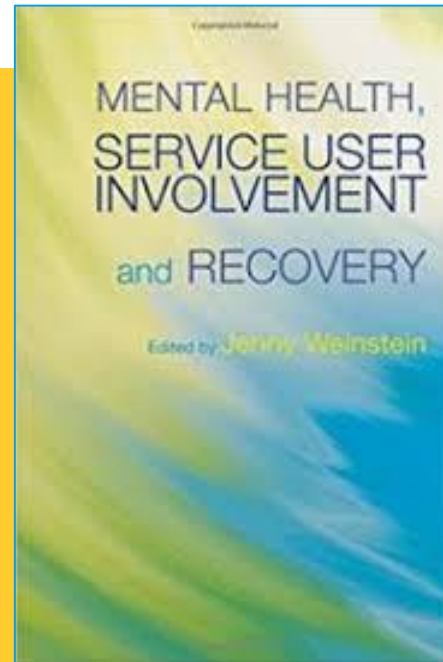


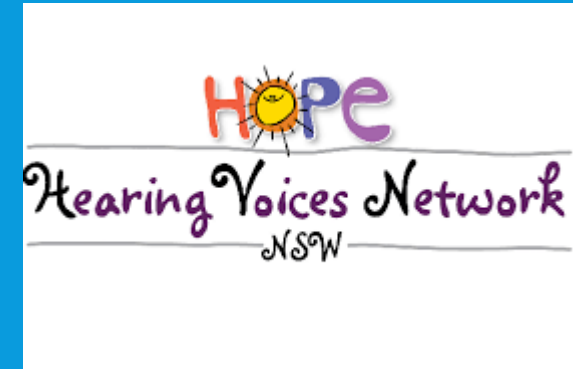
Mental Health Education: Week 2

The Service Users and Survivors – Their role in Mental Health Intervention



SERVICE USERS AND SURVIVORS

- What does the term mean?
- Different things to different people?
- Patients, users, survivors and providers...
- Began in the 1970's in The Netherlands and USA.
- User involvement – from active participation in service planning, to evaluation, training and research.
- According to Peck et al. (2002) user involvement operates at four levels:



1. Interaction between service users in the form of self help
2. Interaction between the service users and the professionals working with them
3. In the management of local services
4. In the planning of overall services

WHY IS USER INVOLVEMENT SO IMPORTANT?

1. Users are experts about their own illness and the need for care;
2. Users may have different but equally important perspectives regarding their illness and their care;
3. User involvement may increase the existing limited understanding of mental distress;
4. Users are able to develop alternative approaches to mental health and illness;
5. User involvement may be therapeutic in itself;
6. User involvement will encourage greater social inclusion.

BARRIERS AND BENEFITS

Barriers

- Accessible information for meaningful involvement
- Financial costs of involvement, including transport and payment
- Representativeness
- Professional resistance

Benefits

- Involvement in research (see paper by Patterson, Trite and Weaver (2014))
- Involvement in staff selection
- Employment as paid mental health workers
- Involvement in planning and redesign of mental health services
- Involvement in education and training

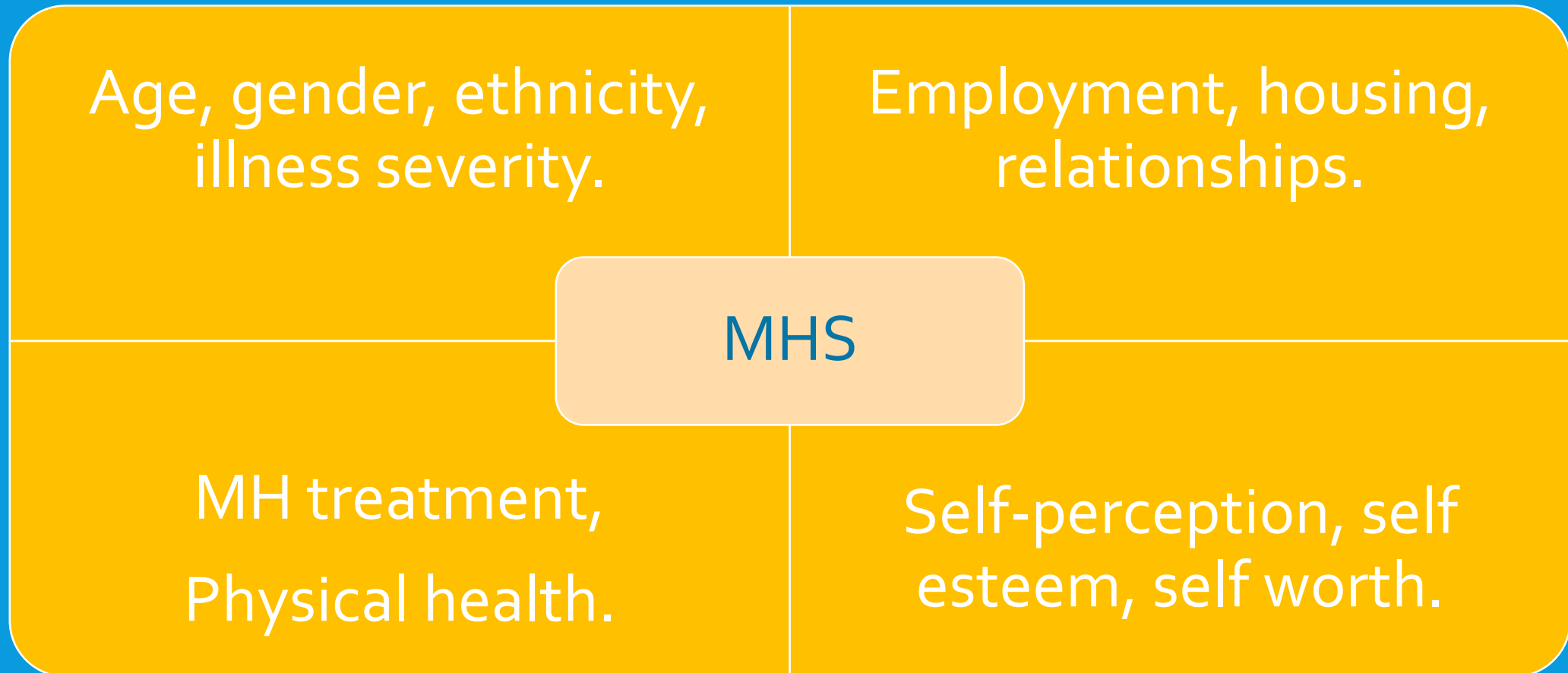
PATIENTS, CONSUMERS AND SURVIVORS: A CASE STUDY OF MENTAL HEALTH SERVICE USER DISCOURSES (SPEED, 2006)

- Discourse Analysis of three separate service user views
 - Case study one – Harry and the patient discourse
 - Case study two – Ian and the consumer discourse
 - Case study three – John and the survivor discourse
- Active versus passive service user and the impact this has on their prognosis for an improved standard of life

STIGMA IN MENTAL HEALTH

- To recap-
- Stigma in mental health (MH) is a “social cognitive process in which the public perceives certain cues as to an individual’s mental health status, which in turn activates stereotypes which may lead to prejudice and discrimination” (Corrigan, 2004; p614).
- Don’t forget that you also have perceived stigma and self-stigma.
- How do we measure it? You’ve used the CAMI, take a look at the EASI (Vogt, Di Leone, Wang, Sayer, Pineles & Litz, 2014).
- What are the sections A – E measuring?
- Any problems?

GENERAL EFFECTS OF STIGMA



STIGMA IN GENDER, RACE AND SOCIAL CLASS

- Whilst there are no differences in overall experience of MI, there is a difference in how men and women attribute the causes of MI. E.g women tend to suffer with internalising disorders (Kessler, 2008) where they turn feelings against themselves, compared to men who externalise their disorder in terms of substance dependency and antisocial behaviour.
- Culture and race shapes every aspect of patient care, from who they disclose to, their treatments and the diagnosis (Kirmayer, 2006).
- Social class?
- Help seeking behaviour (Corrigan, Druss & Perlick, 2014)

STIGMA IN DEPRESSION

- Stigma contributes to a reduction in help-seeking behaviours and full engagement with health services (Sheehan, Dubke & Corrigan, 2017).
- We also know that the level of stigma varies by illness and diagnosis (Sheehan et al., 2016).
- It appears that whilst stigma and prejudice vary considerably by diagnosis, discrimination does not- regardless of diagnosis, individuals seen to be suffering with a MI all experience a restriction of rights and opportunities.
- Who is at greatest risk of stigma for Depression?
- Is this self-stigma, perceived stigma or public stigma?
- Does self-stigma develop as a result of public or perceived stigma over time?

STIGMA IN DEPRESSION

- Individuals with high levels of depression report higher **perceived** stigma (Griffiths et al., 2008), but not **public** stigma.
- Yen et al. (2005) found that higher depressive symptoms predicted higher **self**-stigma.
- Higher psychological distress is associated with higher **perceived** and **public** stigma (Griffiths et al., .).
- Females report higher **perceived** stigma than males (Grant, Bruce & Batterham, 2016).
- **Perceived** stigma predicts treatment discontinuation in older but not younger adults, despite younger adults reporting more **perceived** stigma.
- Greater knowledge and contact with sufferers is associated with lower **public** stigma (Ventieri et al., 2011).

SO WHAT CAN WE DO?

Interventions for stigma reduction

TYPES OF INTERVENTIONS

- Multiple types of intervention –
- Short, medium and long term, use of RCT's.
- Differences in frequency and intensity; mass media, TV, Cinema, Radio, Social Media.
- They often use a personal narrative (think of the recent initiative of the HRH) and works by increasing awareness of the variation amongst members of groups and contact theory (Corrigan, 2012).
- In addition, mass media campaigns bring about change in social norms which can result in behavioural change (even if individual attitudes are not changed; Wakefield, 2010). I.E. without conscious choice.
- The main aim is for research to be based on sound theoretical principles as part of a multi-faceted campaign.

EDUCATIONAL AND CONTACT INTERVENTIONS

- We know there are short term benefits to contact based interventions for **public** stigma, but less evidence for the long term benefits.
- The key appears to be the intensity of the programmes.
- Moreover, changing attitudes and increasing knowledge are two different things; the most effective interventions appear to be a narrative embedded in social contact (Corrigan et al,.).
- And for **self**-stigma, Yanos et al. (2015) found that a combination of techniques including CBT, MI, Psychoeducation, consciousness raising and group therapy.
- Corrigan, Morris, Michaels, Rafaez and Rusch (2012) reported from their meta-analysis that overall contact interventions are best for adults, whereas educational interventions work best for adolescents. Face to face is better than via video.

META-ANALYSIS OF EARLY INTERVENTIONS

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., ... & Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia bulletin*, 27(2), 187-195.

Intervention incorporating Education, Contact and Protest with 132 students from a college in USA.

- Overall small but significant reduction in public stigma. The outcome was significant when all studies were combined regardless of intervention type or regardless of disorder.
- Generally Educational interventions when used in combination were effective, although contact interventions alone were not.
- There were fewer studies exploring perceived or self-stigma, therefore effectiveness could not be established.

MORE RECENTLY - ONLINE E-LEARNING RCT: AN EXAMPLE

- Jorm, A. F., Kitchener, B. A., Fischer, J. A., & Cvetkovski, S. (2010). Mental health first aid training by e-learning: a randomized controlled trial. *Australian and New Zealand Journal of Psychiatry*, 44(12), 1072-1081.

