing these problems, is still being used today.

New price.

The CMHA-Calgary Region continued to promote and deliver both the "Copernican Shifts" and the "What's Up with Biff?" programs. It also promoted and sold the train-the-trainer package for both programs. In 2009-2010 a new tiered price scale was adopted, dependent upon company size, with smaller companies paying a lower price than larger corporations.

In December 2010, the CMHA-Calgary Region's job position for promotion and delivery of The Copernicus Project™ was eliminated.

Reasons for purchasing the program.

Organizations participating in this research project described similar reasons for purchasing one or more of the programs under the umbrella of The Copernicus Project™. Reasons cited by these organizations included a perceived high number of workers off for stress-related illness.

> *"I looked at the statistics I realized that probably 25% of our people were off for stress related illness."*
>
> (P1- L9)

A lack of resources or skills from their managers in dealing with MH issues in the workplace, such as what to do when someone discloses a MI, was also cited.

> *"… six or seven months ago that I was contacted by one of our branch managers and the branch manager asked for some guidance and it was associated with an employee that had self-disclosed they had obsessive compulsive disorder and the branch manager said, you know, here is the situation and I am not sure how to deal with it."*
>
> (P4-L23)

Lastly, they also mentioned a lack of resources and challenges that their managers were experiencing in facilitating the return to work of staff that had been on leave due to MH issues.

> *"... our supervisory staff were having issues reintroducing people back into the workforce after they have been off, they were uncomfortable, we had no tools to give them and it wasn't a pleasant experience for the person returning and the supervisor and the co-workers sometimes. So, that was one of the main reasons as well we thought, you know, we need to do some education on this."*
>
> (P1-L16)

> *"... They may not be able to come back, not because they don't want to but because the workplace isn't friendly enough or accepting enough."*
>
> (P5- L544)

The Mental Health Commission of Canada.

The Mental Health Commission of Canada (MHCC) was created in March 2007 and it is housed in Calgary. The MHCC's missions are: to promote MH in Canada, to improve services and support for those affected by MI, and to change people's attitudes towards MH issues (MHCC, 2011). In October, 2009 an anti-stigma initiative called "Opening Minds" was launched. Opening Minds is a systematic effort to decrease stigma and includes strategies to combat stigma amidst health care professionals, youth, workplace and the media. The relationship between the MHCC and the CMHA-Calgary Region is undisclosed and uncertain to us.

Next, the results the results of the data analysis will be presented based on the themes that form the components of the program logic model. Each of these themes will be defined and will contain data from the three sources used in this project: documents,

interviews with the staff at the CMHA-Calgary Region, and interviews with the purchasers participating in this project. The themes that will be presented are the goals, target population, outcome objectives, program components and activities, and resources.

Goals

A program description should clearly state the program's purpose in terms of goals and objectives. Goals are general and abstract statements that represent a broad rationale for a program, and indicate the desired state that the program is intended to achieve (Dwyer & Makin, 1997; Rossi et al., 1999). Objectives are more defined and represent more specific outcomes (Rossi et al., 1999); these will be presented in a later section of this report.

Goal - documents.

There is no clear description of the goal of the "What's Up with Biff?" program in the documents reviewed; rather, they contained assumptions. According to the documents reviewed there are two assumptions underlying the "What's Up with Biff?" program: the lack of language or lack of comfort in talking about MH issues is at the root of stigma to MI; and stigma to MI is at the root of most of the problems experienced by people afflicted or affected by MI.

> *"The Copernicus Project is based on our premise that the single biggest barrier to addressing mental health problems is a centuries-old perspective of stigma and silence. Even in today's 'enlightened' workplace, stigma is an insidious reality. The Copernicus Project argues that stigma is not AN issue; it is THE issue; and that when it comes to effective problem-solving regarding mental health we need a fundamental 'Copernican' shift in perspective."*
>
> (A Business Case for Conversations on MH, p. 1, ¶ 2)

This connection between silence around MH issues and stigma is repeated often throughout the documents. When describing The Copernicus Project™, the "What's Up with Biff?" train-the-trainer manual does not explicitly state the goal of the program; rather it indirectly leads to an understanding that the program's goal is to decrease stigma to MI by facilitating informed dialogue on MH issues.

> *"... facilitate informed dialogue regarding MH issues. In learning to communicate more effectively about these issues, participants develop tactics to reduce stigma."*
>
> (Train-the-Trainer Manual, L23)

When describing the Copernicus Project™, however, the Business Case document leads the reader to infer that opening dialogue around MH issues is the goal of the program.

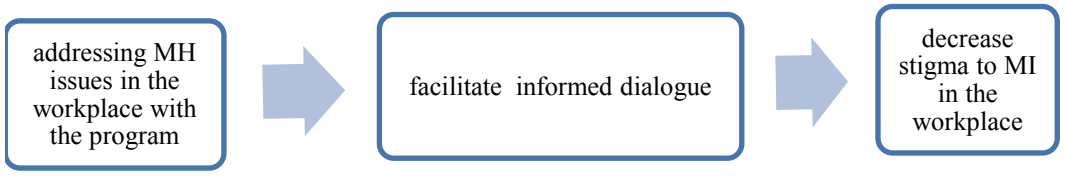
> *"The central theme, the heart, of The Copernicus Project, is a simple one: to generate conversations about mental health."*
>
> (A Business Case for Conversations on MH, p. 2, ¶1)

The "What's Up with Biff?" Workshop Synopsis document describes the program as breaking the silence.

> *"... the workshop breaks through the silence around mental health issues."*
>
> (Workshop Synopsis, p. 2, ¶4)

Although a bit confusing, these documents led to the understanding that the goal of the "What's Up with Biff?" program is to decrease stigma to MI by facilitating informed dialogue around MH issues (Figure 1).

Figure 1. Program theory derived from the program documents

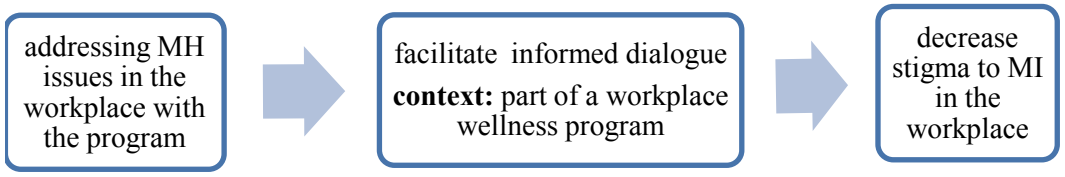


There appears to be, however, some important conditions for the program to attain its goal. It is suggested in the documents reviewed that the "What's up with Biff?" program provides only an introduction to the topic and should be one part of an ongoing workplace health and wellness program (Figure 2).

> *"... this workshop is intended as an introduction only. Participants are encouraged to seek additional information and to continue the dialogue beyond the workshop."*
>
> (Workshop Synopsis, p.2, ¶1)

> *"'What's up with Biff?' is recommended not as an end in itself, but rather as part of a comprehensive ongoing workplace health and wellness education program."*
>
> (Workshop Synopsis, p. 4, ¶3)

Figure 2. Program theory derived from the program documents with conditions



Goal - CMHA-Calgary Region.

Two interviewees from the CMHA-Calgary Region identified that the goal for the program was to decrease stigma to MI.

> *"I would see that people, that the whole stigma associated to MI is gone."*
>
> (P7+6-L386)

> *"He said that the "What's up with Biff?" program aimed at decreasing the stigma surrounding MH issues [sic]."*
>
> (Biff Observation Field Notes, L145)

> *"And also as we talked about in the beginning try to address the stigma. That is, stigma is pervasive when you think about mental illnesses and mental disorders, and so that is the primary objective."*
>
> (P7+6-L 189)

Confirming the information in the documents, interviewees from the CMHA-Calgary Region acknowledged the connection between conversations and the reduction of stigma.

> *"The way it is presented, it is a conversation starter. It is the starting point for not only reducing the stigma but getting the information, disseminating the information in a broader context."*
>
> (P7+6-L203)

> *"So it would allow people to start to have some language that they can talk about the issues."*
>
> (P3-L99)

However, one of the interviewees from the CMHA-Calgary Region would only state that the goal of the program varied, depending on what the purchasing organization did with the program.

> *"… it is difficult to answer with one answer because if, I knew that it would depend entirely on what an organization did with it."*
>
> (P3-L320)

When asked about the ultimate changes expected to be achieved with the program, this participant seemed a little reluctant and uncomfortable making claims related to the program's expected outcomes.

> *"I never over, I am very hesitant to over claim."*
>
> (P3-L124)

Nonetheless, this person seems to indicate that the goal is to start some conversations on the topic of MH issues.

> *"Well, in my experience, that again it depended, it varied from organization to organization, my goal with it is that even if, say there were 20 participants, even if a couple of them had a conversation about this after the workshop was over, 3 days later mentioned it to somebody, I felt that was, that was worth something if the, if in those organizations in which Biff was delivered more extensively what I hoped for and what the feedback to me was, was that in general people started to be more able more open about talking about these issues."*
>
> (P3-L290)

> *"… but many times is just a one shot, so there is a limit to what you can expect from it, my goal with it was to give it to set it up in such a way, to use the material in such a way that the people participating would be, would have something about which they could have a conversation. So it would allow people to start to have some language that they can talk about the issues."*
>
> (P3-L95)

Although this interviewee seemed to describe the program goal as opening up conversations about MH issues, this person states that the more people in the workplace that participate in the program, the more likely the program would have a larger impact. More people involved in conversations about MH issues would help to change the perception of MI to a more normal occurrence in the workplace.

> *"I think if you delivered the Biff workshop, I mean, in my opinion, if an organization of however many, you know, three or four hundred people even, put everybody in their organization, most anybody through this workshop, not that this is the be all and end all, I mean the workshop of this nature I think it would have an impact. To me the key was how many people can you get having the same conversation? Because it is not that you have, the more people that are involved the more normal that it becomes the more, oh yeah I heard of that, the more open it becomes, so I think you could have a pretty big impact just using this one workshop within an organization but the fewer people the fewer percentage of*

people that are involved the less likely there will be a broad impact. That is reality."

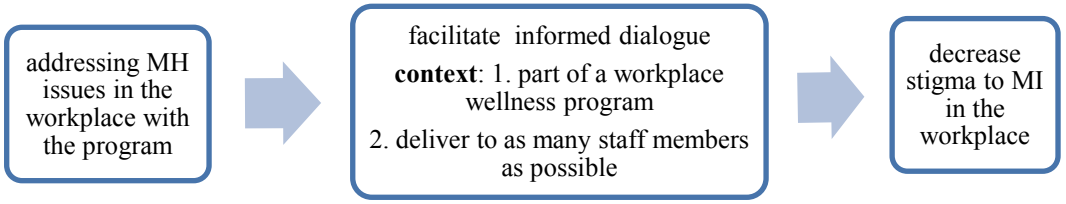
(P3-L395)

There was also a strong assertion that context was a key variable in the program attaining its goal. According to this participant, besides delivering the program to most people in the workplace setting, the "What's Up with Biff?" program needs also to be part of a larger workplace wellness program initiative (Figure 3).

"Well, the Biff program is, for one thing, because it's a one time, one shot workshop a lot of time, I mean, as I said ideally, it is part of a larger comprehensive approach."

(P3-L93)

Figure 3. Program theory derived from the CMHA-Calgary Region



Staff from the CMHA-Calgary Region had organizational goals that were related to the program, but were not specifically goals of the "What's Up with Biff?" program. For example, one of the participants identified as a goal that the program become self-sustainable or that it generate revenue.

"... I think if we had this program self sustained that would be a fantastic success."

(P7+6-L509)

"... not only does it pay for itself but if we ended up, for me, you know, with considerable revenue to the organization."

(P7+6- L522)

They also expected that organizations purchasing the program could help the CMHA-Calgary Region promote it by becoming ambassadors for the program.

> *"... and hopefully optimistically some of these people could become ambassadors for us."*
>
> (P7+6-L710)

Goal - purchasers.

The two purchasing organizations that had a previous connection with the CMHA-Calgary Region and The Copernicus Project™ identified a similar goal, that of decreasing stigma to MI.

> *"... our goals at this point are really to look at stigma and basically change how the perception of MH as depression."*
>
> (P5-L142)

> *"... one of the things we really want to change and by making this more available more acceptable or less stigma."*
>
> (P5-L546)

> *"... to take the stigma away from it, you know."*
>
> (P1-L510)

Although indirectly, one purchaser mentioned also the connection between starting conversations about MH issues in the workplace and decreasing stigma to MI.

> *"I don't think that being more comfortable about talking about MI, is a bad thing, I think it is a great thing. It is important for people to debate, talk about it, to be aware of and if you want a culture where you think it is safe."*
>
> (P5-L533)

> *"... but the process of the way we deliver the conversation is where the power isn't that right? in getting people to talk about it [MH issues] and those people in my mind if we were able to get them to*

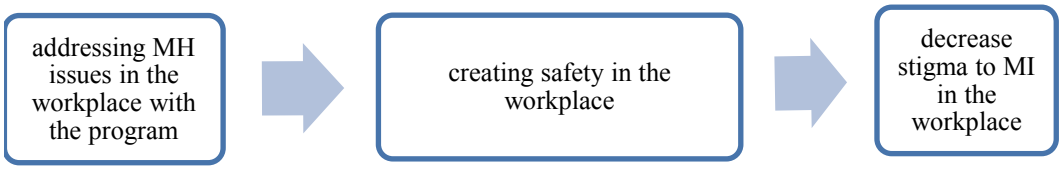
> *talk not necessarily about their own experiences but just about what they know we will be able to bring quite a bit and that is the power of this, and for what I've seen in the past, you know, all you really need is to start a conversation because then things happen on their own."*
>
> (P5-L562)

The third organization spoke of MI as something that an employee may not need to hide anymore after the organization uses this program. This person mentioned giving the workers a safe and supportive workplace in which they could disclose and seek help when afflicted or affected by MI; that is, a workplace where MI is perceived to be largely free from stigma (Figure 4).

> *"... so for those people that are in distress it would be: Golly, the company is talking about this, I no longer have to feel as if I have this birth mark that people can see."*
>
> (P4-L337)

> *"My view is that as a result of introducing this program and people given the sense that, you know, this doesn't have to be hidden anymore or I do have support."*
>
> (P4-L349)

Figure 4. Program theory derived from a purchaser



On the other hand, one interviewee that participated in the program seemed to think that breaking the stigma around MH issues was a difficult task to achieve.

> *"I think we are trying to encourage both physical and mental disability to be welcome and included and that people know that they can be accommodated, but the stigma piece is a hard one and*

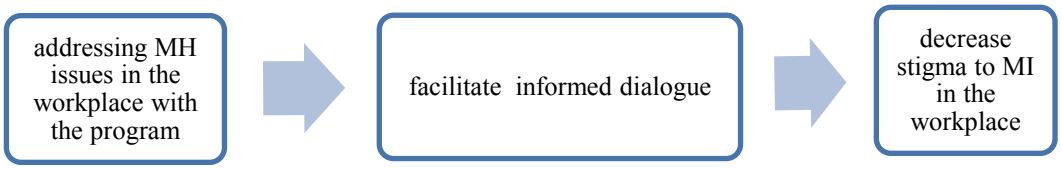
> *I don't know if you will ever, kind of break the, I think it happens with other disabilities too, that is what I am saying."*
>
> (P2-L260)

This person agreed, however, that the "What's Up with Biff?" program could help people be more comfortable talking about MH issues, which is considered by the CMHA-Calgary Region to be the enabling factor to decrease stigma.

> *"... breaking the silence of issues around MH to make people less afraid of it and more comfortable talking about it or hearing about it and then the idea is that people would be more comfortable or more aware and look for help earlier rather than later and which P2: Yeah, yeah, and I think that this will do." (pointing to the program binder)*
>
> (P2-L277)

The preponderance of the data led to the conclusion that the intended goal of the "What`s Up with Biff?" program is to decrease stigma to MI in the workplace by facilitating informed conversations around MH issues (Figure 5).

Figure 5. Program theory derived from the data



Target Population

A target population for a program is defined as the units (such as people or organizations) to whom the program is intended to be delivered (Dwyer & Makin, 1997; Rossi et al., 1999). These units can be settings; health promotion programs can be carried out in settings or places where people interact such as a workplace or a school (Green et

al., 2000). When a program targets a setting, the entire population contained in the setting is included.

Target population - documents.

In the documents reviewed, the target population is described as the general workplace population, indicating that the "What's Up with Biff?" targets the workplace setting.

> *"The 'What's up with Biff?' The Prickly Question of Mental Health is designed for general workplace audiences."*
>
> (Workshop Synopsis p.4 ¶ 3)

In the same document, the Workshop Synopsis, it is stated that the program is geared to a segmented target population of male blue collar workers. However, in the same sentence the document confirms the inclusion of a more universal audience in the workplace setting as a target. Although the documents indicate that the program was originally designed to target male blue collar workers, it appears clear that the program targets various workplace populations.

> *"'What's Up with Biff?' is geared towards a male, blue collar audience; however, the workshop has been delivered to various audiences, including male and female white and blue collar employees."*
>
> (Workshop Synopsis, p. 2 ¶ 5)

> *"Participants include senior level white-collar workers and front line blue-collar workers in non-unionized and unionized environments."*
>
> (A Business Case for Conversations on MH, p.1, ¶1)

With respect to the kind of organization the CMHA-Calgary Region targets, the documents indicate that they are broadly aiming at organizations in both the public and private sectors.

> *"The Copernicus Project™ has been delivered within both public and private organizations in the Alberta corporate community (to date mainly in Calgary)."*
>
> (A Business Case for Conversations on MH, p.1 ¶ 1)

Target population - CMHA-Calgary Region.

According to the interviewees from the CMHA-Calgary Region, the "What's Up with Biff?" program targets the workplace setting.

> *"... in the workplace definitely."*
>
> (P3-L182)

As per the documents, the interviewees from the CMHA-Calgary Region noted also that although this program was intended originally for a particular workplace setting - male blue collar workers - they consider that the program has a universal message and other workers can benefit from it.

> *"Even though the program could be considered to be geared towards the blue collar clientele, the message itself is universal that is generally what I point out when I market this program. This is the scenario but the situation is more broad and it is delivered to a more wider audience."*
>
> (P6- L150)

In its efforts to sell the program to the corporate community, the CMHA-Calgary Region has encountered resistance on occasion from some organizations whose workers would not be classified as blue collar workers and did not believe that the program would be suitable for their employees.

> *"... they look at their corporate culture, the fit of their corporate culture, and sometimes they feel it doesn't fit with their, maybe they have a younger workforce. It is not for them."*
>
> (P6-L162)

The participants from the CMHA-Calgary Region reinforced the view that the program targets the entire workplace by stating that middle managers and upper managers would benefit also from taking part. The CMHA-Calgary Region personnel recommend a universal approach in which both front line workers and managers participate in the program.

> *"I think with this particular program we are targeting the worker but there is also mid managers and upper managers that really can benefit and be part of this process of disseminating this information"*
>
> (P7+6-L237)

With respect to the type of organizations to which the CMHA-Calgary Region sells the "What's Up with Biff?" program, they have a certain target among the local organizations.

> *"... it tends to be more large business to medium size, I worked very little with small business,"*
>
> (P7+6-L231)

The CMHA-Calgary Region participants stated that because part of their mandate is to generate some revenue with this program, the not-for-profit sector is targeted to a lesser degree than the business sector.

> *"I did not work much with the not-for-profit world because part of my mandate was to generate relatively significant revenue with this program."*
>
> (P3-L234)

> *"I would say we target mostly corporate and public sector. The non-profit sector I think that it is probably not a huge customer at this point."*
>
> (P7+6-L283)

Target population - purchasers.

Purchasers viewed all of their staff members as the target, and confirmed the workplace setting as the target unit for the "What's Up with Biff?" program. The managers responsible for the purchase of the program intended to deliver the program to all of their workers, including the managers in their organizations.

> *"... is handling the roll out and I believe it will be for all employees and managers."*
>
> (P2-L46)

> *"You are hoping to deliver the program to all your employees? Absolutely, yeah."*
>
> (P5-L58)

At the time of data collection, two of the three organizations had plans to make the program available not only to the employees but also to employees' families.

> *"... and I can open it to spouses easily and I usually get a few coming which is, you know, then that is even better."*
>
> (P5-L260)

> *"... move it down to our staff yeah, let's work at a plan for presenting it to the families at some point."*
>
> (P4-L461)

Because the "What's Up with Biff?" program was originally geared towards a male, blue collar audience I asked the purchasers if they had any reservations about offering this program in their offices beyond their blue collar workers, to which they replied in the negative. The females interviewed said that women are able to identify with male characters. They felt that the subject was universal and depicting male blue collar workers would not adversely affect the efficacy of the program with male office workers or women.

> *"Oh, I was glad that they were using the man. (Both laugh) Because if they had used the woman, men would have spotted that and said oh, that's how "…women are, they are sensitive, they are menopausal, or PMSing. You know? (Laughing) You know that. So I actually thought that probably drove it home a little bit more. Ah, and I don't think, certainly from my perspective, and from many feedback that I got that there wasn't, the gender did not come in, it was about the issue not the gender. That is how I felt about it."*
>
> (P1-L672)

> *"It is very interesting it keeps it at a very simple basic level, but I think that is also very interesting and it makes it easier. I think, men will connect with this, regardless, I think, of whether they are in a office job and women are very empathetic by nature. So, you know, I don't expect it to be a problem, I don't expect it to be a problem."*
>
> (P5-L479)

Two of the purchasers mentioned that most of the materials they had about MH issues were geared towards office workers and they were happy to find something that depicted blue collar workers for a change. It was suggested that the blue collar workers were the ones that would not identify themselves with women or office worker characters.

> *"It was particularly attractive for me because I went, oh yeah, it won't be, you know, characters with suits and ties on so our field people go and ah, this is probably has something to do with an office tower in Calgary, because we are a working class company, so this will, I don't think will help to sell it but it will help remove any barriers that people might have that it is really not us."*
>
> (P4-L203)

> *"… a lot of the videos that I have on stress management and things like that always look at office workers, you know, often look at this type of workers and then you are forced to have to relate it with employees who don't work in those environments."*
>
> (P5-L474)

It is important to note that the three organizations participating in this project were predominantly composed of male, blue collar workers.

> *"... 60% of our employees are field employees, labour, 30 % of our employees would be professional technical, drafters, computer assistant design professionals or professional land surveyors or persons like myself and the remainder would be our administrative support staff."*
>
> (P4-L199)

> *"... 92% of my employees are male."*
>
> (P5-L150)

> *"... you know, about 75-80% of our employees are blue collar employees, so for that population it is perfect, right? Perfect."*
>
> (P5- L470)

> *"... 85% of our staff is blue collar."*
>
> (P1-L28)

Lastly, the person interviewed that participated in the "What's Up with Biff?" program agreed that the fact that the program depicts male, blue collar workers did not stop her from identifying herself with the characters in the video.

> *"P2: No I would have no hesitation showing it in the office*
> *E: So for you personally it was, you still*
> *P2: Yes, on my personal level, yes, I could identify and think, it made me think of my own self, yeah, so did not stop me from kind of connecting with it."*
>
> (P2-L121)

Outcome Objectives

Objectives are "specific, operationalized statements detailing the desired accomplishments of a program" (Rossi et al., 1999). Well planned objectives should follow the SMART principle; that is, they should be specific, measurable, achievable, relevant, and with a defined time frame (Dwyer & Makin, 1997; Patton, 2008).

Objectives are often described as long-term and short term objective (Dwyer & Makin, 1997). In this section, the long term objective and the short term objectives will be described as they emerged from the data. Indicators are what show that the objectives are being met. Indicators are operational criteria (observable, measurable characteristics or changes) used to monitor intended program outcomes (Patton, 2008). Indicators are normally directly derived from the objectives (Dwyer & Makin, 1997). The indicators will be presented in the program logic model and they will not be discussed here.

Long-term objectives.

There were no clear statements of a long term objective to which the "What's Up with Biff?" program was directed. There is a recommendation for the purchasers to find ways to continue the dialogue about MH issues in the workplace beyond the conversations initiated in the workshop. Because achievement of this recommendation would depend on follow up activities that would be adopted by the purchasers, it cannot be claimed to be a program objective. This recommendation was described in the documents reviewed and by the CMHA-Calgary Region.

Long-term objectives - documents.

"... encourage participants to find ways to continue this conversation."

(Train-The-Trainer Manual, L66)

"... and to continue the dialogue beyond the workshop."

(Workshop Synopsis, p. 2, ¶1)

Long-term objectives - CMHA-Calgary Region.

"... it gives them a vehicle through which to begin to have conversations about these issues and from there the intent is for

the organization to build on that."

(P3-L104)

Short-term objectives.

The short-term objectives have been grouped into three categories as shown in Table 2: Improve Knowledge, Improve Perceptions around MH Issues, and Skills Building. Although not explicitly stated, when the data were reviewed there seemed to be a certain progression the participants would experience in this program. The first category of objectives would be to acquire awareness and basic knowledge about MH issues, and the second category of objectives would be to improve perceptions about MH issues and the need to act upon them. The third category of objectives would be to gain a certain ability to act upon these issues, such as the ability to seek help or to support others. These three categories of objectives are used to present the results.

At the end of this section some ancillary objectives described by some of the interviewees will be presented.

Table 2. Outcome objectives of the program

Categories	Objectives
Improve Knowledge and Awareness	• MH issues, especially depression • Resources available
Improve Perceptions	• Understand challenges of unaddressed depression • Understand stigma/silence and its consequences • Perceive support in the workplace
Build Skills	• Acquire language → initiate dialogue • Ability to look for help • Recognition of patterns that may indicate MI • How to support others afflicted or affected by MI
Ancillary	• Increase the number of workplaces receiving the program • Increase workplace productivity

Improve knowledge and awareness.

There are two objectives in this category. One objective is to improve knowledge and awareness of MH issues and the other is to improve knowledge and awareness of resources available in the workplace.

There was a strong agreement that one of the objectives of this program is to help participants gain knowledge about MH issues, especially depression.

Documents.

> *"Learning objectives: Provide basic information on MH issues, in particular Major Depressive Disorder."*
>
> (Workshop Synopsis, p. 2, ¶ 6)

> *"Intent is to increase awareness and understanding of MH issues."*
>
> (Train-the-Trainer Manual, L30)

CMHA- Calgary Region.

> *"I would hope then, more specifically, that people have more understanding, specific understanding of what is a MI."*
>
> (P7+6-L406)

Purchasers.

> *"The Biff program is a way to raising the awareness both with employees and managers, you know, around MH issues and disabilities. So, it is an excellent program for that."*
>
> (P2-L18)

> *"I think that it [the program] is a really good tool for getting awareness [about MH issues and resources] out there for employees. I think it is very good."*
>
> (P1-L646)

> *"Actually what we are offering is understanding and awareness."*
>
> (P4-L418)

There was also a strong agreement that increased awareness of resources available in the workplace was an important objective.

Documents.

"Offer information and tips on accessing resources."
(Workshop Synopsis, p. 2, ¶4)

CMHA- Calgary Region.

"That they are more aware of what resources are available and they all hopefully accept it."
(P7+6-L412)

Purchasers.

"... that employees understand that the company has resources to provide them with support no matter what issues they are dealing with."
(P4-L314)

"... let the employees know where the resources are."
(P5-L142)

"The resources, where people can find it."
(P1-L436)

"Quite possibly sometime in your life you will want to remember what you heard today and the avenues available so you can access that support that you need or your wife needs or your child."
(P4-L432)

"Mental illness, this is not something to hide from and this is something that we have help for and therefore, if they know that and they will go and look for help."
(P5-L147)

Improve perceptions.

There are three objectives in this category: to understand challenges of unaddressed depression, to understand stigma/silence and its consequences, and to improve the perception of support in the workplace.

Understanding challenges of unaddressed depression was clearly described in the documents reviewed and by the CMHA-Calgary Region, but it was not mentioned by the purchasers.

Documents.

> *"Illustrate the challenges of an unaddressed MI (depression) for the person experiencing it.*
> *Illustrate the challenges of an unaddressed MI (depression) from the point of view of a co-worker."*
>
> (Workshop Synopsis, p. 2, ¶4)

CMHA- Calgary Region.

> *"As the story unfolds one becomes aware of the potential for misunderstanding."*
>
> (P3-L682)

> *"They can see how misunderstandings can happen and how they can be avoided."*
>
> (P3-L693)

Understanding stigma was an objective that was described by all.

Documents.

> *"Demonstrate how stigma, silence and lack of understanding lead to significant and costly outcomes for all concerned."*
>
> (Workshop Synopsis, p. 3, ¶1)

CMHA- Calgary Region.

"If stigma is the problem that gets in the way over and over again and this program tries to both demonstrate how that happens so that people begin to understand what that means because when they think stigma they think labelling somebody or saying nasty things to somebody or whatever, people have trouble understanding that it is so much a broader thing than that so I think it is designed to really try to heighten people's awareness of what that means."

(P3-L158)

Purchasers.

"You know, one of the things we really want to change and by making this [the program] more available, more acceptable or less stigma, and, you know, people understand that a lot of the things are just myths."

(P5-L532)

An expected objective described by the CMHA-Calgary Region and especially by the purchasers was that the workers would feel more supported in dealing with MH issues in the workplace. There was no direct description of such an objective in the documents reviewed.

CMHA- Calgary Region.

"They are supporting their workforce."

(P7+6-L693)

"*It may even give them confidence that their employer is compassionate if they have adopted this program, they may think 'well, my employer is supportive of me because they are providing me with this information.'"*

(P7+6-L449)

Purchasers.

> *"... and let them know that they are not alone. As an employer we are there to help them and what can we do to help you."*
>
> (P1-L728)

> *"... show that the company is available to provide the support then that is a good basis for a working relationship."*
>
> (P4-L415)

> *"... to provide them with support no matter what issues they are dealing with."*
>
> (P4-L314)

Build skills.

There are four objectives in this category: to acquire language and initiate dialogue; to understand when help is needed; to recognise patterns that may indicate MI; and to learn how to support others affected or afflicted by MI.

An objective described by all was that participants would acquire some basic language around MH issues and that a dialogue would be initiated in the workshop.

Documents.

> *"... the workshop breaks through the silence around mental health issues."*
>
> (Workshop Synopsis, p. 2, ¶4)

> *"Initiate an informed dialogue on workplace MH issues."*
>
> (Train-the-Trainer Manual, L57)

> *"... increase understanding and facilitate informed dialogue regarding MH issues. In learning to communicate more effectively about these issues."*
>
> (Train-the-Trainer Manual, L23)

CMHA- Calgary Region.

"… it is building some language and conversation so that people have even the words to describe it in a appropriate way."

(P7+6-L562)

"… the people participating would be, would have something about which they could have a conversation. So it would allow people to start to have some language that they can talk about the issues."

(P3-L97)

"It would facilitate talks about it [MI/MH issues]."

(P3-L675)

Purchasers.

"… if we were able to get them to talk not necessarily about their own experiences but just about what they know we will be able to bring quite a bit and that is the power of this, and for what I've seen in the past, you know, all you really need is to start a conversation because then things happen on their own, and that is really what I am hoping with that."

(P5-L564)

"… the objective of breaking the silence of issues around MH."

(P2-L276)

"I think that certainly it will open that conversation and that is what I am hoping to do."

(P5-L165)

All stakeholders interviewed expect the program to motivate people to seek help in a timely manner. They expect that participants will develop the ability to look for help (i.e., to understand when help is needed, and how to act upon it). The documents reviewed described this objective also.

Documents.

"… and promotes timely access to resources."
(Workshop Synopsis, p. 2, ¶4)

CMHA- Calgary Region.

"… even if someone is suffering from a MI this stigma program might give them that information that pushes them to seek help."
(P7+6-L482)

"Gee I wonder if I should check on that, so look into something that they might not have otherwise."
(P3-L302)

Purchasers.

"Mental illness, this is not something to hide from and this is something that we have help for and therefore, if they know that and they will go and look for help."
(P5-L147)

Recognition of some patterns of behaviour that could indicate MI was described as an objective by the documents and the CMHA-Calgary region.

Documents.

"… may in turn spark future recognition that certain symptoms and behaviours may reflect an underlying health problem."
(Workshop Synopsis, p.1, ¶3)

CMHA-Calgary Region.

"I think I might have seen something like that so that they begin to recognize that there are patterns and there are things that maybe otherwise they wouldn't have realized what is going on."
(P3-L102)

"I think it is designed to really try to heighten people's awareness of what that means and gives them a bit of information about the

patterns that might indicate something like depression."

(P3-L162)

There were no indications in the documents reviewed that learning how to support people afflicted or affected by MI was a potential objective of the "What's Up with Biff?" program. The only mention of skills building that could be interpreted as support for others was found in The Copernicus Project Overview™, where the description seemed to be related to the "gold standard".

"The Copernicus Project™ works with participants to develop problem-solving skills for dealing with mental health issues."

(The Copernicus Project™ Overview, p.1, ¶2)

Some interviewees referred to co-workers learning how to interact or support each other around MH issues as an objective of the program. Two of the three people interviewed from the CMHA-Calgary Region, and one of the purchasers, mentioned that participants could learn how to help others deal with MI.

CMHA-Calgary Region.

"… how they can support people how they can support their own family."

(P7+6-L408)

"Or it may give a person in their office environment the tool to say maybe you need to look at or maybe you need to seek some help."

(P7+6-L488)

Purchasers.

"… what an appropriate response would be, what is wrong with him? I am angry at him but all of a sudden realizing that there are options and there could be a direct role for you know, best friend to play to support a colleague."

(P4-L356)

> *"... you know, to be able to support somebody they care about, so this is a tool that you can use."*
>
> (P4-L429)

Others were clearly concerned with managers learning how to interact and support workers affected by MH issues. One of the CMHA-Calgary Region staff members cautioned about the effectiveness of the "What's Up with Biff?" program in helping managers develop skills in dealing with MH issues arising in the workplace.

CMHA- Calgary Region.

> *"Managers and supervisors need a deeper understanding about MH issues, and Biff does not provide enough information for that. Without this depth of understanding they might not be able to respond well to staff problems related to MH. In the Copernicus Shifts there is a deep conversation and discussion over a long period of time that provides a greater depth of knowledge. These conversations will help managers recognize that workplace problems may be due to MH issues. Managers will be more able to understand and recognize patterns and issues brought about by stress and MH issues. It prepares them to respond in a more appropriate manner."*
>
> (P3-L649)

One of the purchasers agreed that the "What's Up with Biff?" program is not enough to prepare their managers to deal with possible problems resulting from MH issues in the workplace. This purchaser felt that the managers would need more information on how to deal with or support their employees. To cover this gap this purchaser gives the managers special handouts on this topic.

Purchasers.

> *"... it is very important that the manager participates because first of all your input in this is critical you are going to be the person who is going to be dealing with any issues that arises any performance issues and things like that and therefore it is*

> *important that your employee sees you as a person that is interested in that. And because we don't really address in "What's up with Biff", you know, how is the manager supposed to handle, you know, any kind of issues, how are they likely to manifest themselves and things like that, well we look at how they are likely to manifest but then we have just a supplement just a handout that the manager receives."*
>
> (P5-L314)

> *"... it is really just a handout but it tells them exactly, you know, as a manager, what are your duties what you are responsible for, what is that you need to do, if there is a performance issue you need to address it, putting it under the cover will not help that person and then if so how do you go about it and what do we have to support you as a manager. And that is what they get."*
>
> (P5-L349)

Ancillary objectives.

In addition to the three groups of objectives identified above, some of the interviewees referred to objectives that are not stated as program objectives. These are considered ancillary objectives, which can be regarded as supplementary to program objectives.

CMHA-Calgary Region.

The CMHA-Calgary Region identified as an objective to increase the number of workplaces and employees receiving the program.

> *"... the priorities from my perspective are numbers. Getting in there, to give this program to as many workplaces and employees as possible because they can obviously benefit from this."*
>
> (P7+6-L200)

Purchasers.

The purchasers also had their own objectives when using the "What's Up with Biff?" program in their workplace. Some believed in the possibility of increasing

productivity and saving money in the long run when using the program. The purchasers expected that the program would help increase employee attraction and retention.

> *"It would save time and money in the long run."*
>
> (P2-L372)

> *"… this is a matter of productivity it is matter of supporting our employees, so productivity will make us more money supporting the employees will allow us to retaining good people and attract people over time."*
>
> (P4-L322)

Program Components and Process Objectives

According to Dwyer and Makin (1997) "Program components are groups of program activities that seem to belong together conceptually. Each component is given a label to define that collection of strategies" p.423. They can be organized into groups such as education, or marketing (Dwyer & Makin, 1997). The process objectives specify the activities that will need to be implemented in order to achieve the outcome objectives (Dwyer & Makin, 1997). In this section the process objectives will be referred to as program activities.

Program components.

The only program component clearly described about the "What's Up with Biff?" program is education. The "What's Up with Biff?" program was clearly described in the documents and by the CMHA-Calgary Region as an educational program, and as such all program activities are grouped under the education component.

As the program was planned and developed by the CMHA-Calgary Region, little information about the components and activities of the "What's Up with Biff?" program

was obtained from the purchasers. For this reason, the purchasers will not be represented in this theme.

Program components - documents.

"The Copernicus Project: Risk Management for Workplace Mental Health is an education initiative of the Canadian Mental Health Association - Calgary Region."

(The Copernicus Project™ Overview, p1, ¶1)

Program components - CMHA-Calgary Region.

"I think originally the program is about educating people and CMHA has a mandate and that is one of our core pillars of our mandate is education so we provide education in a variety of ways very sort of broad based ...public, general public, but we also go to schools, junior high schools, corporations, businesses and so forth. So this is an education program and it does fit in with that part of our mandate."

(P6+7-L183)

"So, primarily education and stigma are in the mandate of our organization."

(P7-L197)

Process objectives (program activities).

Program activities - documents.

The best description of the activities of the "What's Up with Biff?" program is contained in the Workshop Synopsis document.

"Through a combination of presentation materials, animated narratives and discussion exercises, the workshop breaks through the silence around mental health issues, provides information, and promotes timely access to resources."

(Workshop Synopsis, p.2, ¶4)

"What's Up with Biff? uses two versions of a real-life case study. The first version is the story of a construction worker whose

> *fictional name is Biff. The second version is the same story but told from the perspective of Biff's apprentice, Spike.*
> *"What's Up With Biff?" incorporates an innovative format for presenting the case studies. Through the use of Multi-Media Flash Animation, Biff and Spike 'come to life'."*
>
> (Workshop Synopsis, p.2, ¶2)

Although the program is a one-hour stand-alone program, it is divided into six sections. The first two sections are Power Point™ presentations.

> *"Section 1 introduces the topic of mental health and mental illnesses, and provides a list of common mental illnesses.*
>
> *Section 2 narrows the focus to the illness of Major Depressive Disorder, or depression, and discusses depression in the context of leading workplace disabilities."*
>
> (Workshop Synopsis, p.3, ¶2)

These Power Point™ presentations are followed by video clip presentations interspaced with a short discussion, first in small groups and then with the whole class.

> *"Section 3 uses animated video to tell the story of Biff, a construction worker who is experiencing increasingly disabling symptoms but has no idea what is going on and is afraid to tell anyone. A discussion of Biff's story, and the symptoms of depression, follows the video.*
>
> *The intent is not to diagnose Biff as having depression but to highlight that he is experiencing a number of symptoms that could point to an illness like depression. Emphasis is placed on Biff's lack of awareness and his fear of what others might think if they knew what was happening, both of which prevent him from seeking help.*
>
> *Section 4 uses animated video to tell Biff's story from Spike's perspective. Again the video is followed by a discussion exercise. This section illustrates Spike's confusion and anger with a situation he doesn't understand and the inaccurate assumptions he inevitably makes.*

> *Section 5 discusses what's at stake for all concerned in this situation. Biff, Spike and the organization they work for all stand to lose a great deal. Emphasis is placed on the fact that with appropriate, timely interventions, many of these losses could be avoided. Section 5 also provides resource information.*
>
> *Section 6 brings Biff's boss, Charlie into the picture, and points out that Charlie has both the authority and the responsibility to intervene in this situation. Section 6 uses an animated video to offer one example of a conversation between Biff and Charlie that could result in a much more positive outcome for all concerned. This is followed by a brief recap of the workshop objectives of the workshop and suggestions for generating ongoing conversations about mental health issues."*
>
> (Workshop Synopsis, p.3, ¶4)

Program activities - CMHA-Calgary Region.

A Power Point™ presentation, video clips and class discussions are the main activities of the "What's Up with Biff?" program.

> *"... you deliver the presentation and there is some really good discussion."*
>
> (P6+7-L737)

> *"You know, the video and stuff like that we developed, I mean I would have liked to developed it regardless but it was the very, I knew that with the train the trainer stuff it was essential because a lot of the time the companies that had trainers that were saying, you know, we've got our health and safety trainers they don't know anything about this so whatever you develop for them it has to be very easy for them to present and so but apart from that. I felt that the cartoon, the video would capture the audience's attention."*
>
> (P3-L209)

Ancillary components.

Marketing was described as a component by both the CMHA-Calgary Region and the purchasers. Marketing is related to the "What's Up with Biff?" program, but is not a

component of the program per se. It comprises a group of activities, such as presentations and letters, undertaken by the CMHA-Calgary Region and the purchasers to promote the program.

Ancillary components - CMHA-Calgary Region.

As this program falls into the fee-for-services category, the CMHA-Calgary Region has undertaken some marketing activities to promote the program in the corporate community.

> *"The way I have been promoting it regionally has been through a letter campaign, specifically writing letters to individual companies and following up. As well as I had some request through some of advertisements and web based advertisements and people contact me through those."*
>
> (P6-L26)

Further, the person responsible for the program at the CMHA-Calgary Region also promotes the program internally with the objective of raising awareness with other staff members so that they can promote it outside of the CMHA-Calgary Region.

> *"… to make all of our staff aware of [name]'s program and what he is doing and getting him in front of people so that if others are out there talking about what we do in our organization or talking to friends who work in another corporation is a way to market the program. We try to get [name] in front of people from time to time so that he can market the program to our own staff."*
>
> (P7-L334)

Ancillary components - purchasers.

The person in an organization responsible for purchasing the program often needs to obtain the buy-in from other managers to approve the purchase and also to promote the delivery of the program to all workers.

> *"… although being a prudent professional I spent time thinking about how I would go though explaining to my internal clients the value of doing this project and the need for a level of funding.*
> *E: Who are your internal clients?*
> *P4: Our CEO, VP and managers of each of our 6 branches."*
>
> (P4-L57)

Resources

Resources refer to the supplies available or required to implement a program (Dwyer & Makin, 1997). Resources include personnel, equipment and materials. In this section the resources needed to implement the "What's Up with Biff?" program will be presented.

Resources - documents.

There is mention in the documents reviewed that all materials necessary to deliver the program will be provided to the purchasers.

> *"The purchaser will be provided with either a web location, username and password or a CD containing all materials needed to deliver 'What's Up with Biff?'"*
>
> (Workshop Synopsis, p.4, ¶1)

The documents state also that if the organization has an experienced facilitator, even if this person has no background knowledge about MH issues, he or she can be considered competent to deliver the program.

> *"Both the 'Copernican Shifts' Series and the 'What's Up with Biff?' one-hour workshop packages include all the information a facilitator with no background in mental health needs to confidently and competently deliver a mental health workshop. No additional training or instruction is required."*
>
> (The Copernicus Project™ Overview, p.1, ¶4)

There is mention in one of the documents that the program was successfully test-marketed by facilitators with no background in the MH field.

> ***"Note:** Facilitation skills and experience are needed to deliver this workshop, however a background in mental health, while it is an asset, is not a requirement. The workshop has been successfully test-marketed by facilitators with no background in mental health. The information and resources provided in the workshop materials have proved sufficient for experienced facilitators to effectively deliver the workshop."*
>
> (Workshop Synopsis, p.4, ¶2)

Although the facilitator does not need to have a background in the MH field, the train-the-trainer binder provides a reference list on recommended readings about MH issues for the facilitators.

> *"This session provides a list of recommended background readings for the facilitator. These readings provide practical information that may be of use to anyone dealing with MH issues in the workplace."*
>
> (Train-the-Trainer Manual, p.3, ¶2)

There is reiteration in the train-the-trainer binder that the CMHA-Calgary Region does not provide training to facilitators of the program and that facilitators need to be experienced.

> *"The train-the-trainer does not provide training in facilitation. Facilitators are expected to have knowledge and experience in delivering programs/teaching adults."*
>
> (Train-the-Trainer Manual, p.2, ¶1)

Resources - CMHA-Calgary Region.

The CMHA-Calgary Region interviewees described the resources they use in their organization to promote, sell and deliver the "What's Up with Biff?" program.

> *"We work closely with communications department as well, communications manager."*
>
> (P6+7-L301)

> *"... there is certainly IT support, specifically when we have an organization as a purchaser with copying the CDs and specifics related to computer application."*
>
> (P6+7-L307)

> *"... whatever we have in here is available to [the person in charge of the program at the CMHA-Calgary Region], [she/he] can have help from communication, [she/he] can have help with IT, we certainly provided [her/him] with the reception, of course, takes call and sends them through and all of the logistic around office space, computers and so forth."*
>
> (P7+6-L318)

The CMHA-Calgary Region described also what resources the organizations purchasing the program would need to provide, confirming what was described in the documents about the skills necessary for a person to facilitate the program.

> *"To deliver the program through the person, not necessarily have to have a background in MH but they need to be a comfortable presenter, a trained facilitator or have facilitation skills, the program itself is a "full meal deal", we provide them with all the information, background research, scripts, anticipated questions and answers to those questions so, it is really, if they have the facilitation skills they will be able to pick this program from start to finish and deliver effectively an educational anti-stigma program."*
>
> (P6 –L193)

Another staff member from the CMHA-Calgary Region expanded on the equipment necessary to deliver the program and confirmed the recommendations for a skilled, experienced facilitator to deliver the program.

> *"All they need is, they need a laptop and a video projector and, you know, speakers that kind of things that's all they need. I mean*

the trained people delivering this program they need to have some knowledge of training because we did not try to include how to be a trainer. We included how to deliver the material but there are things that people need to know in order to be a facilitator that they have to know, but assuming that someone has the experience in delivering, training or education, everything they need is in the workshop material, they need to read them, they need to follow them, they ideally need to practice them a few times, but everything they need is in there they don't need to. If you are a trainer and you pick up this program and follow the instructions and do what it says to do, you can deliver it."

(P3-L251)

Resources - purchasers.

The purchasers and the participant in the workshop shared their opinion about the program and its contents.

"I think the video is a really good tool and the scenario that is described there is one that, the way it is portrayed is, is a very good illustration of MH in the workplace and the issues that can arise and it is non-threatening, it is entertaining in a way, I like the drawing, and then having the discussions afterwards was a good way of, kind of reinforcing and think though what you were seeing."

(P2-L108)

"It was very simple and very good."

(P2-L161)

"… the video and the involvement in the discussion was very good."

(P2-L194)

"I think it is excellent."

(P2-L330)

"My overall opinion is positive there are several things I really like about it and one is its simplicity, the fact that it doesn't try to

do too many things, which to me it is important, it is very specific."
(P5-L554)

"... Absolutely excellent. Easy to use, easy to understand, well thought out."
(P4-L465)

The purchasers and the participant in the workshop referred also to the importance of having a good facilitator delivering the "What's Up with Biff?" program.

"However, what I think, what really sells it as well, is who facilitates it, is who presents the message, that is important and [name of the person] would be a hard act to follow, you know."
(P1-L694)

A participant in one of the workshops mentioned that the discussion was a bit stilted and the facilitator could possibly make a difference in the degree of animation of the discussions.

"... it might have been just because of the facilitation of the discussion or the group that I was in it [the discussion] was a bit stilted."
(P2-L138)

"I think it is good to have a good facilitator and maybe somebody that goes around to each table to help, if necessary."
(P2-L161)

Later, this person explained what a good facilitator meant to her/him.

"In my mind a good facilitator for this program would be able to: understand and empathize with people with mental illness as well as people who hold stereotypes of people with mental illness. They would also understand the impact on families and the stigma attached; be able to facilitate discussion and help people reframe their comments or thoughts to positively learn new ways of viewing these situations; be able to handle people who are too vocal or

> *disruptive; and be willing to share appropriate personal stories related to the topic, if and when appropriate."*
>
> (P2-L391)

In short, all print and electronic resources, including references for further reading, are provided to the purchaser. The organization purchasing the program need only supply an experienced facilitator, schedule the workshop(s), and select the group(s) of participants to attend.

Summary of Results

The results that emerged from the data are summarized in Table 3. They are presented in the logic model format that was constructed on the basis of the review of the documents, interviews with stakeholders, and direct observation of the program. Appendix E depicts the full logic model summarized in Table 3.

The results indicate that there are several issues that merit exploration and will be addressed in the following chapter. These issues include: the compromises made by CMHA-Calgary Region when responding to the demands of the corporate community for a shorter program; the conditions that they attach to the program goal; the issue of universal applicability of a program depicting male blue collar workers; the achievability of the outcomes; and the importance of the attributes of the facilitator delivering the program.

In Chapter 4, the discussion will be presented using the same structure that was used in this chapter (i.e., context and logic model themes). Each of the themes will be explored in depth as the discussion progresses, always linking the issue discussed to the relevant theory and information found in the literature. Recommendations are presented to improve the evaluability and performance of the "What's Up with Biff?" program, and

a recommendation is provided on the type of evaluation most appropriate for the program at this time. These recommendations answer the research questions.

Table 3. Summary of results

Logic Model Themes			
Goal	Decrease Stigma to MI in the workplace Conditions: part of a multi-pronged program and delivered to as many workers as possible		
Target Group	Workplace setting		
Long-term outcome objectives	Participants will continue informed dialogue about MH issues in the workplace (Purchasers' responsibility)		
Short-term outcome objectives	**Improve Knowledge and Awareness** MH issues, especially depression Resources available	**Improve Perceptions** Understand challenge of unaddressed depression Understand stigma and its consequences Perceive support in the workplace	**Build Skills** Acquire basic language and initiate dialogue Ability to look for help Recognition of patterns that may indicate MI How to support others afflicted/affected by MI
Components	Education	Social Contact	Practice Skills
Process Objectives/Program Activities	Lecturette Power Point™ presentation	Video with real-life story (animated story) Provides opportunities for "in video" social contact	Discussions in small groups and in class (questions provided related to the video)
Resources	Experienced facilitator Train-the-trainer material Computer, printer, LCD projector, coloured paper, binders, appropriate space		

Chapter 4: Discussion

Introduction

This chapter contains a discussion of the results presented in the last chapter, and follows the same order as the results. It starts with a discussion of the context and then proceeds to the themes that comprise the logic model. A discussion on the limitations of this research project is then presented, followed by recommendations. Recommendations are provided to improve the evaluability and performance "What's Up with Biff?" program, thereby answering the primary research question. Recommendations for the appropriate program evaluation are also presented, answering the secondary research question. The chapter concludes with recommendations for future research and a discussion of the significance of this research project.

Before proceeding, a brief discussion of the use of language in the MH field is in order. The term *MH issues* is widely used in the field instead of the term *MI issues* or *MI and related problems*. One might ask why the term MH issues is used when, in fact, we are dealing with MI issues. First, it is worth noting that we generally refer to *health care* and not to *illness care* when we are speaking about care of people with illnesses. Thus, the use of the term MH issues is consistent with general usage in the health care field. More broadly, language can reflect and shape social reality, and the use of negative language can create expectations or self-fulfilling prophecies (Walker, 2006); for example, "I am a schizophrenic, so there are some symptoms, and perhaps some behaviours, that I expect to experience." As explained by Walker (2006), the Recovery Model, where the person is said to have a diagnostic versus being a diagnostic, uses positive language to maximize optimism, (e.g., he is experiencing symptoms of

schizophrenia versus he is schizophrenic). The Recovery Model seems to explain, at least in part, the adoption of the term MH issues in the field.

Context

In Chapter 3 context was defined as a set of facts or circumstances within which an event or phenomenon happens or exists, and that are relevant to the event. These facts or circumstances, such as time, social structures, economic resources, background or environment, influence the event and help to ascertain, specify or clarify the meaning of the event (Lincoln & Guba, 1985; Patton, 1987; Scott & Thurston, 2004; Scott & Hofmeyer, 2007).

Discussion of the salient aspects of the context will be presented in this section. These aspects of context are points that were deemed important in understanding not only the development of the "What's Up with Biff?" program, but also how the CMHA-Calgary Region came to adopt its current approach to presenting and describing the program to potential clients.

Although considerable work was done in collecting information from the corporate community and from the literature, there was no evidence of scientific-based preliminary development work done in preparation to design The Copernicus Project™. There is no mention and no evidence that a needs assessment or a critical literature review was done. Needs assessment "is a systematic approach to identifying social problems, determining their extent, and accurately define the target population to be served and the nature of their service needs" (Rossi et al., 1999, p. 119). Consultations were done with Calgary corporate community members known by the CMHA-Calgary Region board members, but there was no indication of a systematic approach. A critical

literature review is a form of analysis, a structured search of the literature to evaluate and interpret all available relevant research on the topic of interest (Rychetnik, Frommer, Hawe, & Shiell, 2002; Stufflebeam, 2007). These procedures are important to confirm the firmness and validity of any conclusions made by the researcher (Stufflebeam, 2007).

Based on the review of the historical development of the Copernicus Project™, it appears that there were compromises made in the development of the "Copernican Shifts" and the "What's Up with Biff?" programs. There was pressure from the corporate community for a shorter version of the programs that could be delivered by staff members of purchasing organizations, and the CMHA-Calgary Region expected some revenue from these programs. In giving in to these pressures, the "What's Up with Biff?" program became a stand-alone program that is different from the "gold standard" recommended by the developer of these programs. Such compromises could have affected the effectiveness of these programs or, at a minimum, changed the expected outcome of the programs when only one part of the recommended program is delivered.

The business case document is used to promote all of the programs under the umbrella of The Copernicus Project™. Although the reasons for an organization to consider purchasing the programs offered by the CMHA-Calgary Region have probably not changed, the programs being commercialized by the CMHA-Calgary Region have changed. The "Copernican Shifts", the "What's Up with Biff?", and the "gold standard" are different enough that one can reasonably expect that they would produce different outcomes. As the programs are promoted as a group, the goals and objectives for each individual program are not clearly presented, which could mislead prospective purchasers.

The change in the price structure for The Copernicus Project™ programs by the CMHA-Calgary Region could reflect the changes in Calgary's economy. In 2009 the economy in Calgary was certainly different from the boom that Calgary was experiencing in the earlier 2000s when The Copernicus Project™ was initiated (Calgary Economic Development, 2009). The slowdown in the economy might explain the elimination of the position at the CMHA-Calgary Region responsible for the promotion and delivery of The Copernicus Project™.

Two of the three purchasers participating in this research had previous experience with the original Copernicus Project™ and the "gold standard". This fact made it difficult to discern if their answers to the interview questions were in reality related solely to the "What's Up with Biff?" program. Even when reminded that we were talking about the "What's Up with Biff?" program, they seemed to lapse easily into their past experiences with the "gold standard". Given that experienced users seemed confused about the different outcomes to be expected from the programs under the Copernicus Project™ umbrella, it indicates that the expected outcomes of these programs are not clear, and it is likely that new purchasers would also experience the same confusion.

Presenting the context sheds light on the current promotion and use of the "What's Up with Biff?" program. The program was intended initially as part of the "gold standard" and it has, over time, been separated from it. This separation has resulted in a lack of clarity about its expected outcome. The promotion of the programs under the umbrella of the Copernicus Project™ can be misunderstood, and potential purchasers of "What's Up with Biff" may believe that the program will deliver the outcomes that the "gold standard" is intended to achieve.

Goals

Goals are usually general and abstract statements that set out a broad rationale for a program. Goals indicate the desired state that the program is intended to achieve (Dwyer & Makin, 1997; Rossi et al., 1999). In this section, the description of the goal in the documents and by the interviewees, the logic behind the program theory, and the conditions necessary for the program to attain its goal will be discussed.

It was somewhat difficult to interpret the data related to the goal of the program. Decreasing stigma to MI was directly or indirectly described as the program goal by all participants. Some of the interviewees were clear about their expected program goal. Others used different words to express their expected outcomes, such as "mental disability will be welcomed, MI will not have to be hidden anymore", and that the challenges associated with MH issues will "become more normal" or more acceptable in the workplace. These outcomes are all associated with the goal of creating a workplace with little or no stigma to MI.

The strong connection described in the data between breaking the silence surrounding MH issues and reducing the stigma to MI was an important program assumption. According to the data, the "What's Up with Biff?" program's goal is to decrease stigma to MI in the workplace, and the program will attain its goal through the intervening factor of initiating conversations around MH issues.

The next question to ask is whether or not this concept is supported in the literature, and whether there are reasonable grounds to believe that it could be successful. Is it possible that an increase in conversations about MH issues actually backfires and increases stigma? Intuitively, one might think that conversations about a topic based on

speculation or gossip, where people reinforce myths and taboos, such as in some media stories about MI, could certainly reinforce stigma. However, the literature supports the idea that starting informed conversations about an issue can help decrease the stigma attached to it (Hendriksen et al., 2009; Knifton et al., 2010).

There is evidence that increasing informed conversations about an issue such as MI or HIV/AIDS can indeed help change people's attitudes and decrease stigma. Knifton et al. (2010) delivered a community-led anti-stigma to MI workshop with minority groups from India, Pakistan, and China. The 90-minute workshop was aimed at providing information and facilitating discussions on MH issues, including stigma. They concluded that "community conversation workshops effectively engaged participants, and resulted in reduction of reported stigma" (p. 501).

Interestingly, Knifton et al. suggested that such programs could be further enhanced by including narratives and by being delivered in settings such as schools and workplaces. They stated also that broad, national anti-stigma programs are often inadequate for certain ethnic minorities. Their intervention was developed through engagement with the community and with an understanding of how MH issues are perceived in the minority cultures that were involved in the program (Knifton et al., 2010).

Hendriksen et al. (2009), in their study on communication and related HIV testing in some African countries and Thailand, concluded that "verbal communication may be an important mechanism for reducing stigma and increasing health behaviours [sic]" (p. 1219). However, they advised caution about the quality of the information exchanged. They suggested that conversations need to be based on accurate information rather than

on gossip or speculation. They reported also that opinion leaders within the community, those people that influence others (Valente & Pumpuang, 2007), are regarded often as more credible sources of information in a social network, and they therefore need to be well informed. Informed opinion leaders that believe in the concept of the program can be a powerful supportive influence on the target population (Hendriksen et al., 2009).

One can conclude that starting informed conversations about MH issues has indeed the potential to decrease stigma to MI. The key is that the conversations are based on accurate information (i.e., informed conversations). Further, it is important that the conversations be handled well. Any intervention should be sensitive to the particular cultural and social context of the target population, and the program delivery can be enhanced by employing well informed or trained opinion leaders.

To achieve its goal, the CMHA-Calgary Region recommends that the "What's Up with Biff?" program be part of an ongoing, comprehensive workplace wellness program. Dwyer and Makin (1997) accept that a program can, in fact, be only one factor that contributes to the achievement of a program's defined goal. Examples of multiple interventions to achieve a goal are often found in smoking cessation interventions, including the use of physician or non-physician counsellors, reinforcing sessions, group or individual sessions and pharmacotherapy (Kottke, Battista, DeFriese, & Brekke, 1988). In a meta-analysis of 39 smoking cessation trials, Kottke et al. found that the number of intervention modalities was the most likely factor to affect success (1988). Similarly, a multi-pronged approach within a planned wellness program could be recommended to reduce stigma to MI in the workplace. In other words, it is acceptable

for the "What's Up with Biff?" program to be one component in an anti-stigma to MI program.

Caution, however, should be exercised with a program that is but one part of a multi-pronged approach. Any circumstances or conditions that are required for the program to attain the desired goal should be clearly expressed by all documents and staff of the CMHA-Calgary Region. Providing this clarity would ensure that all purchasers have a correct understanding of the program's limitations and possibilities. Although there seems to be a consensus by the stakeholders on the goal of the program, it is unclear that all the purchasers interviewed understood the conditions attached to this goal.

In addition, one of the CMHA-Calgary Region interviewees seemed to believe that a necessary condition for the program to be successful is that the program be delivered to a high percentage of people in the workplace. This person stated that to have a big impact the program needed to be delivered to most people in the workplace. This statement raises a question as to whether this is indeed a necessary condition. This question will be discussed under program components and activities.

Any conditions placed on the program by the CMHA-Calgary Region should be well documented and explained to potential purchasers of the "What's Up with Biff?" program. The CMHA-Calgary Region has no control over how the program will be used once an organization purchases it. If the CMHA-Calgary Region wishes to make any claims about the outcomes the program could potentially deliver, they must clearly state the conditions.

In summary, the goal of the "What's Up with Biff?" program that emerged from the data is to decrease stigma to MI by breaking the silence and facilitating informed

conversations on the topic of MH issues in the workplace. This program theory is in accordance with the literature review on combating stigma to MI and HIV/AIDS. However, the goal of decreasing stigma to MI in the workplace can be only accepted with the condition that the "What's Up with Biff?" program be part of a multi-pronged wellness program. It is recommended that this or any other conditions be clearly stated in the documents and in all the promotional materials used by the CMHA-Calgary Region when marketing the "What's Up with Biff?" program.

Target Population

Two main questions related to the target population for the "What's Up with Biff?" program will be discussed in this section. The first question asks who should be targeted, the workplace setting or a segment of the population? The "What's Up with Biff?" program was originally designed with male blue collar workers in mind. However, it is delivered to organizations with other than blue collar workers (i.e., professionals and administrative staff). Therefore, a second question arises as to whether or not it is appropriate to deliver the program to workplaces that are not composed mainly of male blue collar workers.

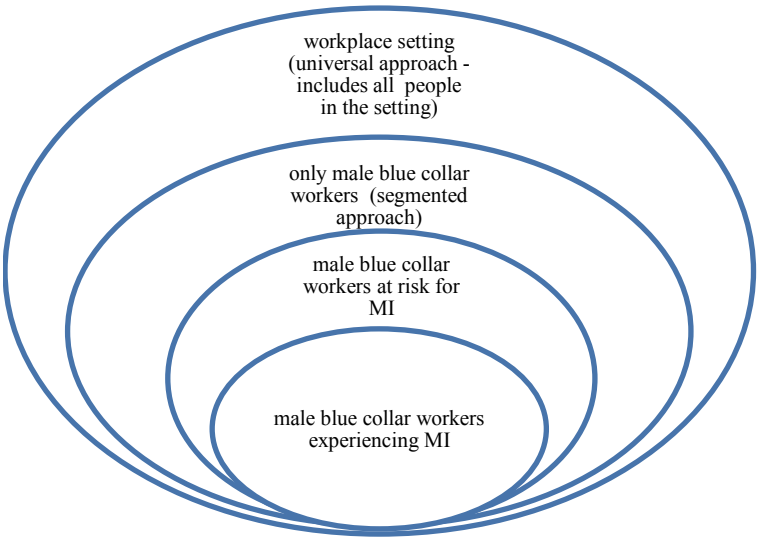
As noted in the Results section, all interviewees, as well as the program documents reviewed, agreed that the "What's Up with Biff?" program should be delivered to all the workers regardless of their sex or job position. As it is currently delivered, the "What's Up with Biff?" program is intended for all people in the workplace setting.

According to the WHO (1998), a setting is a "place or social context in which people engage in daily activities" (p. 19). Targeting a setting means that all people in the

setting are expected to receive the intervention; that is, the approach is universal, and the focus is not on the individual. The setting approach shifts the focus from individual behaviour risk factors to the broader perspective of health determinants, such as the social environment. The individual is not targeted in isolation, but in her/his social context (Green et al., 2000). This is the approach taken by the "What's Up with Biff?" program.

An alternative approach would be to deliver the program to a segment of the population only. A population can be segmented if only a part of the population is the target of the intervention. The decision for segmentation is based on indicators that are applicable to the issue at hand. Segmentation may separate the population by age, sex, job position, or risk assessment, and only certain portions of the population would receive the intervention. If the segmentation is not based on risk assessment, the segment would include people at risk, not at risk, and people experiencing the issue (i.e., afflicted or affected by the issue). For example, if the workplace setting were segmented such that only male, blue collar workers were to receive the intervention, all male, blue collar workers would be included regardless of their risk or experience with MI, but other workers would be excluded (Figure 6).

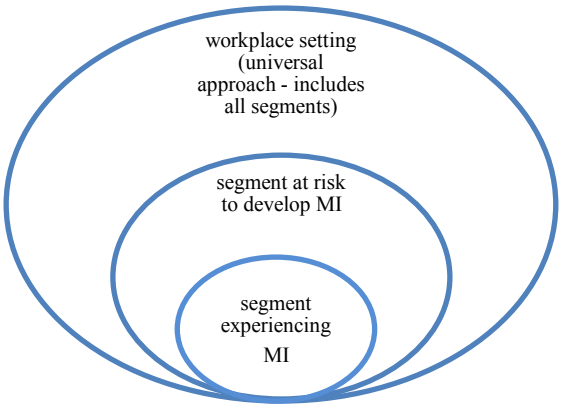
Figure 6. Target population: universal versus segmented approach



Although targeting a segment of the population would be a possible approach, the "What's Up with Biff?" program purports to target the entire workplace setting. The logic behind this stance can be seen in the context of health promotion strategies.

An important health promotion strategy is to create supportive environments where people "live, love, learn, work, play, and pray" (Vollman, 2008, p. 223). Supportive environments can be created by programs that target settings such as schools or workplaces (Vollman, 2008). Therefore, when considered in conjunction with the goal of the program, which is to decrease stigma to MI in the workplace, the "What's Up with Biff?" program can be considered to be a health promotion intervention. The aim is to improve the social environment in the workplace and, as such, it makes sense that it should be delivered to all people in the targeted workplace including those not at risk, those at risk to develop MI, and those already afflicted or affected by MI (Figure 7).

Figure 7. Universal approach to target population



When settings are targeted they can be defined in terms of the characteristics of their members (Rossi et al., 1999). For example, the workplace targeted could be predominantly female or male, white collar or blue collar. As presented in the results, the

"What's Up with Biff?" program was initially geared to a workplace setting with mostly male blue collar workers. However, the CMHA-Calgary Region recommends and delivers the programs to workplaces with different characteristics. This raises a question as to whether employees other than male blue collar workers would be likely to identify with the characters depicted in the program.

Traditional theories agree that people engage and identify with characters in the media by means of empathetic feelings (Konijn & Hoorn, 2005). According to Rueckert and Naybar (2008), studies using self-reported questionnaires show that women are more empathetic than men. Some researchers were sceptical about these results and suggested that women's higher empathy levels were due to the traditional gender role of caring that is expected of and adopted by women (Rueckert & Naybar, 2008). However, studies using brain imagery have shown that women indeed show more empathy towards the suffering regardless of the similarities between themselves and the other person (Derntl et al., 2010; Rueckert & Naybar, 2008). If people identify themselves with others through empathic feelings, and women show higher levels of empathy towards others than men, one can infer then that women would more easily identify themselves with male characters with different life situations than would men.

The CMHA-Calgary Region, the purchasers interviewed, and a participant of the "What's Up with Biff?" program agreed that the program could be delivered successfully to females and white collar workers. The program participant said that she would have no hesitation in delivering it to office workers. They all seem to agree with the CMHA-Calgary Region that the issue experienced by the characters in the program are universal and people in general would be able to transfer the experiences depicted in the videos to

their own lives and situations. However, the three organizations participating in this research project were predominately composed of male, blue collar workers. Further, the CMHA-Calgary Region has experienced resistance from organizations whose workers were not primarily composed of male blue collar workers and were concerned that the program would not be suitable for their employees.

One strategy that could possibly increase the connection between white collar workers and the blue collar characters depicted in this program would be to enhance the instructions given to participants prior to watching the videos. Davis et al. (2004) suggest that the degree to which a person identifies or empathizes with a character when watching a video depicting a real case scenario depends on the instructions received prior to watching the video. People receiving instructions that prompt self-identification with the character were more likely to empathize with the character in the video than people that were prompted to just watch the video. In fact, the latter decreased their level of empathy. This result is explained by the fact that "perspective-taken efforts increase the likelihood of self-related thoughts" (Davis et al., 2004, p.1630), which are linked to feelings of empathy (Davis et al., 2004).

Lastly, a comment can be made about the possible reason why the CMHA-Calgary Region targets medium to large organizations more often than small ones. The "What's Up with Biff?" program is expected to attain its goal as part of a more comprehensive, on-going, wellness program in the workplace. Small businesses are less likely to have an Occupational Health and Safety program, and are less likely to have a comprehensive, on-going wellness program (Laird, Olsen, Harris, Legg, & Perry, 2011).

In summary, the "What's Up with Biff?" program is a health promotion program that targets the workplace setting. The program aims to improve the social environment of the workplace and is delivered to all people in the workplace, in accordance with the setting approach for health promotion. There is evidence in the literature that women participating in the program could identify themselves with the characters in the video. Nonetheless, there are some doubts about the appropriateness of delivering it to workplaces other than those comprising predominantly male, blue collar workers. Studies assessing the effectiveness of the "What's Up with Biff?" program should take into consideration the characteristics of the workers in the workplace settings.

Long-term Objective

As noted in the results there is no clear statement of a long-term objective for the "What's Up with Biff?" program. Rather, there are recommendations for the purchasers to find ways to continue the dialogue around MH issues in the workplace.

Although the continuation of informed dialogue about MH issues was described as a stepping stone to attaining the goal of decreased stigma to MI in the workplace, a one-hour workshop alone would not be sufficient to support the continuation of such dialogue in the workplace. The CMHA-Calgary Region counts on the purchasers to provide ongoing support for such dialogues.

Short-term Objectives

In this section, the following will be discussed: the formulation of the objectives by the CMHA; the categories of objectives; the degree of agreement among the stakeholders around these objectives; the extent to which the objectives are aligned with

attaining the goal of the program; any potential problems with the objectives; and whether or not the objectives are attainable through the "What's Up with Biff?" program.

Formulation of the objectives.

It is expected that, after determining the problem to be addressed, assessing the local needs, and performing an environmental scan, the first step in program planning is to develop the program objectives (Rossi et al., 1999). What will the program accomplish? The activities of a program should be guided by its objectives (Dwyer & Makin, 1997).

The objectives of the "What's up with Biff?" program described in the documents reviewed are presented as process objectives wherein the activities of the program are described instead of the outcome expected. One example is found in the descriptions of what is termed "learning objectives", where it states "Provide basic information on MH issues, in particular Major Depressive Disorder". In other words, the objectives are stated as activities rather than as outcomes. If the above teaching objective were stated as an outcome objective it would be stated in words such as "To increase knowledge about MH issues, in particular Major Depressive Disorder". The documents describe the program activities or what the program will offer, and not how a person may change or gain by attending the program. These objective descriptions seem to reflect a certain lack of planning of expected outcome objectives when the program was developed or a lack of knowledge of how to write objectives that are evaluable or SMART. Undertaking an EA will help to clarify and redefine objectives, such as the one above, using the SMART criteria.

Categories of objectives.

The objectives were presented in Chapter 3 according to four categories: improve knowledge and awareness; improve perceptions; build skills; and ancillary objectives. The first group of objectives falls into the category of acquiring awareness and basic knowledge about MH issues, and about the resources available in the workplace. The second group of objectives falls into the category of improving perceptions and understanding of the issues that surround MI, such as stigma and silence. The third category groups objectives around gaining skills (i.e., ability, confidence, competence, and comfort to act upon the issues of MI and stigma). The fourth category, ancillary objectives, relates to additional objectives that are not stated program objectives, but indicate certain organizational interests for the program's implementation.

Agreement among stakeholders.

As shown in Table 4 there was a large degree of agreement about the objectives among the interviewees and in the documents. While not every interviewee or document described explicitly each of the objectives in the Table, there was no conflict in the descriptions of the objectives. Representatives of each group, Documents, CMHA-Calgary Region, and Purchasers, made statements that indicate that increasing awareness, improving perceptions around MH issues, and skills building are part of the program's objectives.

An ancillary objective described by one of the purchasers was to increase worker productivity and save money. Presumably, the purchasers believed that the program would help the organization save expenses that are incurred on health benefits, disability services, and replacement for workers off work because of MH issues. This perspective

Table 4. Agreement on objectives

Objectives Long Term	Objectives Described by Documents	 CMHA- Calgary Region	 Purchasers
1. Continue Informed Dialogue (purchasers' responsibility)	Yes	Yes	Yes
Short Term **1. Improve Knowledge and Awareness**			
A. MH issues, especially depression	Yes	Yes	Yes
B. resources available	Yes	Yes	Yes
2. Improve Perceptions			
A. understand challenges of unaddressed depression	Yes	Yes	No
B. understand stigma/silence and its consequences	Yes	Yes	Yes
C. perceive support in the workplace	No	Yes	Yes
3. Build Skills			
A. acquire basic language→ initiate dialogue	Yes	Yes	Yes
B. ability to look for help	Yes	Yes	Yes
C. recognition of patterns that may indicate MI	Yes	Yes	No
D. how to support others afflicted/affected by MI	No	Yes	Yes
4. Ancillary			
A. increase the number of workplaces receiving the program	No	Yes	No
B. increase workplace productivity	Yes	Yes	Yes

might have emerged from the discussion of the "business case" for the intervention. An enlightened purchaser would see the program as both contributing to a safe and supportive workplace, and saving money for the organization in the long run, thus producing "win win" outcomes for the employees and the business. As discussed previously in the section about program goals, however, this program alone cannot

achieve this objective, and needs to be part of a multi-pronged, more comprehensive workplace wellness program.

Alignment between objectives and the program's goal.

The first question to be addressed is whether or not these objectives align with the overall goal of the program to decrease stigma to MI in the workplace. In other words, if these objectives were achieved would the overall goal be achieved? The short answer is "yes".

Stigma is a social process that involves a combination of knowledge, attitudes and actions (Corrigan et al., 2003). The stigmatizer perceives an attribute of the stigmatized person; this attribute is considered to be negative, and gives rise to stereotyping and prejudice. The prejudice is associated with a lack of knowledge and understanding, and often gives rise to associated myths and fears; for example, "people with MI are unstable and dangerous". Prejudice can result in acts of discrimination by the stigmatizer towards the person being subjected to stigma (Stuber, Meyer, & Link, 2008).

The first two categories of objectives in the "What's Up with Biff?" program—increasing knowledge and awareness, and improving perceptions about MH issues—are aligned to combat the lack of knowledge and prejudice in the process of stigma. If these objectives are achieved, there will be a heightened awareness of the issue of stigma to MI, there will be more accurate information in the workplace, perceptions about MH issues and people affected or afflicted by MI should improve, and the acceptability of stigmatizing behaviour will decline.

The category of skills building is intended to provide people with skills to better respond to MH issues in the workplace. The development of skills can give people the

capacity to respond to MH issues (i.e., the knowledge, confidence, and comfort to interact with people afflicted or affected by MI).

The CMHA-Calgary Region interviewees mentioned the importance of people in the workplace being able to recognize patterns of MI, especially depression, as one of the objectives of the program. This recognition has the potential to result in a positive or negative outcome. If a person afflicted by MI is able to recognize his or her problem and consequently seek help, that situation would be positive. Among co-workers, assuming that the recognition was made correctly, if the person with MI wants help and his or her co-worker is able and willing to help, it could result in a positive outcome. The recognition on its own, however, has the potential to do harm. If the culture of the workplace is one of competitiveness and the other objectives of the program have not been achieved, recognition could be used as a "weapon" to undermine the person with MI and reinforce stigma. Nonetheless, the discussion here is meant as a caution and not as an opinion that recognition of patterns should not be one of the objectives of an anti-stigma program. Recognition of patterns is important so that people can recognize when help is needed for others or themselves.

Achievability of the objectives.

While the objectives of the program align theoretically with the overall goal, the question of whether or not the program will actually deliver on the objectives has not yet been addressed. The objectives of improving knowledge and awareness of MH issues and resources available could potentially be attainable with a one-hour program. A focussed one-hour session should be sufficient to communicate basic information about MH issues in the workplace and the resources available in the workplace.

The next question to be discussed is whether or not the "What's Up with Biff?" program can deliver on the other objectives uncovered in the data. Rogers' Diffusion of Innovation Theory, as explained by Valente and Fosados (2006), and the Transtheoretical Model of Change (TTM) by Prochaska and Di Clemente (as cited in Prochaska et.al, 2004) will be referred to in this discussion. The main discussion is related to time. Can a one-hour program deliver on the objectives of Improving Perceptions and Building Skills?

Diffusion of Innovation Theory is often used in health promotion to help people adopt new behaviours. Diffusion of Innovation is the process by which a new behaviour, idea, attitude or opinion is disseminated among the members of a social system (Valente & Fosados, 2006). According to this theory, people go through different stages in the adoption process and take different amounts of time to go through these stages, and for that reason Diffusion of Innovation often takes a long time. Usually, there is a learning hierarchy when people adopt a new behaviour. First people acquire awareness or knowledge of the problem and the expected new behaviour; second comes a change in attitudes towards the issue; and third comes the practice of the behaviour. It is important to note that the learning processes do not always occur in this order. People may be coerced, influenced or motivated to adopt a new behaviour before their attitude has changed. In any event, the main point is that people need to go through a process to adopt new behaviours and that process takes time (Valente & Fosados, 2006).

The TTM explains behaviour change as a process that happens over time and involves the progression through five stages of change: pre-contemplation; contemplation; preparation; action; and maintenance (Prochaska et al., 2004). These

stages refer to an individual's readiness to change and adopt a new behaviour. In the pre-contemplation stage the person is unaware of the problem and is not considering any change. In the contemplation stage the person is aware of the problem but is ambivalent about change. In the preparation stage the person is trying to change and has taken small steps towards change. In the action stage the person is practising the new behaviour, and in the maintenance stage the person continues the commitment to sustain the behaviour (Prochaska et al., 2004). People move through these stages at different rates, according to their individual experiences and the tasks they complete on the path to change. Although TTM is used mostly to explain how one ends high risk behaviour and adopts a new healthy behaviour, it has been applied to organizational changes (Prochaska et al., 2004). While a full explanation of TTM is beyond the scope of this paper, it is another theory that supports the idea that behavioural change is a process that requires time.

With the Diffusion of Innovation Theory and the TTM in mind, it appears clear that a one-hour workshop would be inadequate to achieve the objectives of changing perceptions and building skills (behavioural changes). It would take more time and reinforcement for these changes to occur.

Although it is clear that a one-hour, stand-alone program is not enough to help people change behaviours or adopt a new one, people attending the program could be at different stages of readiness for change and will have varying predispositions to adopt a new behaviour. The readiness for change will depend largely on their previous experience and attitudes towards MH issues. A program such as "What's Up with Biff?" will have a different effect on each individual and workplace, depending on their previous individual and collective experiences. The impact on the participants in the

program will depend on their stage of readiness to learn and adopt new behaviours towards MH issues.

The objective of building managerial skills for dealing with workplace problems related to MH issues was considered to be unrealistic by two of the interviewees. One of the purchasers and one of the CMHA-Calgary Region staff members interviewed mentioned that the "What's Up with Biff?" program on its own is not enough to develop the skills needed by managers and supervisors to deal with problems resulting from MH issues in the workplace. The CMHA-Calgary Region interviewee that developed the program clearly stated the difference between the "Copernican Shifts" and "What's Up with Biff?" programs and stated that the "Copernican Shifts" program is more appropriate for reaching such an objective. This distinction brings to light once more the compromises made when the "gold standard", both the "Copernican Shifts" and the "What's Up with Biff?" program, are not used together. This compromise should be emphasized by the CMHA-Calgary Region when an organization purchases only the "What's Up with Biff?" program.

In summary, while the objectives were not explicitly stated, the review of the data indicates that there is general agreement on the implied objectives among stakeholders. Although not all objectives were described by all stakeholders, there were no conflicts observed. These objectives are indeed aligned with the overall goal of the program of decreasing stigma to MI in the workplace. However, there is inadequate time and resources for the "What's Up with Biff?" program to attain all of the objectives that were postulated in the data.

Recommended Objectives.

The recommended objectives are related to improved knowledge and awareness of MH issues, especially depression, and resources available to help those afflicted or affected by MI in the workplace. By examining the activities of the program and some of the information from the data, these objectives were restated using the SMART criteria. The recommended objectives are that, after attending a workshop, the participants will have improved knowledge and awareness of: the potential for misunderstanding when a co-worker is afflicted by depression; the potential for worsening of depression if untreated; and the resources available in their workplace. These are more specific objectives that can be measured pre and post-workshop using a survey. According to the previous discussion they are achievable and, as they are derived from the data, there is a high probability that the stakeholders will find them to be relevant. The objectives are time bound because they can be assessed at specific points in time; for example, pre-workshop and immediately after the workshop. It is recommended that the CMHA-Calgary Region discuss these objectives with key stakeholders for agreement and consensus.

Program Components and Activities

This section presents the discussion on program components and activities. A program component is a group of activities that seem to belong together (Dwyer & Makin, 1997). Program activities are those actions or interventions adopted in order to attain the program objectives. This discussion starts by presenting the program components and activities from the perspective of strategies for a successful anti-stigma intervention suggested in the literature. It will be followed by a brief discussion of the

applicability and relevance of Bloom's Taxonomy of Learning to the components and activities of the program. Program congruence will be discussed and, lastly, suggestions for improvement of the program delivery will be offered.

Strategies to combat stigma.

The "What's Up with Biff?" program was described by the CMHA-Calgary Region and in the documents as an educational program. However, when the objectives described by the stakeholders and the activities of the program were examined, two more components were recognized: contact and skills practice. Thus, the program activities were grouped under three components: the Power Point™ presentations under Education, the video clips under Contact, and the discussions under Skills Practice (Table 8).

Education is often used in anti-stigma interventions with the aim of combating the predisposing factors that contribute to stigma to MI. Education provides information about specific illnesses, countering false assumptions and misunderstandings on which stigma is thought to be based (Heijnders & Van Der Meij, 2006). A well done Power Point™ presentation has the potential to convey basic information to a group, and it is a simple way to do it.

Information alone may not be enough to influence the stereotype attributed to people afflicted or affected by MI. Education strategies can be more effective in decreasing stigma when combined with other strategies such as contact and skills practice (Corrigan & Penn, 1999). The "What's Up with Biff?" incorporates elements of contact and skills practice.

The video clips used in the program can be considered as a form of contact. Contact refers to all interactions between the stigmatized and the stigmatizer, with the

specific objective of reducing stigmatization. It can be done successfully in person or by videos (Heijnders & Van Der Meij, 2006). The use of a video depicting a real life story is an effective strategy used to combat stigma (Corrigan, Larson, Sells, Niessen, & Watson, 2007; Kulik, Bainbridge, & Cregan, 2008). The video clips used in the "What's Up with Biff?" program are very engaging and add a human dimension to the issues of MI presented in the program, and were described favourably by the interviewees.

Contact with the stigmatized groups is effective because it tends to modify negative stereotypes held by the stigmatizer (Kulik et al., 2008). The video clip of Biff, a person afflicted by depression, has the potential to help the program participants gain insight and understanding on depression from the perspective of the person afflicted by the disease. The video clip of Spike, Biff's apprentice, has the potential to help the program participants gain insights on misunderstandings and the negative consequences of unaddressed depression. These insights can help the participants change any negative and oversimplified images they may hold towards MI. Nonetheless, as noted previously, there is inadequate time in the program to effect changes in attitude and perceptions.

The discussions in the program that follow the viewing of the videos allow for some degree of skills practice. By answering the questions given for discussion after each video clip, a conversation about MH issues is initiated in the class. These discussions have the potential to reinforce the messages delivered in the educational component of the program. Through these discussions, participants have the potential to learn from each other by sharing their reactions, perceptions and experiences in an informed, safe, and positive manner. Once again, however, there is inadequate time in the program to achieve the objective of building skills.

From the foregoing discussion, it can be concluded that there is theoretical alignment among the program goal, the objectives, the components, and the types of activities proposed. Although the types of program activities are supported in the literature to decrease stigma to MI, when they are implemented in a one-hour workshop there is insufficient time to attain all of the program outcomes that emerged from the data. The program activities would need to be substantially redesigned and extended to provide adequate time and to create the conditions to enable behavioural changes.

Bloom's taxonomy of learning.

The "What's Up with Biff?" program is also designed in a manner that is consistent with Bloom's Taxonomy of Learning. According to Bloom (1956), a person going through the process of learning should acquire new knowledge, new attitudes and/or new skills. According to this theory, for learning to occur, a program's educational component should include activities that involve the cognitive domain to acquire knowledge, the affective domain to acquire new attitudes, and the psychomotor domain to acquire new skills (Bloom, 1956).

Bloom's Taxonomy of Learning "is designed to be a classification of the student behaviours which represent the intended outcomes of the educational process" (Bloom, 1956, p. 12). Each domain is divided into categories, and each category represents a progressive step in the process of learning. It is expected that a student would change at each step in the process of learning. A program designed with Bloom's Taxonomy of Learning in mind would incorporate these categories. Tables 5, 6 and 7 depict the categories for the cognitive, affective, and the psychomotor domains respectively. A description of the categories and the intended outcomes as applied to the "What's Up

with Biff?" program for each category is presented. The outcomes depicted in the tables did not emerge from the data; rather the tables illustrate the outcomes for the participants as Bloom's Taxonomy could apply to the "What's Up with Biff?" program.

Bloom and his associates described only categories for the cognitive and affective domains (Clark, 2010). Bloom's Taxonomy of Learning has been modified or interpreted by different authors, educators and researchers (Clark, 2010). The tables in this report are based on the tables depicted in Clark's discussion on Bloom's Taxonomy of Learning Domains (2010).

Bloom's cognitive domain involves knowledge and intellectual skills, such as the ability to recognize patterns, and to recall specific facts and concepts (as cited in Clark, 2010). As shown in Table 5, there are six categories within the cognitive domain.

Table 5. Bloom's cognitive domain categories

Category	**Description**	**Application for participant**
Knowledge	Recalls information.	Remembers information given in the workshop.
Comprehension	Understands the meaning of the information.	Understands key messages delivered in the workshop (see outcome objectives).
Application	Applies the learning s in a new situation outside the classroom.	Relates information learned about MH issues into the workplace.
Analysis	Organizes the information in a way that can be understood.	Analyses and reflects on the information about MH issues.
Synthesis	Puts diverse elements of the information together creating a new meaning.	Starts to understand MH issues from a different point of view.
Evaluation	Makes judgements about the value of the information.	Appraises the information gained about MH issues according to own values.

The affective domain in Bloom's taxonomy deals with emotions, including feelings, values and attitudes. The affective domain shows how one's attitudes towards a

subject influence the learning process. The five categories developed by Krathwohl, Bloom, and Masia (as cited in Clark, 2010) within this domain are shown in Table 6.

Table 6. Bloom's affective domain categories

Category	Description	Application for participant
Receiving phenomena	Willingness to hear the information.	Attentive and respectful in workshop.
Responding to phenomena	Active participation in the learning process.	Participates in the discussions in workshop.
Valuing	Worth attached to the phenomenon learned, from acceptance to commitment.	Becomes sensitive to the problems faced by people afflicted or affected by MH issues in the workplace.
Organization	Organizes and prioritizes values and resolves conflicts between values in light of the new information.	Accepts the importance of own behaviour in view of the information received about problems related to MH issues.
Internalizing values	Adopts the value attached to the information as one's own and behaviour becomes more consistent.	Revises judgement about MH issues and changes behaviour in light of new information.

The psychomotor domain encompasses physical senses and skills that require practice, precision and technique to properly execute. The sub-categories within this domain as identified by Simpson (as cited in Clark, 2010) are shown in Table 7.

The activities of the "What's Up with Biff?" program have the potential to influence changes in the participants that are depicted in some categories of all three domains of Bloom's Taxonomy of Learning. As mentioned before, these changes would depend on the individual's readiness to learn new skills and behaviours, and the collective previous experience and attitudes towards MH issues in the workplace setting. However, there is not enough time and depth in a one-hour program for participants to go through the full learning process and effectively acquire new behaviours. In particular, there are not enough opportunities to learn or practice new skills in the categories of the

psychomotor domain. Each of the steps/categories within the three domains requires some time and some practice for the new skills/behaviours to be learned and the "What's Up with Biff?" program does not provide this time.

Table 7. Bloom's psychomotor domain categories

Category	Description	Application for participant
Perception	The ability to use sensory cues to guide behaviour.	Starts to detect when new behaviour could be used.
Set	Mindset - physical, mental and emotional readiness to act.	Recognizes abilities and limitations, and shows willingness to learn the new behaviour related to MH issues.
Guided response	Early stage in learning a new behaviour (includes practice from imitating a role model).	Reproduces behaviour learned as illustrated in one of the video clips (e.g., how to initiate a discussion about MH issues).
Mechanism	Intermediate stage in learning a new behaviour. Becomes more confident and proficient.	Adopts behaviour in a more natural way.
Complex overt responses	Behaviour is performed accurately and skilfully to person's satisfaction.	Uses behaviour adequately.
Adaptation	Behaviour is well developed and can be adapted to new situations.	Responds effectively to unexpected situations related to MH issues.
Origination	Creates new and more sophisticated behaviour to respond to a new and specific situation.	Has become one of the role models in the workplace related to appropriate response to MH issues.

Addressing the contributing factors to stigma to MI.

In Chapter 1, three types of contributing factors to stigma to MI were identified: predisposing factors; enabling factors; and reinforcing factors (Green & Kreuter, 2005). Predisposing factors include fear of an unknown disease, misconceptions about people with MI, and discomfort in interacting with people with MI. In short, predisposing

factors arise largely due to lack of knowledge and experience with people who are dealing with MI. The education component of "What's Up with Biff?" addresses these predisposing factors by providing factual information that helps dispel misconceptions and helps to normalize people who have MI.

Enabling factors are those that facilitate the behaviour of stigmatization (Green & Kreuter, 2005), and include lack of knowledge and skills on how to interact with people afflicted or affected by MI, and lack of role models. On its own, the "What's Up with Biff?" program does little to address the enabling factors as more time and depth would be required, for example, to build effective interaction skills.

Reinforcing factors are those that reward the behaviour of stigmatization (Green & Kreuter, 2005), and generally refer to environmental influences that support those behaviours. As discussed in Chapter 1, the issue of stigma to MI arises in a social context. Given that the "What's Up with Biff?" program targets the workplace setting and it aims at improving the workplace social environment, it addresses the environmental influences that support stigmatization. To be more effective, however, it would need to be clearly supported by complementary actions by management; for example, clear workplace policy statements. Another strategy would be to use opinion leaders to act as role models of the desired behaviours. A visible commitment by management to provide follow-up support to the "What's Up with Biff?" program, such as targeted training for managers to help employees who are dealing with MI issues, would further help address the environmental factors that reinforce stigmatizing behaviour.

In summary, on its own "What's Up with Biff?" can make a contribution to addressing the predisposing and reinforcing factors that support stigmatizing behaviour in the workplace. However, to be really effective in combating stigma to MI in the workplace, it would need to be complemented by other strategies.

Program congruence.

In summary, there is theoretical alignment between the goal, objectives, the components, and the types of activities of the program. The alignment among the short-term objectives, program components, and program activities is shown in Table 8. However, the activities are of insufficient depth and duration to achieve the program outcomes. Hence, the program is not designed to deliver on its intended outcomes, and one must conclude that there is a lack of congruence in the program's design.

Strategies to enhance the delivery of the program.

Next follows a discussion about some of the shortcomings around the delivery of the program, and some suggestions for improvement. In the foregoing discussion about objectives, it was concluded that there is not enough time or resources in the "What's Up with Biff?" program to attain all of the objectives described in the data. This is a serious shortcoming and there is little to be done about this without redesigning the program. However, there are strategies that could potentially enhance the delivery of the "What's Up with Biff?" program within the current design and timeframe.

Table 8. Program objectives, components and activities

Objectives	Objectives Described by			Components	Activities
	Documents	**CMHA-Calgary Region**	**Purchasers**		
Long Term					
Continue informed dialogue (purchasers' responsibility)	Yes	Yes	Yes	None	None
Short Term Objectives					
1. Improve knowledge and awareness				Education	Power Point™ presentation
A. MH issues, especially depression	Yes	Yes	Yes		
B. resources available	Yes	Yes	Yes		
2. Improve perceptions				Contact	Video
A. understand challenge of unaddressed depression	Yes	Yes	No		
B. understand stigma/silence and its consequences	Yes	Yes	Yes		
C. perceive support in the workplace	No	Yes	Yes		
3. Build Skills				Skills Practice	Discussions
A. acquire basic language → initiate dialogue	Yes	Yes	Yes		
B. ability to look for help	Yes	Yes	Yes		
C. recognition of patterns that may indicate MI	Yes	Yes	No		
D. how to support others afflicted/affected by MI	No	Yes	Yes		

Corrigan et al. (2007) found contact to be a more effective strategy when the stigmatizer and the stigmatized have some common characteristics, share common status and goals, and when contact is supported by authority, such as managers. This suggests that the "What's Up with Biff?" program would be more effective when presented in a predominately male, blue collar workplace with management's visible and explicit support for the workers' participation in the program.

Another strategy that could be used when presenting the video is that of giving specific instructions that prompt self-identification with the characters in the video. This strategy was presented previously in this paper. According to Davis et al. (2004), people receiving instructions that prompt self-identification are more likely to empathize with the characters when watching such videos. These strategies could reinforce the effect of empathy and decrease negative stereotyping of people affected or afflicted by MI.

Using opinion leaders in the workplace could be also an important strategy to further enhance and guide the dialogue initiated in the workshop (Hendriksen et al., 2009; Valente & Pumpuang, 2007). They can act as role models and promote behaviour changes when used in health promotion programs. Programs using opinion leaders are more likely to succeed (Valente & Pumpuang, 2007). One simple technique to select an opinion leader in the workplace as described by Valente and Pumpuang (2007) is to observe staff interaction and determine those that appear to be opinion leaders. These people could be trained more in depth to act as role models when dealing with MH issues.

Percentage of workers participating in the program.

A question was earlier identified with respect to the need to deliver the program to a high percentage of workers in the workplace. One of the CMHA-Calgary Region interviewees stated that, in order for the program to have a big impact, it needed to be delivered to a high percentage of the people in the workplace. This raises a question as to whether this is really necessary or whether there are alternative strategies, such as using opinion leaders, to provide the necessary influence to attain the multi-pronged goal of reducing stigma to MI in the workplace.

One reason why it may be important to deliver the program to as many people as possible in the workplace could be related to the desirability of raising awareness. In the discussion about the program objectives it was concluded that improving knowledge and awareness on MH issues and resources available is a potential outcome for the "What's Up with Biff?" program. According to the theory of Diffusion of Innovation, adoption of innovation, such as a new behaviour, is a process with five stages: awareness-raising, persuasion, decision, implementation and confirmation (Rogers, 1995). Awareness of the issue is an important pre-requisite for adoption of innovation (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004). When awareness is raised, people will then be ready to potentially move to the other stages of adopting a new behaviour. The strategy of improving knowledge and awareness is also supported by Bloom's Taxonomy of Learning and by the literature reviewed on anti-stigma programs.

There is an advantage in quickly increasing the collective awareness of an issue when intervening with the intention to change behaviours. Media campaigns have been used in health promotion interventions to quickly spread knowledge in the population,

especially in the early stages of the diffusion process (Valente & Fosados, 2006). The intention is to increase awareness of as many people as possible to capture early adopters and shorten the time it takes for people to move from acquiring knowledge, to changing attitudes, and to adopting the new behaviour (Valente & Fosados, 2006). According to Rogers (1995) "adopter distributions follow a bell-shaped curve over time and approach normality" (p. 260). Categories for the timing of adoption include: innovators; early adopters; early majority; late majority; and laggards. Although innovators tend to adopt the innovation faster than early adopters, early adopters are typically people that are respected more by others and more socially integrated. They are often role models and opinion leaders. "Potential adopters look to early adopters for advice and information about the innovation" (Rogers, 1995, p. 264). Thus, when more people are made aware of an issue at the outset of an intervention, a larger number of earlier adopters are captured, and the progression toward adoption of new behaviours should occur more quickly.

Another reason to aim at increasing collective awareness is to attain more quickly the point of critical mass. Critical mass occurs at the point where enough people have adopted an innovation such that continuous snowballing occurs. Critical mass is an important factor in decreasing individual thresholds for adoption. The number of people embracing an innovation is a factor that influences other individuals to adopt the innovation (Rogers, 1995).

One might still argue that awareness-raising could be done through other strategies, such as the use opinion leaders. However, the literature on social networking indicates that the use of opinion leaders works best when there is already good awareness

of an issue (Helme et al., 2011; Valente & Fosados, 2006). When awareness is already high, opinion leaders can act as important agents of change and influence psychosocial factors of behaviour adoption, such as norms and attitudes (Kelly, 2004).

Other means, such as mass media or a program such as "What's Up with Biff?", when delivered to a high percentage of people in a workplace, can be effective at raising collective awareness. A workshop may also have an added benefit when dealing with the complex issues of MI and stigma. The workshop format has the potential of creating an opportunity for a shared experience amongst employees, thereby reinforcing their initial learnings.

To conclude this discussion, the literature supports the concept that awareness-raising is an important step in any program aimed at changing behaviours. It is important to raise awareness with as many people as possible to facilitate the conditions for the adoption of change. The "What's Up with Biff?" program has the potential to improve knowledge and awareness of MH issues and resources available in the workplace. Therefore, it is reasonable to conclude that the CMHA-Calgary Region is correct when it states that the "What's Up with Biff?" program should be delivered to as many people in the workplace as possible if it is to have a large impact.

Turning now to the long-term objective, the "What's Up with Biff?" program does not have any program components or activities that are directed at achieving the long-term objective of continued conversations around MH issues. The CMHA-Calgary Region recognizes the importance of these continued conversations in having a lasting impact in the workplace, but it recommends that the purchasing organizations take responsibility for ensuring this happens.

As a last observation, while there is no evidence that the CMHA-Calgary Region has based the development of the "What's Up with Biff?" program on solid scientific procedures, the program is consistent with the literature on anti-stigma, theories of behaviour change, Bloom's Taxonomy of Learning, and with the Ottawa Charter for Health Promotion.

Resources

In this section the resources needed to successfully deliver the "What's Up with Biff?' program by its buyers will be discussed. All of the material needed to deliver the program is included in the train-the-trainer package, and there were no negative comments about these materials by any of the purchasers. The equipment needed, such as a computer and LCD projector, seem to be common among the CMHA-Calgary Region's target market. In short, there do not appear to be any issues about the adequacy of the materials provided. Rather, the most important resource discussed was the prospective facilitator for the program; the key factor is considered to be the competency of the facilitator.

There was a lot of discussion about the prospective program facilitator in the documents, by the CMHA-Calgary Region, and by the purchasers, including a workshop participant. The CMHA-Calgary Region interviewees and the documents focused on two things; the importance of having an experienced facilitator, and the statement that the facilitator does not need to have a background in the MH field. The purchasers and the workshop participant focused more on the attributes of the facilitator.

According to the documents and the CMHA-Calgary Region interviewees, trained and experienced facilitators that do not have a background in the MH field can

successfully deliver the program if they familiarize themselves with the material provided and follow it carefully. There is mention in one of the documents that the program was successfully test-marketed by facilitators with no background in the MH field. Test-marketing is a type of marketing research used to verify the likelihood of success of a new product or service. The product/service is introduced to a small sample of the total market. Systematic collection of data about the performance of the product/service is conducted and analysed to help management make decisions about the product/service. Such a research project can be long and costly (Stone & Desmond, 2006). There is no evidence that such in-depth market analysis was done by the CMHA-Calgary Region. Therefore, the question as to whether or not the facilitator needs to have a background in the MH field is still unanswered and requires some discussion.

It is important to note, however, that the "What's Up with Biff?" program is only one hour long and the program is delivered in a highly prescriptive manner. The train-the-trainer material includes all that is needed to deliver the program, including scripts, anticipated questions and answers, and a list of references on MH issues. It is expected that the facilitator becomes familiar with the material and practices it before delivering the program. Further, the audiences in the workplaces in which the program is delivered are not composed of experts in the field. Therefore, it is reasonable to conclude that there is little need for the facilitator to possess a background in the MH field or to have specialized knowledge around MH issues. Nonetheless, in order to provide effective facilitation, the facilitator should have broad familiarity with the issue and should therefore read the background materials provided by the CMHA-Calgary Region prior to any facilitation.

The calibre of a facilitator is a key factor to the success of a program (Ooms & Wilson, 2004). To be a good facilitator one needs to possess certain characteristics, such as being respectful, trustworthy, genuine, empathetic, positive, and caring. In addition, the facilitator should have also good group management skills (Burrows, 1997; Lekalakala-Mokgele, 2006; Ooms & Wilson, 2004).

Facilitation is a complex teaching strategy. It involves moving from a traditional teacher-centered approach to a student-centered approach (Balasooriya, di Corpo, & Hawkins, 2010; Burrows, 1997). According to Burrows (1997), one of the important attributes in the process of facilitation is the practice of critical reflection. This attribute was well described by the workshop participant when she stated that a facilitator should "be able to facilitate discussion and help people reframe their comments or thoughts to positively learn new ways of viewing these situations". This attribute is especially important when dealing with sensitive issues such as MH issues.

In adult education settings, the facilitator should promote an atmosphere of partnership in learning – not the teacher as expert, but one in which the facilitator and the participants learn from each other (Knowles, Holton, & Swanson, 2005). The facilitator recognises that, as adults, workshop participants have lived experiences that can contribute to a shared learning encounter; some participants will be neutral about the topic, others will have experienced mental illness themselves, others will have experienced it vicariously through family or friends. The facilitator should be able to assess the level of understanding of participants and gauge the mood of the group about mental health issues. A practiced facilitator will be able to draw out workshop participants and help them to share and learn together. In a similar manner, the facilitator

should also create a milieu in which participants feel safe about sharing their lived experiences without shame or embarrassment. To overcome these challenges, the facilitator requires time to build participants' confidence; yet, time is short in the "What's Up with Biff?" program. Hence, the more experienced the facilitator, and the more comfortable the participants are with the facilitator, the more likely it is that workshop participants will be open to participate fully in the learning process.

The CMHA-Calgary Region does not provide training to prospective facilitators when selling the train-the-trainer package. One would expect that a trained, experienced facilitator, as recommended by the CMHA-Calgary Region, would possess most of the qualities of a facilitator of the calibre discussed above. However, in view of the concerns voiced by some of the purchasers, and the importance of the facilitator in the success of the program, the CMHA-Calgary Region could implement some strategies to ensure that the facilitation is of the quality required.

Strategies to ensure the quality of facilitation were described by Lekalakala-Mokgele (2006). One strategy would be to have the purchasing organization's facilitator supervised by the program expert from the CMHA-Calgary Region. Alternatively, the CMHA-Calgary Region expert and the prospective facilitator could co-facilitate the program at least for the first few times the organization delivers it. Another strategy would be for the CMHA-Calgary Region expert to offer telephone consultations when facilitators have any questions prior to the delivery of the workshop or when they go through post-workshop reflection. These strategies would help ensure that the facilitation would be of high quality and that the program would be delivered as intended.

Program fidelity is a term that refers to the adherence to the core blueprint/elements of a program when the program is implemented (Patton, 2008). The "What's Up with Biff?' program is short in duration and highly scripted with little room for unintentional deviation from the core information. Adoption of the above strategies with respect to facilitation would further ensure that the program would be implemented in a consistent manner. While it is important to maintain consistency in the core elements of the program, a skilled facilitator may also adapt the delivery of the program according to the particular circumstances of the workplace receiving the program. Once again, this illustrates the importance of having a skilled facilitator supported by the CMHA-Calgary Region delivering the program.

In summary, the train-the-trainer package offers all the materials that are needed for a trained and experienced facilitator to deliver the program, including references for pre-readings on MH issues. Considering that the quality and attributes of the facilitator are so important to the success of the program, it is recommended that the CMHA-Calgary Region put in place strategies to ensure that the facilitation is of the desired quality, ensuring also that program fidelity is maintained.

Logic Models

As defined in chapter two, a logic model is a diagrammatic representation of a program. It depicts and links the goal, target population, objectives, indicators, program's components and activities and resources used to deliver the program (Dwyer & Makin, 1997; Thurston et al., 2003). A logic model is a simple way of presenting what was learned through the analysis and discussion of the different parts of the program that were studied in this EA.

Two logic models were built to present and assist in understanding the "What's Up with Biff?" program. The first depicts the program according to the information obtained from the documents, interviews and observations, and as such it shows the program as it emerged from the data (Appendix E). A simplified form of this logic model was presented as a summary of the results in Chapter 3. The second logic model depicts the final recommended logic model, which would represent the program after the recommendations to improve the program's evaluability are adopted (Appendix F).

Table 9. Differences between logic models

Goal	Decrease Stigma to MI in the workplace		
Goal (recommended)	Break the silence about MH issues in the workplace		
Short-term outcome objectives	**Improve Knowledge and Awareness** • MH issues, especially depression • Resources available	**Improve Perceptions** • Understand challenge of unaddressed depression • Understand stigma and its consequences • Perceive support in the workplace	**Build Skills** • Acquire basic language and initiate dialogue • Ability to look for help • Recognition of patterns that may indicate MI • How to support others afflicted/affected by MI
Short-term outcome objectives (recommended)	**Measured pre-workshop and immediately post-workshop** Improve knowledge and awareness of: • potential misunderstanding when a co-worker is afflicted by depression • potential worsening of depression if untreated • resources available		
Resources	• Experienced facilitator • Train-the-trainer materials • Computer, printer, LCD projector, paper, binders, appropriate space		
Resources (recommended)	• Experienced facilitator (trained and supported by the CMHA-Calgary Region) • Train-the-trainer materials • Computer, printer, LCD projector, paper, binders, appropriate space		

The main differences between the logic model that emerged from the data and the recommended logic model are depicted in Table 9. The expected outcomes emerging from the data, as discussed previously in this chapter, are too ambitious for a stand-alone one-hour program. More realistic outcomes are recommended, and the objectives were restated following the SMART criteria. In view of the importance given to the quality of the program facilitators, training and support for prospective facilitators is recommended. These recommendations are further explained under the section of recommendations to improve the program's evaluability and performance.

Limitations of the Research Project

There is a limitation of this research project related to the composition of the sample. Two of the three purchasers participating in this project had past experience with the original Copernicus Project™ and the "gold standard", making it difficult to discern if their answers to the interview questions were in fact related solely to the "What's Up with Biff?" program. Even when reminded that this project was focused on the "What's Up with Biff?" program, they seemed to lapse easily into their past experiences with the "gold standard". This previous experience could explain the unrealistic goal and objectives emerging from the data obtained from the interviews. The third purchaser had not yet used the program in his/her organization, compromising his/her ability to comment on the program.

A degree of member checking was performed in this project as post-interview follow ups were conducted with interviewees to clarify their responses and to ensure understanding. However, there were no opportunities to meet jointly with all the participants to discuss and attain a consensus on the program logic model. Stakeholder

consensus around the goals and objectives is an important step in preparing a program for evaluation because it increases the likelihood that stakeholders will act on the evaluation results (Patton, 2008; Wholey, 1987). Although no conflicts were perceived in the data obtained from the interviewees, not all interviewees described all objectives presented in this project. It would have been useful to present the program logic model to all research participants for discussion and agreement. These discussions could have provided the opportunity to fine tune the program logic model and attain consensus among the research project participants (stakeholders).

Recommendations to Improve Program Evaluability and Performance

This section presents the recommendations to improve the evaluability of the "What's Up with Biff?" program, answering the primary question of this research project: what modifications to goals, objectives and activities would strengthen the evaluability and performance of the "What's up with Biff?" program?

The first recommendation is that the program's goal of decreasing stigma to MI in the workplace needs to be clearly described and presented always in conjunction with the conditions attached to the program by the CMHA-Calgary Region. The first condition is that the program should be only one part of a comprehensive multi-pronged wellness program approach to decrease stigma to MI in the workplace. The second condition is that the program should be delivered to as many people as possible in the workplace. The CMHA-Calgary Region needs to be clear about these conditions when presenting the program, so that all purchasers understand the outcomes they can realistically expect to achieve with the program, as well as the limitations of a one-hour stand-alone program.

Alternatively, it is suggested that the CMHA-Calgary Region restate the goal of the program separately from the multi-pronged program approach. Rather than stating that the goal of the program is to decrease stigma to MI in the workplace, it could restate the goal as breaking the silence around MH issues in the workplace. As such, this goal could be presented as an important contributor to achieving the larger goal of decreasing stigma to MI in the workplace.

The second recommendation is that the program's objectives need to be reviewed in light of the very short duration of the program. The objectives related to increasing participants' awareness about MH issues, and resources available, could be attainable in a focused one-hour program. Changes in perceptions and skills building, however, take time and should not be presented as objectives of the "What's Up with Biff?" program. It is recommended that the CMHA-Calgary Region adopt the "Recommended Program Logic Model" (Appendix F), which includes restated objectives that are SMART.

The third recommendation is related to the manner in which the program is delivered. The type of instructions given to the participants before they watch the videos has the potential to increase the participants' feelings of empathy towards the characters in the video. Instructions should prompt self-identification, and participants should be asked to imagine themselves in the position of Biff, and how it would feel to go through the same experience.

The fourth recommendation is related to activities the CMHA-Calgary Region could adopt to ensure program fidelity. The program is of short duration and the train-the-trainer material provides a scripted program with fixed content. Therefore, as discussed previously, the key element to ensure program fidelity is the quality of the

facilitators that deliver the “What’s Up with Biff?”program. The facilitators should be able to deliver the program in such a way as to maintain fidelity while adapting it to the particular circumstances of each workplace. Strategies should be in place to ensure that facilitation of the program is of the desired quality. One strategy would be to have the program expert from the CMHA-Calgary Region supervise and give feedback to the purchasing organization’s facilitator. Alternatively, the CMHA-Calgary Region expert and the prospective facilitator could co-facilitate the program, at least for the first few times the organization delivers it. Another strategy would be for the CMHA-Calgary Region to offer telephone consultations to facilitators prior to and after program delivery to help facilitators prepare for delivery and to assist with post-program reflection. While there would be some cost involved in adopting these strategies, they would help ensure program fidelity.

The last recommendation is that the CMHA-Calgary Region try to achieve consensus with some of their key stakeholders related to the “What’s Up with Biff?” program’s logic model. This would bring clarity to all stakeholders with respect to what the program can achieve and what its limitations are.

Once all the recommendations to improve the program’s evaluability are implemented, the program will be ready for an evaluation. There is a high degree of congruence between the program’s goal, objectives and activities in the recommended logic model. If this logic model were adopted, the program would be coherent and does not require any major restructuring.

Recommendation for Program Evaluation

The secondary question of this research project is: what type of evaluation is most appropriate at this point in time for the "What's up with Biff?" program? This section presents the type of evaluation recommended and the reason for the recommendation.

The nature of the issues identified in the EA provides a good indication of the type of evaluation that should be conducted. Issues identified with the program in this EA revolved around the following: the achievability of the program outcomes; the appropriateness of the target population (characteristics of the employees in the workplace setting); the fidelity of the program; the quality of the facilitation; and the importance of the context given the history of the development of the program and the compromises made by the CMHA-Calgary Region. Given that both outcome and process issues were identified, it is recommended that an evaluation of the "What's Up with Biff?" program includes both process evaluation and outcome evaluation.

An evaluation using a CIPP (Context, Input, Process and Product) approach is recommended. The CIPP model is a comprehensive evaluation model devised by Guba and further developed by Stufflebeam (Tan, Lee & Hall, 2010). It is composed of four core components: context evaluation, input evaluation, process evaluation and product evaluation. In the components of the evaluation, the following questions are asked respectively: "What needs to be done? How should it be done? Is it being done? Is it succeeding?" (Stufflebeam, 2007, p. 1). The CIPP approach provides flexibility, and the components to be focussed on can be selected according to the needs of the evaluation.

There are two main reasons for recommending the CIPP evaluation model. First, the stakeholders have an interactive role in this evaluation process. When stakeholders are involved throughout the evaluation, they are more likely to accept and implement the evaluation results (Stufflebeam, 2007). The involvement of the stakeholders is particularly important for the "What's Up with Biff?" program because there was no opportunity to obtain consensus and agreement on the proposed program logic model. The evaluation process could start by acquiring stakeholder consensus on the program logic model, thereby providing continuity to the EA. Second, the CIPP evaluation model is holistic. It takes into consideration the dynamic social context surrounding a program, which is important when dealing with complex social issues such as stigma and MH issues. The holistic approach embodied in the CIPP model provides the tools to assess program implementation, available resources, and expected outcomes (Stufflebeam, 2007).

In view of the desirability for the stakeholders to agree on the recommended logic model, the interactive role of the program's key stakeholders in the CIPP model, and its holistic approach, the CIPP model is an appropriate evaluation framework for the "What's Up with Biff?" program. The CIPP model would provide for a smooth transition from the EA to an evaluation of the "What's Up with Biff?" program.

Recommendations for Future Research

Future research involving the CMHA-Calgary Region should include the "Copernican Shifts" program and the "gold standard". An EA for each of these programs could prepare them for further evaluation. The program logic models for each program could be compared to further clarify the similarities and differences among them. Results

of program evaluation would shed light on the effectiveness of each of the programs under the Copernicus Project™ umbrella, and on the contributions of each in meeting the desired overarching goal to reduce stigma to MI in the workplace.

Significance

The "What's Up with Biff?" program is a health promotion program that aims to create a healthy workplace environment by contributing to decrease stigma to MI in the workplace, a serious and costly problem for Canadians. There are very few programs aiming at decreasing stigma to MI in the workplace (Stuart, 2004), and hence the "What's Up with Biff?" program is filling a critical gap. As such, it has the potential to have a positive impact on the lives of many people in the Calgary workplace.

The program, however, has not been formally evaluated and evaluation research is an essential part of best practices for health intervention programs. Evaluation research points out the strength and weaknesses of an intervention, and addresses important aspects about its effectiveness, such as whether the intervention causes harm (Hawe & Potvin, 2009).

EA is often a necessary preliminary step to an evaluation and helps ensure that the program is ready for a meaningful evaluation. It helps determine if the program outcomes are plausible and measurable, and it helps identify opportunities to change the program and improve its performance (Thurston et al., 2003; Wholey, 1987).

This research project has prepared the "What's Up with Biff?" program for an evaluation which has practical application for the CMHA-Calgary Region. In performing an EA, this project has contributed to the body of knowledge within the discipline of MH promotion and evaluation.

The EA conducted in this research project has clarified the target population, goals, objectives, activities and resources needed to deliver the "What's Up with Biff" program. This EA has uncovered inconsistencies between the activities of the program and the realistic outcomes it can achieve, leading to a number of recommendations to improve the performance of the program, to clarify the expectations for all stakeholders, and to maintain the program's fidelity. Once these recommendations are adopted, the program will be ready for evaluation.

The "What's Up with Biff?" program has the potential to increase awareness of MH issues and resources available in the workplace. A formal evaluation will help ensure that this program reaches its potential.

The CMHA-Calgary Region has an opportunity to be a leader in combating stigma to MI in all levels of our society. By developing the "What's Up with Biff?" program as part of the Copernicus Project™, the CMHA-Calgary Region has not only responded to a demand from the work sector in Calgary, but to a greater need for anti-stigma health promotion in our society.

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Appendix A: Invitation Letter

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Dear Sir or Madam,

I am writing to invite you to participate in a research project by a Master of Science student at the University of Calgary, Faculty of Medicine. Your name and contact information was given to us, with your permission, by the Canadian Mental Health Association – Calgary Region (CMHA-Calgary Region).

Part of a national research agenda on mental health in the workplace is to create business/research alliances to defeat stigma to mental illness in the workplace. The "What's up with Biff?" program, purchased and used by your organization, has as its goal to decrease stigma to mental illness in the workplace. We propose to evaluate this program.

This research project aims at clarifying and helping us better understand the "What's up with Biff?" program from **your** point of view. Your participation would influence any adjustment or modifications that may be made to the program by the CMHA-Calgary Region. This would ensure that this program would better meet your needs and those of organizations like yours. This is your chance to give us feedback

Attached is an information sheet and consent form with a brief description of this project, potential risks and benefits to you for participating in it, and what would be expected from you.

We will follow this letter of invitation with a phone call to answer any questions you may have and to elicit your participation in the evaluation.

Thank you so much.

Sincerely,

Dr. Ardene Robinson Vollman
Adjunct Associate Professor
Community Health Sciences
University of Calgary
Telephone: 403-
e-mail:

Elisabeth Cardoso Pereira
M.Sc. Student
Community Health Sciences
University of Calgary
Telephone: 403-
e-mail: ecardoso@ucalgary.ca

Appendix B: Interview Guide

Before starting the interview:

- ☐ Review risks and benefits.
- ☐ Remind participant of her/his right to refuse to answer any question and to withdraw at any time.
- ☐ Make sure consent form is signed.

Tips:

- ✓ Use open-ended questions.
- ✓ Ask for description, elaboration and clarification of topics discussed.

Possible Questions:

1. **Program Activities:**
    a. What kind of activities happens in the "What is up with Biff?" program?
    b. Could you describe them?
    c. Who is eligible to participate in this program?
    d. Who normally attends the program?
    e. Is it a compulsory program in your organization?
    f. How does one enrol in the program?
    g. How long do people spend in the program?
    h. Can people attend it more than once
2. **Program Goals:**
    a. What is the ultimate change that you expect to achieve with this program?
    b. What is the ultimate change you think one can achieve with this program as it is?
3. **Program Outcomes and Indicators:**
    a. What does success look like for this program?
    b. If you are successful, how would the participants in the program be different from they were before?
    c. In your opinion what would show you that the program was successful?
    d. What kind of changes would tell you that the program was successful?
    e. What kind of changes would you like to see in the participants?

f. How would people benefit from this program?

g. How would the organization benefit from this program?

4. If the interviewee is a participant:

a. What did you expect from this program?

b. Did you benefit from this program? In what way?

c. How could you have benefited from this program?

d. What changes in the program could help you benefit more from it?

e. What kinds of activities did you do in this program?

f. Could you describe the program's activities?

g. Could you give me your impressions about these activities?

h. What is your overall opinion about the program?

Adjourn the interview: THANK THE PARTICIPANT.

Explain what will happen next.

Appendix C: Observation Guide

Participant code:

Date: **Starting Time** **Ending Time**

Location of presentation:

People Present:

Description of Environment (including personal belongings, set up, and how it is used)

People:

Dress

Nonverbal behaviour (e.g., tone of voice, posture, facial expressions, eye movements, forcefulness of speech, body movements and hand gestures)

Interactions (who talks to whom, tension points)

Presentation:

1st Part:

Duration

Description

Content of presentation (e.g. use of key words, topics, focus, exact words or phrases that stand out)

Participants' reactions

Researcher's impressions (e.g. discomfort of participant with certain topics, emotional responses to people, events, or objects)

2nd Part:

Duration

Description

Content of presentation (e.g. use of key words, topics, focus, exact words or phrases that stand out)

Participants' reactions

Researcher's impressions (e.g. discomfort of participant with certain topics, emotional responses to people, events, or objects)

3rd Part:

Duration

Description

Content of presentation (e.g. use of key words, topics, focus, exact words or phrases that stand out)

Participants' reactions

Researcher's impressions (e.g. discomfort of participant with certain topics, emotional responses to people, events, or objects)

4th Part:

Duration

Description

Content of presentation (e.g. use of key words, topics, focus, exact words or phrases that stand out)

Participants' reactions

Researcher's impressions (e.g. discomfort of participant with certain topics, emotional responses to people, events, or objects)

Researcher's auto analysis

Analysis (e.g. researcher's questions, tentative hunches, trends in data, and emerging patterns)

(Adapted from course notes: Nursing 683, Fall 2009 by Dr S. Raffin Bouchal)

Appendix D: Project Description and Consent Form

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Title: Evaluation of a program to combat stigma to mental illness in the workplace.
Sponsor: Community Health Sciences Department
Investigators: Dr. Ardene Robinson Vollman and Elisabeth Cardoso Pereira

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Twenty percent of Canadians are at risk of developing some kind of mental illness (MI) at some point in their lives (Public Agency of Canada, 2002). Unfortunately, people affected by MI are often stigmatized and treated with discrimination. Stigma and discrimination, or even fear of stigma and discrimination, can profoundly affect people and add another layer of suffering to their lives. People suffering from MI often feel stigma and discrimination at work (Stuart, 2004). The workplace, where most adults spend many hours of their lives, is an ideal place to promote health and combat stigma and discrimination to MI.

The Canadian Mental Health Association - Calgary Region (CMHA-Calgary Region), has developed a program to combat stigma to MI in the workplace called "What's up with Biff?". This program has been used in Calgary by various workplaces. We feel that it is time for this program to be evaluated. This evaluation research can help the CMHA-Calgary Region determine if there is anything they can do to improve this program and add value to such a worthwhile cause, that of combating stigma to MI in the workplace.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to perform an evaluation research on the program "What's up with Biff?". We want to clarify and increase the understanding of this program from the point of view of various stakeholders, such as the people that developed the program, the people responsible for the program, the people that buy and use the program, and the people that participate in the program. We will check for gaps, contradictions and how well we expect that the program will attain its objectives. In so doing, we may discover ways that the performance of this program can be improved. It will allow us to improve our knowledge on how to combat stigma and discrimination to MI in the workplace. Finally, this study will fulfill one of the requirements for a master's degree.

WHAT WOULD I HAVE TO DO?

You will be asked to:

- ✓ participate in an interview of up to one hour
- ✓ allow us to tape the interview

- ✓ if necessary, we will ask you for a follow up interview of up to 30 minutes
- ✓ sign this consent form before participating

We will aim to have the interview(s) carried out at your workplace during your working hours. If your manager does not approve of this arrangement, we will do our best to accommodate another time and place of your choice.

WHAT ARE THE RISKS?

There are no risks to participating in this research project. However, talking about a program designed to decrease stigma to mental illness could evoke strong emotion in some people.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you. If you want your opinion about the "What's up with Biff?" program to be heard, this is your chance. We will listen. The information we get from this study may help researchers better understand, design and evaluate programs to combat stigma to MI in the workplace in the future.

DO I HAVE TO PARTICIPATE?

Your participation is completely voluntary. If you decline to participate there will be no consequences to you. If you decide to participate in this study, you are welcome to decline to answer any questions. You can withdraw from this study at any time with no penalty.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid for participating in this study. There should be no expenses to you. In the event that you are not allowed by your manager to use working time for the interview, alternative options will be explored with no expenses to you.

WILL MY RECORDS BE KEPT PRIVATE?

Absolutely! Only the researcher and her supervisory committee will have access to your data. Your interview will be transcribed without your name or anything else that might identify you as the interviewee.

Participants' privacy will be ensured by assigning a code to each participant. This code will be stored in a secure location separated from all other information about the participants. All recording of interviews will be downloaded to a password-protected laptop and kept in a password-protected file for the duration of this project. Any names will be obscured on written transcripts. As per the "Integrity in Scholarly Activity Policy" of the Faculty of Medicine of the University of Calgary, all records from this project will be archived in a CD-ROM and stored in a secure location for seven years, after which they will be destroyed.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the Community Health Sciences department, the University of Calgary, the Alberta Health Services or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

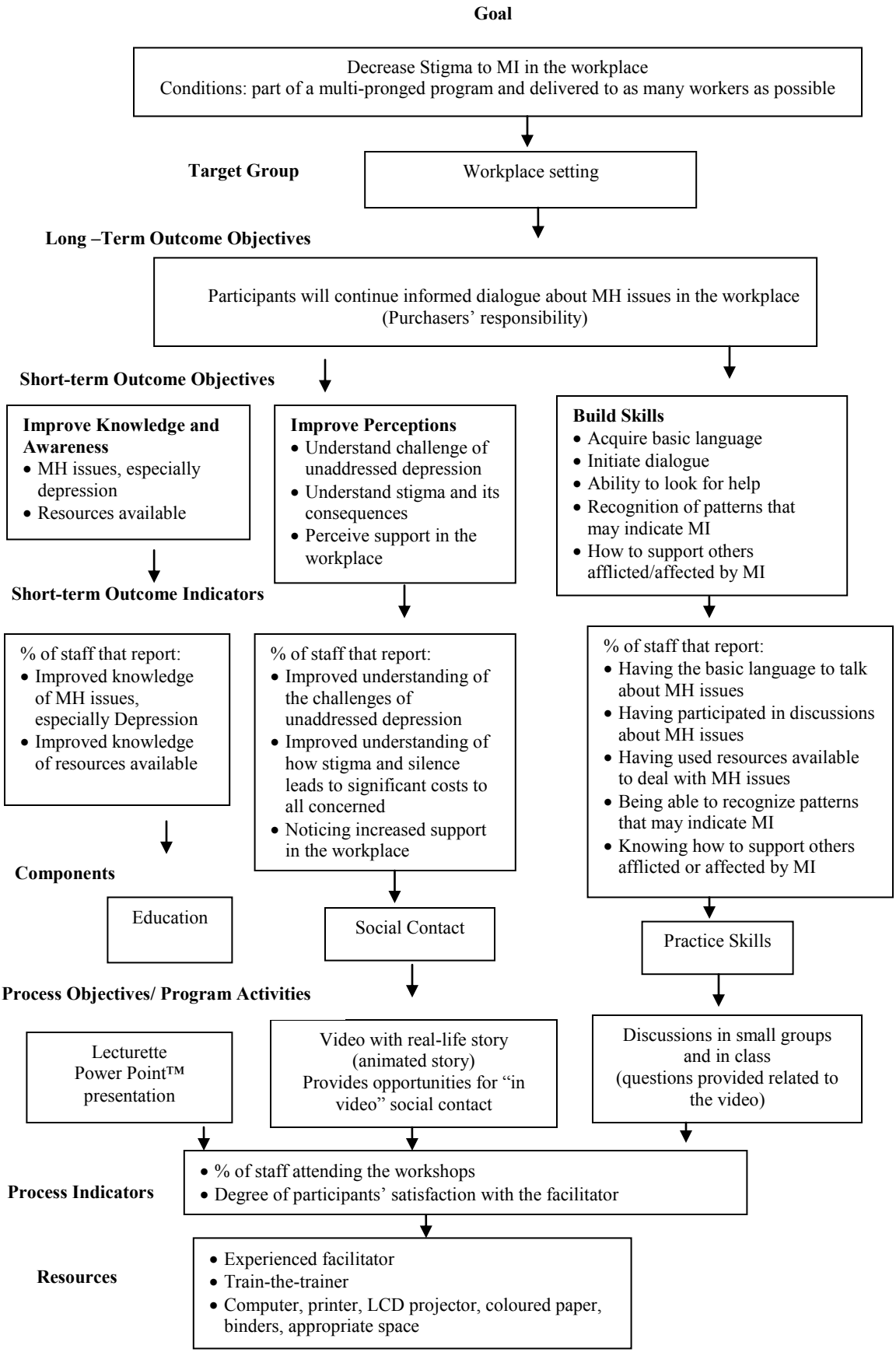
Dr. Ardene Robinson Vollman
(403)

If you have any questions concerning your rights as a possible participant in this research, please contact The Director of the Office of Medical Bioethics, 403-220-7990.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.
A signed copy of this consent form has been given to you to keep for your records and reference.

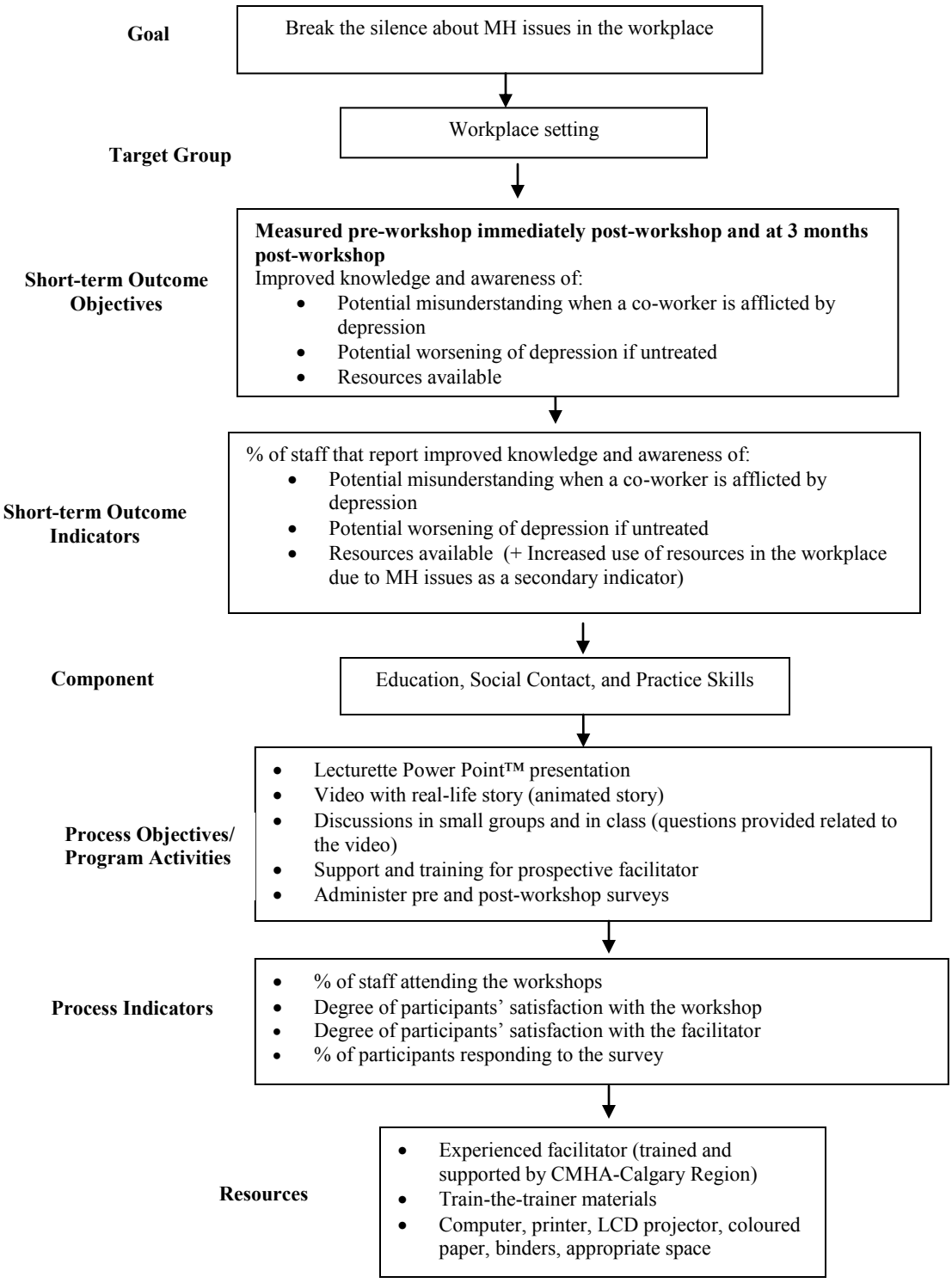
Appendix E: Stakeholders' Perspective Logic Model



Based on model by Dwyer & Makin, 1997

Appendix F: Recommended Logic Model

"What's Up with Biff?" Program



Based on model by Dwyer & Makin, 1997