STRENGTH IN UNITY

Men Speaking Out Against Stigma

Toronto Site Community Research Report

October 2019

Strength In Unity
Men Speaking Out Against Stigma
Mental Health Promotion in Asian Communities

FUNDED BY MOVEMBER® FOUNDATION

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- Bangladeshi-Canadian Community Services;
- Council of Agencies Serving South Asians;
- Woodgreen Community Centre
- Hong Fook Mental Health Association;
- Ontario Chinese Senior Association;
- Peel Multicultural Council;
- Punjabi Community Health Services;
- Social Service Network;
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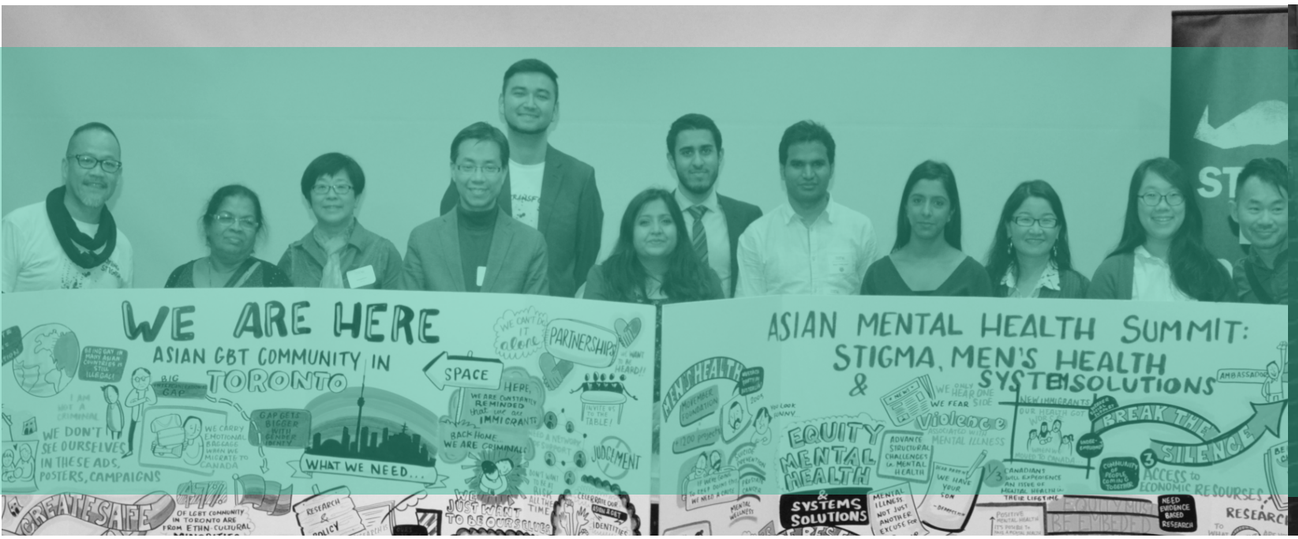


Strength in Unity Toronto Summit

01. **TERMINOLOGY**

The Strength in Unity study explores issues of mental health and wellbeing that can carry deep meaning for people depending on their personal experiences and/or context. The term mental health itself, can mean different things to different people.

To clarify how these terms are being used in this report some commonly used terms are defined below. Any additional terms are defined throughout the report as necessary.

Mental Health:

Mental health typically refers to a person's emotional, mental and social well-being. The World Health Organization defines it as a "state of well-being in which every individual realizes their 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." This understanding of health is driven by a more positive understanding of health that focuses on a holistic sense of well-being and not only on the absence of illness.

World Health Organization. (2014). Mental health: A state of well-being. Retrieved from http://www.who.int/features/factfiles/mental_health/en/

Mental Illness:

Similar to physical illness, mental illness can take many forms; conditions can include anxiety, depression, bipolar disorder or addiction.

Men:

We use this term to refer to all male-identified persons on the gender spectrum.

Asian Men:

For the purposes of this study Asian men refer to first or second-generation men living in Canada with origins in East, South and Southeast Asian countries.

Community Empowerment:

Community empowerment refers to the process of enabling communities to increase control over their lives. Community stakeholders work toward shared goals to increase collective self-determination and improve quality of community life. The term 'communities' also refers to people who may be bounded together not only by geography but also by common identities or interests.

Capacity Building:

Capacity building refers to actions that are aimed at developing available human and social resources to solve collective problems and improve individual or community well-being through informal social processes and organized effort.

Stigma, and Mental Illness Stigma:

Stigma refers to fear and misunderstanding about mental illness and can lead to prejudice and discrimination for those living with or affected by various mental illnesses. Social stigma attached to mental illness can deter people from seeking help and treatment. It can also negatively affect someone's access to employment, social support or safe housing and often compounds the effects of mental illness alone.

02. EXECUTIVE SUMMARY

Strength In Unity (STRENGTH IU) is the first comprehensive Community-Based Action Research study in Canada that mobilizes Asian Canadian men to explore mental health and, mental illness stigma and promote mental wellbeing.

Why study mental health among Asian men:

One in five people in Canada experience mental health challenges in their lifetime and yet, many do not seek support due to fear of stigma and discrimination. Mental health stresses for racial minority groups, immigrants and refugees are further compounded by systemic barriers to adequate income, employment, and housing; and the lack of culturally inclusive health services. While much research exists on mental health, available evidence addressing the stigma of mental illness is limited because of small samples, lack of diversity in study participants and exclusion of people living with mental illness. Funded by the Movember Foundation, the STRENGTH IU study focuses on mental health and stigma of mental illness among men in Asian communities, a vastly diverse group that makes up 15% of the Canadian population.

What the study aimed to achieve:

Using a health promotion framework grounded in principles of community empowerment and capacity building, the study engaged East, South and Southeast Asian men and community leaders living in Toronto, Calgary and Vancouver with the following objectives:

01

Raise awareness of the social determinants of mental health, misconceptions of mental illness, and knowledge of community mental health resources

02

Build capacity among Asian men to identify their mental health needs, address mental illness stigma, and advocate for effective and inclusive mental health care for Asian men and their communities.

Who was involved in the study?

Strength-in-Unity is a national project set in Calgary, Toronto and Vancouver. The project team is made up of academic researchers, mental health professionals, and community partners. *(For a full list of the research team please see 'Acknowledgements')*

How the study was designed:

The study was designed to apply two (2) training interventions to address mental health stigma and mobilize Asian men to engage in anti-stigma efforts as Mental Health Ambassadors in their communities.

(a) Acceptance and Commitment Training (ACT): an evidence-based behavioural therapy that promotes psychological flexibility through experiential learning activities of acceptance, mindfulness, value clarification, and committed action.

(b) Contact-based Empowerment Education (CEE): a community-based empowerment education that focuses on skills development and increased understanding of mental illness through the opportunity to interact with individuals living with or affected by mental illness.

Data was gathered prior to, and following the interventions using both quantitative and qualitative methods. Asian men aged 17 to 65+ were randomized into four groups: an active control group with one educational session on mental health and mental illness; an ACT only group; a CEE only group; and, a group that applied a combination of both ACT+CEE. Outcome data was collected through surveys, focus groups and activity logs pre and post intervention with follow-ups at the three and six month marks.

In Toronto, 1000 Asian men were engaged through recruitment and outreach efforts and 609 men took part in the intervention training and became Mental Health Ambassadors. *For a further breakdown of participants by age, sexuality, or ethno-cultural background please see the section on Design and Methodology.*

What was learned?

(1) Asian men's experiences and perception of mental health & illness:

- Asian men's mental health is influenced by a myriad of individual and structural factors from gender norms and intergenerational differences to migration, racism and employment.
- Asian men's understanding of and responses to mental illness stigma are complicated by their social identities, minority status and cultural perceptions.
- Barriers to addressing mental illness stigma include invisibility of role models and leaders, misconceptions about mental illness, silencing of the issues and shame, dominant discourses of danger, and perceived insufficient knowledge to speak out.

(2) Data on the effects of the interventions was collected through pre and post survey comparisons and the following changes were identified:

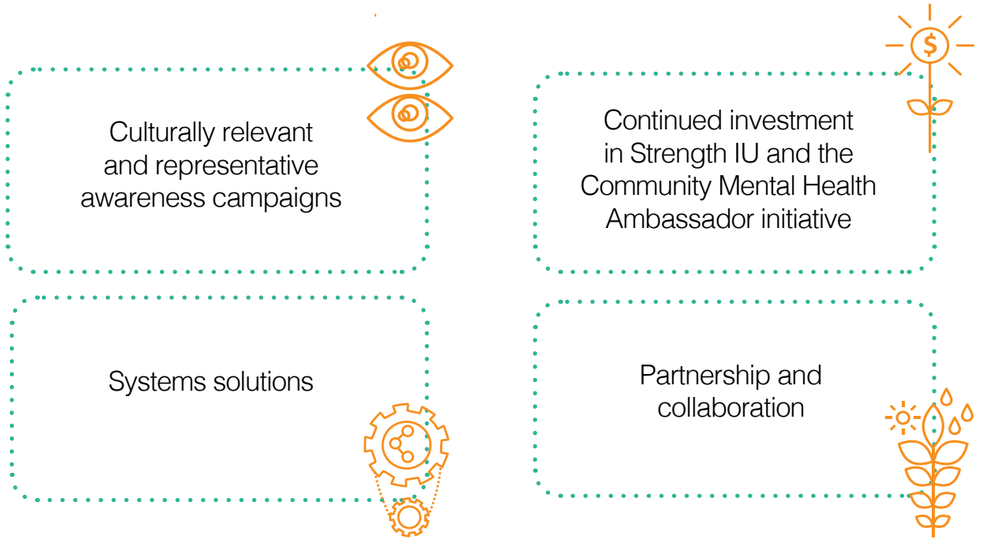
- Psychological changes: The ACT and ACT/CEE combination groups increased psychological flexibility; all intervention groups increased consistency between their actions and values; and, all demonstrated increased mindfulness.
- Stigmatizing Attitudes: All the intervention groups decreased mental illness stigma in the Authoritarianism Subscale. The CEE group also reduced stigma in all other subscales including Benevolence, Social Restrictiveness, and Community Ideology. The Control and Combination groups showed reduction in Social Restrictiveness.
- Internalized Stigma: The Combination group significantly decreased internalized stigma in two subscales: decreased sense of Alienation and increased Stigma Resistance.
- Attitudes to Social Changes: The CEE and Combination groups increased Perceived Behavioural Control, i.e. increased confidence that they can have a positive impact on social change. Both ACT and CEE groups increased Behavioural Intention, i.e. increased intention to work on social changes.

(3) The effects of the interventions were also assessed qualitatively through post-intervention focus groups and activity logs. Following the interventions, participants demonstrated the following gains:

- Awareness of how stigma is perpetuated in one's own social networks
- Commitment and ability to engage in self-care, especially among Mental Health Ambassadors (MHAs) living with or affected by mental illness
- Motivation to learn more about mental health and mental illness
- Confidence to speak out against stigma in different situations
- Efforts to initiate awareness and address stigma
- Commitment to community involvement demonstrated by joining community groups and expanding social networks
- Willingness to engage family, friends, peers and others in conversations about mental health mental illness, and stigma

What are the recommendations for future work?

Data gathered from participant focus groups, Mental Health Ambassador activity logs, and the Asian Men's Mental Health Summit collectively informed the development of recommendations. Key suggestions included:



Overall, Asian men involved in the study believed that effective stigma interventions for racialized and immigrant men in Canada must consider the intersecting effects of social determinants such as racialization, ethnicity, gender, age, socioeconomic status, education, and the length of time living in Canada.

03. **BACKGROUND**

Why mental health and Asian men?

Mental illness is an important, multifaceted health concern in communities worldwide. According to the Canadian Mental Health Association (CMHA), *"mental illness indirectly affects all Canadians at some time through a family member, friend or colleague and in any given year, 1 in 5 people in Canada will personally experience a mental health problem or illness"*

In Canada, there are significant efforts made to recognize and support the mental health and mental illness needs of communities through research, education, and service initiatives. However, a review of the existing research demonstrates a lack of diversity among study participants, the exclusion of people living with mental illness, and a lack of evidence on interventions addressing the stigma of mental illness.

The stigma of mental illness can be felt at the individual, community, and systemic levels and can result in delays in seeking help, underutilization of mental health services, or poor adherence to treatment. To date, no published studies have evaluated anti-stigma interventions for Asian men in Canada.

Immigrants from East, South and Southeast Asian countries represent approximately 15% of the total Canadian population. The mental health of this growing population is affected by limited access to income, employment, and health and social resources, and the pressure to meet social expectations. Given systemic barriers, racism, xenophobia, social stigma, and gendered expectations that Asian men should be strong, successful, and self-sufficient, they can experience heightened effects of stigma that deter them from seeking mental health services.

The Strength IU study aims to bridge the gaps in the available research evidence of anti-stigma interventions among Asian men. In this study, Asian men includes all male-identified persons from East, South, and Southeast Asian countries. Strength IU combines psychotherapeutic, collective empowerment, and critical health promotion approaches to meaningfully engage Asian men to advocate for change and strategize anti-stigma efforts.

04. **DESIGN & METHODOLOGY**

Strength in Unity is guided by a population health promotion framework and grounded in principles of social justice. Underpinned by concepts of community empowerment and capacity building, the focus is on increasing collective self-determination and improving community well-being through social processes and organized effort.

As a community-based action research study, Strength IU includes people Living With and/or Affected by mental illness (LWA) and Community Leaders (CL). The LWA group included people with lived experience of mental illness or family members of people with mental illness. The CL group included people who were interested in health promotion or advocacy in Asian communities. The study uses an experimental design with repeated measures and mixed methods for data collection. Eligible consenting participants were randomly assigned to two training interventions to address mental health stigma and mobilize Asian men in anti-stigma efforts:

Acceptance and Commitment Training (ACT):

an evidence-based behavioural therapy that promotes psychological flexibility through experiential learning activities of acceptance, mindfulness, value clarification, and committed action.

Contact-based Empowerment Education (CEE):

a community-based empowerment education that focuses on skills development and increased understanding of mental illness through interactions with individuals living with or affected by mental illness.

Asian men aged 17 to 65+ were randomized into four groups: an active control group with one educational session on mental health and mental illness; an ACT only group; a CEE only group; and, a group that applied a combination of both ACT+CEE. Outcome data was collected through surveys, focus groups, and activity logs pre and post intervention with follow-ups at the three and six month marks. One thousand Asian men were engaged through recruitment and outreach efforts and 609 men completed the intervention training and became Mental Health Ambassadors.

Research ethics approval for this study was received from Ryerson University, University of Toronto, University of Calgary, Simon Fraser University, University of British Columbia, Vancouver Coastal Health and Saint Mary's University.

4a. **PARTICIPANTS**

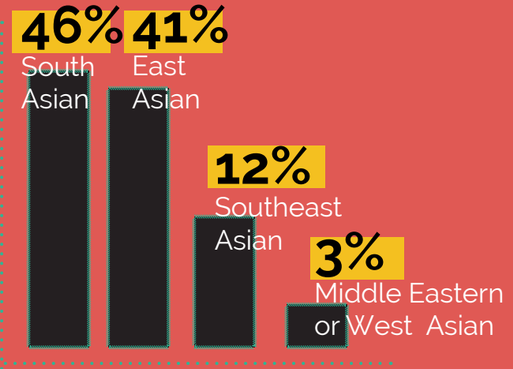
609 Asian men

86.5%
born outside Canada

69%
were Canadian citizens

26%
were landed immigrants

17-84
years young representing diverse sexualities and enthnocultural backgrounds



1 in **4**
participants self-identified as living with a mental illness

35%
have family members living with mental illness

Participants continued...

37%
completed post secondary **education**

35%
completed graduate school

22%
completed high school

4.6%
completed less than high school

71%
Despite relatively high levels of education the majority of participants also experienced high levels of **unemployment**

50%
married

6%
divorced or separated

37%
single

50%
had no **children**

50%
had **children**

Table 01: Participant Demographics

	Community leader (CL) (n = 394)	Community leader (CL) (%)	Living with or affected by mental illness (LWA) (n = 215)	Living with or affected by mental illness (LWA) (%)
Age				
Young Adults (< 25)	106	26.9	33	15.3
Adults (26 – 54)	158	40.1	87	40.5
Para-Retirement/ Transitional (55-65)	53	13.5	29	13.5
Older Adults (>65)	75	19.0	63	29.3
Missing / NA	2	0.5	3	1.4
Ethnicity				
East-Asians	157	39.8	97	45.1
South-East-Asians	39	9.9	18	8.4
South Asians	187	47.5	96	44.7
Other	11	2.8	1	0.5
Missing / NA	0	0	3	1.4
Marital Status				
Single	162	41.1	67	31.2
Married	191	48.5	115	53.5
Common Law	7	1.8	5	2.3
Divorced	13	3.3	8	3.7
Separated	9	2.3	7	3.3
Widowed	1	0.3	9	4.2
Other	11	2.8	2	0.9
Missing / NA	0	0	2	0.9
Number of Children				
None/NA	220	55.8	89	41.4
One	45	11.4	35	16.3
Two	78	19.8	52	24.2
Three+	53	13.0	39	18.1
Citizenship Status				
Canadian Citizen	258	65.5	163	75.8
Landed Immigrant/ Permanent Resident	115	29.2	43	20.0
Other	17	4.3	6	2.8
Missing / NA	4	1.0	3	1.4

	Community leader (CL) (n = 394)	Community leader (CL) (%)	Living with or affected by mental illness (LWA) (n = 215)	Living with or affected by mental illness (LWA) (%)
Education				
Less than High School	17	4.3	11	5.1
High School	94	23.9	44	20.5
Post-Secondary	144	36.5	82	38.1
Graduate	138	35.0	76	35.3
Missing / NA	1	0.3	2	0.9
Employment				
Employed	110	27.9	60	27.9
Non-Employed	284	72.1	154	71.6
Missing / NA	0	0	1	0.5
Living with Mental Illness				
N/A / No Answer	3	0.8	5	2.3
Yes	58	14.7	76	35.3
No	265	67.3	102	47.4
Do Not Know	55	14.0	23	10.7
Do Not Wish to Say	13	3.3	9	4.2
Family Members with Mental Illness				
0	341	86.5	135	62.8
1	43	11.0	69	32.0
2	8	2.0	9	4.2
3	2	0.5	1	0.5
N/A / No Answer	0	0.0	1	0.5

05. RESULTS & ANALYSIS

The quantitative and qualitative data yield considerable information on how mental health, mental illness, and stigma intersect with socio-cultural determinants of health. Data on the impact of the interventions on mobilizing anti-stigma work are particularly useful for current and future programming in Asian communities.

The key themes and learnings that emerged from the results are grouped into three sections:

01 Pre-Intervention Perceptions and Stories:

This section summarizes the findings that focus on Asian men's experiences and perceptions of mental health, mental illness, and stigma. Narratives shared here include the effects of socio-cultural factors on mental health and illness, experiences of stigma, help-seeking behaviour, and community engagement.

02 Post-Intervention Survey Results:

The quantitative results of the intervention surveys are presented here to examine the impact of Acceptance and Commitment Training (ACT) and Community Empowerment Education (CEE) interventions using validated scales that measure psychological flexibility, stigmatizing attitudes, and more.

03 Post-Intervention Perspectives and Stories:

The effects of the interventions were also measured qualitatively through post-intervention focus groups and activity logs. This section summarizes the changes that participants experienced in their lives following the interventions especially as they engaged with their communities and/or families in anti-stigma initiatives.

01. Pre-Intervention Perceptions and Stories

Beliefs, Misconceptions and Stigma related to Mental Health and Mental Illness:

- While some participants shared their understanding that mental illness occurred as a result of genetic susceptibility, biological causes, socio-economic stresses or trauma, misconceptions about mental illness were also vocalized, such as the assertion that mental illness is a result of religious causes or queer identity.
- Many identified the media as a source of their misconceptions of mental illness, where violent cases of mental illness are often sensationalized and featured on the news. This fuels stigma as community members distance themselves from people living with mental illness out of fear and lack of understanding.
- Stigma and prejudice regarding the functional capabilities of individuals living with mental illness still exist (for example, that they are unable to care for themselves; or that they are burdensome). These misconceptions create barriers for individuals as they attempt to participate in systems or engage in community spaces.
- The impact of stigma often manifested as a deep sense of shame and hopelessness, and in some cases, led to suicidal thoughts. People living with mental illness often experienced harassment and isolation. Friends and family members of people living with mental illness were also identified as having to deal with associated stigma.

"The general public know very little about mental illness. So generally when they hear about mental illness, they will immediately think of those horrible scenes from movie"

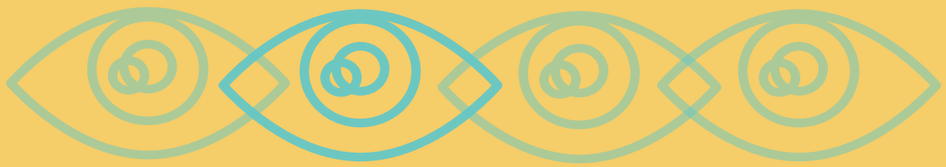
"If you have someone that has mental illness in the family, it is a shameful thing. So, they won't seek help and they also dare not talk about it with others."

"A lot of times, there is shame or there is judgment associated with mental illness and for me, mental illness stigma, that is what it is to me you know like the shame and almost like the guilt of having it which is an added barrier on top of like the other symptoms like being tired and unable to focus."

"There is this stigma that people with mental illness do not contribute to society."

"The community is uneducated about [mental illness]. They don't understand it, so they're afraid of what they don't understand."

"They're put down most of the time because no one wants to hang around with them, maybe cause they think differently, they are in a different world, they have different thinking. I think that is why most people treat them in a negative way because they don't want to be seen with them, they don't want to because they're not like them, they're different."



Visibility and Denial Surrounding Mental Illness:

- Participants stated that unlike physical illness, mental illness is “invisible” and therefore seldom recognized or accepted as a ‘real’ illness in their community. Some categorized mental illness as either violent or non-violent, with violent illness as more severe.

- Participants indicated that many in their communities see mental illness as a “phase that will pass and happens to everyone” while others considered it to be an incurable illness.

- Mental illness stigma was said to be exacerbated by cultural and social norms of non-disclosure and silence, which in turn, leads to denial of mental illness, by the community. Men discussed the notion of how individuals are not supposed to “air out their dirty laundry”

“Let’s say you broke your leg, a lot people would sympathize and offer their help… But if you have a mental illness, they might not treat it the same way and they might say just get over it… Nobody tells you to get over a broken leg, right?”

“One of the things I’ve seen is that because [mental illness] is so silent and so hidden, for those who are affected by mental illness… they think whatever they have, the conditions they have, that is what they feel is normal and therefore, they don’t talk about it, they don’t express it, they don’t seek help”

“because of their traditional cultural influence… first, they [Asian men] will not talk about it, they will not say that they have a mental illness. Also, they will not seek help because this is harmful to their self-dignity”

Sociocultural Factors Affecting Mental Health, Illness and Stigma:

- Migration and settlement was said to create a sense of “cultural confusion” for many. This was described as a feeling of conflict between following traditional values and adapting to change as well as social isolation due to language barriers. Additionally, participants spoke about the burden of carrying past trauma, and the difficulty of unpacking these experiences and moving forward.

- Finding employment and work stress was identified as a significant stressor negatively impacting mental health among participants. Many had difficulty finding work that was similar to their previous occupations in their home country. South Asian youths specifically noted the “family pressure” to excel in school and work.

- Intergenerational differences were identified as a potential source of conflicting ideas about mental health and illness. Older adults were considered conservative in their beliefs, values, and expression while young adults raised in Canada consider themselves more open and understanding of the issues related to mental health.

- Family was considered a source of both stress and support. Stress was felt when high expectations were coupled with low emotional support, especially for youths. However, support was also offered through strong one-on-one connections.

- Participants felt that religion fosters a sense of community and that the values taught through religious practice such as compassion; can encourage understanding and acceptance of people living with mental illness.

- In some South Asian communities, mental illness is perceived as a factor that would hinder a person’s prospects of marriage.

“The fact we are speaking about our experiences with the lack of access and services is an injustice which is part of health inequalities that we experience as an immigrant especially for those that are not born in and who are coming here totally new in this country”

“Within the Chinese circle, quite frankly, we have sympathy, pity but those that actually put it into practice, there are not many. OR I think there is sympathy, but there is no acceptance”

“A lot of stress comes from expectations from parents and they want you to be a successful person and you’re always thinking about am I going to let them down. I have to make them proud of me even though I’m sure they’re proud of me but you know that stress comes from thinking”

“I think there is an economic impact on this issue because the mentally ill people do not get jobs or so.. the difference is that they economically suffer…you can see them homeless”

“There’s this one church group that I started to attend and what I observe from them is that they are very understanding. You can tell them issues whether it be mental health or whatever, they just accept you and they understand”

The Influence of Gender:

- The notion of dignified patriarchy was a common theme among focus group participants. Men revealed that they felt inclined to hide any signs of weakness and keep their struggles to themselves, though they face great stress in their role as 'head of the family.' In general, participants felt that it is more acceptable for women to express emotions openly and that women were more likely to seek help for mental illness.

- While men and women in traditional roles are exposed to different sources of stress, participants agree that all genders are susceptible to mental illness.

- Sexism among some participants was present, as some expressed that they were raised to believe in traditional gender roles where men are breadwinners and women, homemakers. Many felt that women were met with sympathy when experiencing mental illness whereas men were more likely to be ostracized and experience stigma. They also spoke about feelings of turmoil in societies that seem to favour women.

- Participants expressed a lack of understanding and acceptance towards the LGBTQ+ community in Asian culture contributing to harmful attitudes and stigma such as 'people who identify as queer or transgender are at a higher risk of experiencing mental illness.' Racism and mental illness stigma within the LGBTQ+ community itself can also negatively impact one's reputation and can tip power dynamics within relationships.

"Men are more reserved, by themselves, won't make a sound, won't express, so then it becomes worse and worse, more worse"

"women have more facilities than men here so they try to break our religion and way of life"

"...in my community, a long time ago they found out I was gay. They assumed I was mentally [ill], like I have a sickness right?"

"A lot of pressure for men because for men, it's our responsibility to start working and make money, right? And if you live in a family where everybody else is working and you're under pressure on working and you have to work so that sometimes leads to illness, anxiety, or fear of failing."

Barriers to Anti-Stigma Work in the Community:

- Participants reported a lack of Asian role models and/or leaders in Western society in general to lead the efforts on reducing stigma associated with mental health and mental illness. However, participants were keen to become Mental Health Ambassadors in their communities with proper training and education.

- Participants noted that even in the face of limited services for Asian men, when faced with available options, Asian men would still refrain from access due to socio-cultural stigma.

- Participants reported lack of awareness, resources, and time as barriers to engaging in community mental health advocacy. Additionally, the fear of being personally stigmatized was also identified, especially in the context of valuing prestige, 'face' or social status in Asian culture.

"...even if there is no Asian celebrity just positive role models who can be examples who have gone through mental illness or have mental illness touch their life to show that you can get through this so a positive role model would be nice someone to look up to you know an example, I feel like there are no examples."

"I think the very first thing that popped into my mind when you say that question is the fear and the label. I think some people are afraid of being labeled to a certain group when they join certain communities or certain events."

Facilitators to Anti-Stigma Work in the Community:

- Participants suggested community involvement through organizations, school systems, associations, and community networks. Building awareness through social media and increased representation of Asian community leaders in traditional media were also discussed as potential strategies for anti-stigma work.

- Participants noted the importance of working with current mental health organizations and facilitating exchange among community members to build on collective education and increase awareness in diverse community settings.

- Participants acknowledged the importance of changing one's own perception of mental health but also noted the challenges associated with time and personal resources as barriers to initiating change. They felt that empathy and caring are important in advocating for systemic change.

"I think in general people who get involved in social justice advocacy for mental health issues do it because they themselves or their family members or someone they know has been affected by mental illness and they witnessed the stigma and they want to do something to help."

"So my understanding is that we find a seed, go to the community, and then plant that seed in the community, so that everyone will support this work"

"For the queer, Asian community, it would be good if different queer communities could come together and advocate for funding around mental health that intersect because I think sometimes we get so caught up with my issues and their issues but we overlap in so many issues.

"I think by opening all these conversations and being open in talking about it amongst our own family and friends, we can potentially mitigate some of the risks and create safe spaces for people to come for support"

Engagement in the Community: Help-seeking Behaviour

- Barriers for seeking help or support for mental illness identified included stigma and the cost of medications and/or therapy. Several participants noted a fear of medications to treat mental illness and/or cited anecdotes of people who have experienced negative side effects.

- Gay, Bisexual and Trans identified men expressed that along with mental health stigma, the fear of sexuality disclosure acted as a barrier to accessing care. This was further complicated by the intersections of sexual health risks and limited social support networks.

- Some participants expressed a self-reliance attitude where mental illness is viewed as a problem that should be managed individually.

- Participants from diverse Asian backgrounds highlighted the lack of or limited mental health services available to Asian men in their communities. Many believed that most mental health programs and services available are tailored to women and children.

- Many participants reported the benefits of having social support when experiencing mental illness although they also noted how their social support networks have decreased post-migration to Canada. Some described having feelings of isolation with migration. Others identified the elderly as a group at high risk of social isolation given their lack of mobility.

- The role of family as a source of both stress and strength were expressed. Some participants described experiencing the lack of acknowledgement of their mental health issues from their family, while others referred to their parents and family as supports.

"I find that a lot of people, LGBT, suffering from mental illness have a harder time accessing the services because of their identity or talking about their identity because if they ask why are you depressed, you have to also reveal your sexuality along with that and a lot of times that could be linked to why you're depressed or suffering anxiety"

"I think that in Asian culture there seems to be an attitude of not asking for help when we need it."

"But yeah, traditionally men, Filipino men from my experience even with my brother or sometimes even myself like I would rather work on it by myself rather than seeing a doctor"

"the cost of medication and therapy and the proper procedure can discourage them from actually seeking professional help."

"I had friends whose parents they were aware of their mental illnesses and they chose not to seek help because it carries a connotation of seeking help that if you have mental illness it means you are weak and inherently your family is sort of weak so that's why a lot of Asian families don't necessarily always seek help for mental illness."

"Yeah I would say some Asian families, they don't talk much to their kids and some might have a problem, going through stress, my parents won't ask me what happened to you so I need a friend whom I can talk"

02. Intervention Effects (Quantitative Scales)

Overall Changes Pre- to Post-Intervention:
All intervention groups showed outcome improvements from pre to post, accompanied by underlying psychological changes, as evaluated through quantitative scales. The significant results of the intervention are reported in Table 2. (see page 28) Overall statistical tests (omnibus tests) did not significantly distinguish amongst intervention groups. The following details the changes that were observed in some intervention groups but not in others.

Changes in Target Outcomes

Stigmatizing Attitudes:
Changes in stigmatizing attitudes was examined using the Community Attitudes to Mental Illness Scale (CAMI), which yields four subscale scores: authoritarianism, benevolence, social restrictiveness, and community ideology. All intervention groups showed reduction in perceiving those with mental illness as inferior (authoritarianism). The CEE group also showed reduction in perceiving mental illness as a threat to the community (social restrictiveness), increased acceptance of those with mental illness into their local community (community ideology), and increased good will and compassion to take care of them (benevolence). The Control and ACT + CEE groups showed reduction in social restrictiveness.

Internalized Stigma:
Changes in internalized stigma, i.e., the endorsement of negative stigmatizing beliefs applied to oneself, was examined using the Internalized Stigma of Mental Illness Scale (ISMI), which yields five subscale scores: alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. The ACT group reported improvements in four out of the five subscales.

They had decreased feeling of being excluded as a member of the community (alienation), deceased agreement with the negative portrayals of people with mental illness (stereotype endorsement), decreased disengagement from others in the community (social withdrawal), and increased capacity to resist negative attitudes and views (stigma resistance). The CEE group showed a decrease in stereotype endorsement, while the ACT + CEE group reported a decrease in their sense of alienation and an increase in stigma resistance.

Attitudes to Social Changes:
The ACT, ACT + CEE, and Control groups reported increased confidence in creating a positive impact through social change (perceived behavioral control). For the CEE and ACT + CEE groups, there was also an increase in perceived support and encouragement for social change (subjective norms).

Changes in Psychological Processes:
All of the intervention groups had improvements in the consistency between their values in life and actions (valued living), as well as improvements in non-judgemental awareness of the present moment (mindfulness). The ACT group had improvements in the capacity to be in contact with the present moment, face negative emotions or feelings, and take committed actions in the service of their values (psychological flexibility), while both the ACT and ACT + CEE groups also had increased sense of empowerment through beliefs in their own capacity to cope (self-efficacy) and beliefs of hope and confidence for the future (optimism).

Table 2: Outcomes and Process Measures Pre and Post Intervention

	OVERALL	
	Pre-Intervention Mean (SD)	Post-Intervention Mean (SD)
Stigma Attitudes (CAMI)		
Authoritarian	2.50 (.52)	2.37 (.56)
Benevolence	3.86 (.48)	3.89 (.54)
Soc. Restrictiveness	2.29 (.51)	2.19 (.57)
Ideology	3.76 (.57)	3.84 (.62)
Social Change (SJS)		
Attitudes	67.0 (9.8)	67.8 (9.4)
Behavioral Control	28.5 (5.4)	29.7 (5.1)
Subjective Norms	18.4 (5.5)	19.4 (5.4)
Behavioral Intentions	17.8 (2.9)	18.3 (2.9)
Internalized Stigma (ISMI)		
Total	2.24 (.44)	2.12 (.47)
Alienation	2.40 (.61)	2.22 (.61)
Stereotype Endorse	2.06 (.57)	1.96 (.58)
Discrim. Experience	2.29 (.63)	2.22 (.63)
Social Withdrawal	2.34 (.61)	2.22 (.65)
Stigma Resistance	2.89 (.48)	2.96 (.46)
Psychological Flexibility (AAQ)	22.97 (10.13)	22.07 (9.96)
Values (VLQ)	613.68 (185.24)	686.14 (180.18)
Mindfulness	39.77 (7.53)	41.82 (7.11)
Empowerment		
Total	83.68 (8.03)	85.13 (8.45)
Self-Efficacy	28.85 (4.34)	29.66 (4.07)
Power	20.70 (3.66)	20.97 (4.09)
Communication	20.63 (2.39)	20.49 (2.41)
Optimism	11.12 (1.83)	11.53 (1.91)
Righteous Anger	9.91 (1.82)	10.06 (1.72)

Note. CAMI = Community Attitudes towards the Mentally Ill Questionnaire, higher values on subscales of benevolence and Community Approach indicate more positive beliefs towards individuals with mental illness' inclusion into the community, while higher values on subscales of authoritarian and social restrictiveness represent more negative beliefs towards individuals with mental illness' inclusion into the community; Social Change = Social Justice Scale, whereby higher scores indicate more positive perceptions, beliefs, and willingness to engage in social change; ISMI = Internalized Stigma of Mental Illness, whereby higher scores indicate more internalized stigma towards individuals with mental illness, with the exception of stigma resistance. AAQ = Psychological Flexibility, whereby a high score indicates lack of acceptance of painful experiences, feelings, worries, memories, and emotions; VLQ refers to the values living questionnaire, whereby higher scores indicate higher action-values consistency weighed by importance; Mindfulness refers to the sum on the Freiburg Mindfulness Inventory, whereby a high score indicates high levels of mindfulness; Empowerment refers to the total scores on the Empowerment Scale, whereby higher scores represent stronger perceived efficacy towards effecting change in various domains. Bolded values indicate statistical significance p <.05.

03. Post Intervention Perceptions and Stories

Following the Acceptance Commitment Training (ACT) and the Community Empowerment Education (CEE) training, participants had much to share about how their understanding and perceptions of mental health and illness began to change. The interventions also had an effect on how participants engaged with their families and larger communities on topics of mental health and illness. Many also discussed their efforts in anti-stigma work as Mental Health Ambassadors.

Effectiveness of the Intervention Activities:

- Participants found that activities such as Mindfulness Meditation allowed space for reflection, contemplation and decreased self-imposed or personal stigma.
- Other activities such as the Inclusion/Exclusion Circle increased their psychological flexibility, decreased personal stigma and allowed for increased empathy and understanding of the discrimination faced by people living with mental illness.
- Health ambassadors discussed developing an increased level of comfort and skill set in interacting with other people in the community. Participants who attended both the ACT and CEE training indicated that ACT offered more opportunities for critical thinking.
- Participants of the ACT training specifically felt that it was practical and provided the necessary resources and tools to implement anti-stigma interventions on a personal and community level.
- Participants found that when guest speakers came to share their stories, this created a powerful and safe space to learn about mental health, develop empathy for people living with mental illness and feel comfortable disclosing their own stories.
- Men felt that the activity and monthly logs they kept inspired ideas about how to reduce sigma in daily life and helped keep them on track with anti-stigma activities.
- Participants felt the CEE trainings specifically helped them feel more equipped to speak out and challenge attitudes and perceptions of mental illness among community members, to educate people in their lives and promote help-seeking by connecting men to available resources.

Participants who attended a combination of the ACT and CEE sessions generally felt that the ACT training made a greater impact on their anti-stigma work in the following ways:

- It was engaging, increased psychological flexibility, and was applicable to community settings
- It promoted a sense of unity among members of the focus groups and this developed sense of comfort was transferable to a community setting. This was attributed to the peer-based model of the ACT training
- By engaging in anti-stigma activities themselves, ambassadors were able to experience the outcome on the exercise, build their confidence and promote critical dialogue. Experiencing the effects of these exercises motivated participants to further engage in anti-stigma work.
- Participants felt supported throughout the Strength IU project and thought there was a safe space for them to share their experiences. They felt respected, validated and acknowledged by other participants and the facilitators.

Stories of Engaging in Anti-Stigma Work, Challenges and Support:

When engaging in anti-stigma efforts surrounding mental illness in the community, participants shared the challenges they faced and/or supports they encountered:

- People in the community were resistant to sharing or talking about mental illness due to fear of disclosure. The fear of the implication that they were living with a mental illness was a strong source of shame and was compounded by cultural and gender norms.
- There was a lack of knowledge about mental illness and the effects of stigma on community.
- Participants felt they were lacking in some skill-sets such as public speaking if they had opportunity to engage larger groups of people. They also felt that at times, community members they attempted to engage challenged their position or legitimacy as an ambassador for mental health. To overcome this, participants suggested working with appropriate professionals and involving them in community engagement efforts to add credibility.
- Having a system or method to stay connected with other health ambassadors and share experiences helped to stay engaged in anti-stigma work.
- Resources such as funds, space and culturally-specific tools helped further their work.
- They appreciated clear instructions and guidance on how to implement anti-stigma work.

- Participants discussed the importance of sharing and engaging with topics of mental health on social and traditional media and suggested culturally relevant anti-stigma awareness campaigns
- Leveraging community spaces such as religious spaces, community centres, schools or workplaces were suggested to further the reach of anti-stigma work.
- Participants acknowledged the need for self-reflection and honesty about the issues at hand and discussed the feeling of being empowered by engaging in volunteer work. Despite living with mental illness, engaging in volunteer work fosters a healthy and purposeful life.

"The reason why [ACT] worked so well was because we had to apply the training theory to ourselves first... if you know if it works for yourself, you know it will work for other people."

"It helps a lot, it makes it a lot easier considering it's based on a peer model as well so the ACT training helped with the transition from you know what kind of questions to ask to what kind of actions you can take cause it was just interesting cause I think through the ACT training, I was able to get like three friends to go to counselling cause that just for me blew my mind cause oh my god, I'm actually doing something good [laughs] I'm actually applying what I learned at Strength IU"

"ACT training allowed me to be able to understand my own mindfulness, how my body feels, how my mind feels in relation to my body and how I feel in the present moment. It also allowed me to realize that my psychological flexibility might not be at the same level as someone else's. Someone might be stuck in [their own] mindset and being able to help them understand themselves through the mindfulness training, through the exercises that we learned in ACT, was a lot more helpful compared to the CEE training."

"Learning is an important tool, so the education aspect of [CEE], it has erased a lot of my misconceptions about mental illness... Learning about [mental illness and mental health], meeting people and listening to their experiences has really had an impact on me."

"I think the guest speakers are... very good. They were willing to share their experience with us, and the result was that they created a safe space for us, so the people in this group could share their personal experiences."

Experiences of Personal Change:

- Many participants talked about the personal changes they had experienced in their lives as a result of their involvement in the Strength IU study and/or as being ambassadors. Some general themes in this area included:

- Participants found the experience of being involved with Strength IU as life changing and life enhancing. Specifically, they felt empowered when taught to "honour their emotions", which was a completely new concept for many Asian men.

- The sharing component of the project helped participants gain different perspectives on their own understanding of mental health and mental illness, this especially supported the utilization of different coping strategies while living with mental illness.

- Participants' sense of shame and fear of opening about their mental health dissipated over time as they felt more accepted and educated about stigma reduction.

- Participants talked about the need for personal reflection to challenge internal prejudice before community engagement. Some believed that their actions had to come from the heart; this authenticity of the activism seemed to be a shared value.

- Most participants have learned to be more mindful in their day-to-day activities; when communicating with family and friends, they also learned to view community impact from an advocacy lens.

"In the past, I didn't have a lot of knowledge about my own mental state. I felt that I am sick, I felt restless. It's like I have this illness, so when I interact with people, I felt that because I have this illness, and so I feel restless. After all, I am the patient. And then, through this training, I understood a lesson. That is, I, myself, should not stigmatize myself, right? And then, after I learned more about this problem, I realize there are ways to handle it. For example, to live in the moment, these lessons are very good."

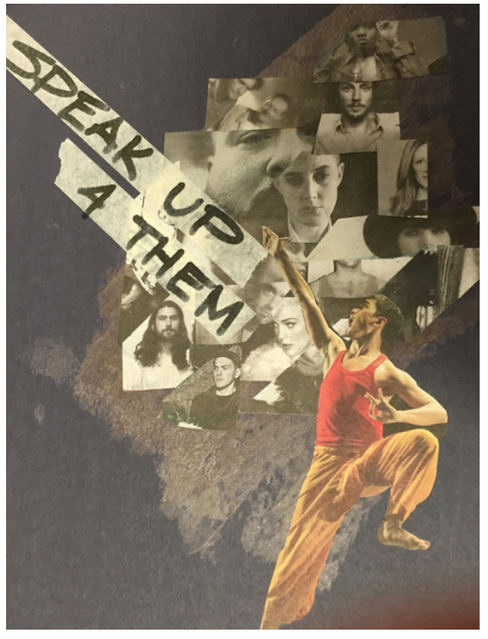
"when I used that method of forgiveness like I was to you know set myself a free and forgive and that was a really important lesson, forgiveness and like now me and my family member, we're in a good relationship and that actually really help"

"now I am more independent than I ever thought. I live on own, I pay my own bills, I cook for myself, I have a job, I volunteer, so I am very, very much independent and I proved to my family that I can be independent, that I can overcome obstacles even though I have a mental illness like I'm proving to myself every day that I achieve anything even if you have a mental illness and it's just a label."

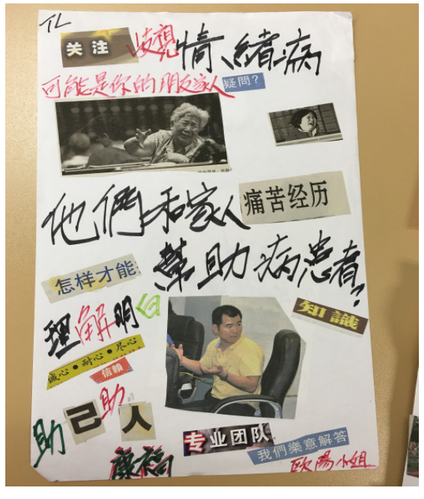
"Before I participated in these gatherings, I don't pay much attention to people with depression or mental illness. So after I came here, and when I have conversations about it with my friends, I discovered that almost each family has some sort of similar problems. In each family, there is perhaps one or two person, or the parents have depression."

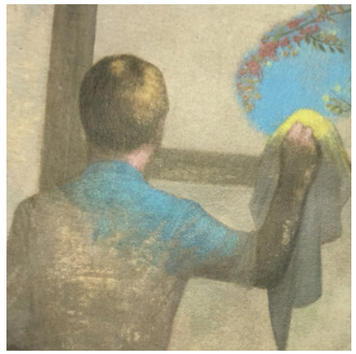
"my wife is a very anxious person, she is anxious, so she hopes that she does the best in everything she does. So then, it gives her a lot of pressure, whether it is in her company or, because we work together, she is also my boss. So when I get home ...we'll bring what hapened in the office back home, we discuss about it, but within a few sentences, we became loud. At first, I wasn't aware of it, I will argue with her, just like before, if you are loud, I am going to be louder than you, and being loud doesn't mean that I am impolite... But after this program, I realize what I was doing was wrong... So now I changed, if she is loud, I became soft...now we are harmonious, our attitudes towards each other have improved a lot."

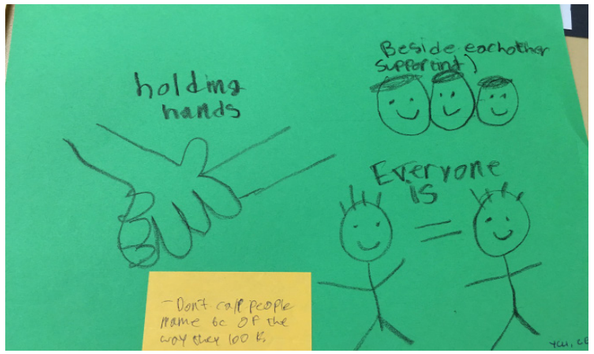
"I'm just more accepting of the fact that yes mental illness exist. Before I was looking at it from a perspective that people just say oh I'm depressed because they want to get away from stuff you know but no, they say they're depressed because they are feeling a certain way and we are overlooking the fact that they might going through some sort of trouble, right? ...I have a friend who has a habit of saying, I don't feel good today, I feel really down, I'm depressed. I used to look at that particular person from a very different point of view saying this person just has a habit of just saying I'm depressed ...but couple months down the road, she got treated by a doctor saying she has clinical depression but she was saying that to me every single day, every single day, I'm depressed, I'm depressed. It was her way of communicating with me but since I was not open to the fact because I just looked at the way... I was at fault, I never really paid any attention towards her because you just tend to think if a person says they're depressed that they trying to move away from a certain thing, that they don't want to do a certain task or whatever or they're not, they just don't feel like doing it, they're lazy. That's my perception towards it but joining this group has helped me change that."



The collages and artwork on pages 33-35 were created by participants as part of a facilitated art-based research exercise.







"I plan to talk to my colleagues every week about the issues with mental health. The most important is, first... the venue is limited. Sometimes three or four of us go to Tim Horton's and people sitting next to us will sometimes hear us, right? The venue at times is not so convenient, right? But if you go to the library at night, it closes too early, right? At Tim Horton's, there's 24 hour ones. So the venue is a problem, it is a big problem."

"It has helped me with like just building the capacity of you know I may be a staff, you might be the volunteer but I'm still there for you even as a friend and it's just like it created a more strong leadership role for me because cause like it allowed me to be very, I was always empathetic but being even more so empathetic because now at least I can have the skill sets and I have the tools necessary for me to actually produce results that are beneficial compared to just saying something I think might work but now I can actually use tools and methods that I know will work..."

"I have a friend that suffers from a lot of anxiety and I went over with her about the ACT, the things we did in ACT and I was surprised to see that she actually downloaded stuff like it was just a normal coffee conversation but like I guess people reflect on themselves and do seek the help that they need so yeah, she downloaded, she started practicing mindfulness seriously for three months."

"I don't know cause there is a lot of media outlets you can use right so for example Youtube is a very big one right now, everybody is hopping on Youtube. We can use that to spread the word right but you have to, it's how you package it, deliver it to the people so that they want to get to know more about it. For example, that ice bucket challenge or that thing. A lot of people know about that so you got create something that will bring awareness to that".

06. **RECOMMENDATIONS**

A number of recommendations were suggested by the participants during the course of the study focusing on how to maximize the impact of anti-stigma work in their communities. Overall, study participants believed that effective stigma interventions for racialized and immigrant men in Canada must consider the intersecting effects of the social determinants such as racialization, ethnicity, gender, age, socioeconomic status, education, and length of time living in Canada. In particular, data from the focus groups, the Mental Health Ambassadors (MHAs) activity logs, and the summit discussions converged on the following recommendations:

Culturally relevant and representative awareness campaigns:

Participants repeatedly pointed out the lack of cultural representation in mental health awareness campaigns and the lack of Asian leaders or role models to champion anti stigma efforts. They recommended the development of campaigns for and by Asians using new and traditional media. Promoting these campaigns in diverse spaces such as religious centres, health clinics, or schools was suggested to increase their visibility and accessibility in the Asian community.

Continued investment in Strength IU and the Community Mental Health Ambassador initiative:

A number of participants talked about the need to build on the mental health ambassador initiative through continued training, capacity development, and support. Some suggested a mentorship program between Strength IU facilitators and MHAs so that they can get access to more learning opportunities while collaborating on community projects.

Participants stressed the importance of emotional learning, support, and safety that they had experienced in their involvement in the study as MHAs and were hesitant for this to end. Efforts to secure additional funding and/or research opportunities were also common suggestions.

Systems solutions:

Participants discussed the importance of improving larger systems that contribute to mental health, mental illness, and stigma such as sociocultural factors, employment access, and racism. This was particularly true of the discussions held at the Asian Mental Health Summit supported by the study. Men at the summit strategized around initiatives to increase social inclusion or access to economic resources. Overall the need for effective mental health programs and services to be coordinated and implemented at multiple levels was highlighted to reduce the burden of stigma and systemic access barriers.

Partnership and collaboration:

The importance of building and strengthening partnerships with community groups and organizations in order to increase opportunities for MHAs to do anti-stigma work was repeatedly discussed. Participants stressed the need to facilitate multi-disciplinary and multi-sectoral partnerships that can collectively support individuals with different levels of knowledge and or experiences. The more diverse the partnering organizations are, the better the collaboration will be.

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Strength In Unity

Men Speaking Out Against Stigma

Mental Health Promotion in Asian Communities