

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/7569875>

Active ingredients in anti-stigma programmes in mental health

Article in *International Review of Psychiatry* · May 2005

DOI: 10.1080/09540260500073638 · Source: PubMed

CITATIONS

176

READS

1,008

4 authors, including:



[Vanessa Pinfold](#)

McPin Foundation

127 PUBLICATIONS 3,701 CITATIONS

[SEE PROFILE](#)



[Peter J Huxley](#)

Bangor University

202 PUBLICATIONS 8,744 CITATIONS

[SEE PROFILE](#)

Some of the authors of this publication are also working on these related projects:



The People Study [View project](#)



Viewpoint Survey [View project](#)

Active ingredients in anti-stigma programmes in mental health

VANESSA PINFOLD,¹ GRAHAM THORNICROFT,² PETER HUXLEY², & PAUL FARMER¹

¹*Rethink, Kingston-Upon-Thames, Surrey, and* ²*Health Service Research Department, Institute of Psychiatry, King's College London, De Crespigny Park, London, UK*

Summary

This paper draws upon a review of the relevant literature and the results of the recent Mental Health Awareness in Action (MHAA) programme in England to discuss the current evidence base on the active ingredients in effective anti-stigma interventions in mental health. The MHAA Programme delivered educational interventions to 109 police officers, 78 adults from different community groups whose working lives involved supporting people with mental health problems but who had received no mental health training and 472 schools students aged 14–15. Each adult target group received two intervention sessions lasting two hours. The two school lessons were 50 minutes each. Knowledge, attitudes and behavioural intent were assessed at baseline and follow-up. In addition focus groups were held with mental health service users to explore the impact of stigma on their lives and facilitators of educational workshops were interviewed to provide expert opinion on 'what works' to reduce psychiatric stigma. Personal contact was predictive of positive changes in knowledge and attitudes for the school students but not the police officers or community adult group. The key active ingredient identified by all intervention groups and workshop facilitators were the testimonies of service users. The statements of service users (consumers) about their experience of mental health problems and of their contact with a range of services had the greatest and most lasting impact on the target audiences in terms of reducing mental health stigma.

Introduction

This paper draws upon a review of the relevant literature and the results of the recent Mental Health Awareness in Action (MHAA) study in Kent, England, to discuss the current evidence base on the active ingredients in effective anti-stigma interventions in mental health. The persistent and disabling nature of psychiatric stigma has recently led to the establishment of global mental health awareness campaigns, as well as local educational sessions. However, practical initiatives that challenge negative stereotypes and discriminatory responses are rarely evaluated. There is increased interest in the topic of psychiatric stigma, for example Link and Phelan (2001) measured a rise in the number of peer reviewed papers citing the word 'stigma' from 33 in 1980 to 175 in 1999. There are also published guides supporting service user trainers who are involved in sharing their illness experiences (Corrigan & Lundin, 2000; Wahl, 1999), and at the first International Conference on Stigma and Discrimination in 2001 there were delegates from 51 countries.

However, despite these activities the evidence base explaining how to reduce psychiatric stigma is weak

(National Institute of Mental Health England [NIMHE], 2004; Sayce, 2003). Valuable mental health promotion resources are being invested in initiatives that do not have a robust evidence base supporting their effectiveness and service users and carers report that stigma and discrimination is an ever-present problem in their lives.

In recent years, the public health problems associated with psychiatric stigma have become recognised global health concerns. An estimated 450 million people worldwide are affected by mental disorders at any one time and they account for 31% of all years lived with disability although there are substantial global variations (Thornicroft & Maingay, 2002). However, the stigma and discrimination associated with severe mental illness often makes it more difficult for people with mental health problems to benefit fully from these new treatments and so can hinder their recovery and reintegration (British Psychological Society, 2000; Schulze & Angermeyer, 2003a). In the 1999 US Surgeon General report on mental illness, stigma was found to be the most significant obstacle to the treatment of mental disorders. The World Health Organization (WHO) report 'New Understanding,

New Hope' underlined the importance of attending to attitudes that generate social disability and called for countries to launch campaigns to educate the public (WHO, 2001). In England the strategic plan for mental health includes a standard for reducing mental health discrimination and promoting mental health for all (Department of Health, 1999).

As a field of academic study, stigma research is expanding. There are a number of relevant reviews (Bhugra, 1989; Byrne, 2001; Crocker, Major & Steele, 1998; Guimon, Fischer & Sartorius, 1999; Haywood & Bright, 1997; Link, 2001; Rabkin, 1974). Personal testimonies, campaign groups and research studies can all identify sources of stigma, for example, pre-dominantly negative media portrayal of people with mental health problems in television soap opera dramas and tabloid headlines (Philo, 1996; Wilson et al., 2000) or attitudes of doctors (Royal College Psychiatrists, 2001) or the history of psychiatric treatment (Porter, 2002). Different mental disorders may be associated with particular stereotypes and prejudices (Crisp et al., 2000) and although the public can have a relative sophisticated understanding of disorders such as schizophrenia, associations with dangerousness and fear dominate public perceptions (Angermeyer & Schulze, 2001a; Thompson et al., 2002).

Research into the origins of 'stigma' has produced different theoretical positions explaining the nature of stigma (Corrigan, 2003; Corrigan et al., 2003; Haghghat, 2001) and frameworks for tackling both psychiatric stigma and discrimination are emerging (Angermeyer & Schulze, 2001b; McKenzie 2002). Although education underpins most stigma-change programmes, whether involving mass-media initiatives or groups addressing self-esteem and self-stigma, conceptual approaches vary. Dominant frameworks currently include biomedical perspectives, the recovery model and disability inclusion (Sayce, 2000).

Increased interest in stigma research ensures that the way forward for reducing stigma is being signposted. Link (2001) identifies two key principles to direct effective and sustained change for reducing psychiatric stigma and discrimination: approaches must be multi-faceted and multi-level. They should address the deeply held attitudes and beliefs that are the fundamental causes of stigma. Research also indicates that psychiatric stigma programs should employ strategies that focus upon personal contact, education and empowerment (Alexander & Link, 2003; Corrigan et al., 2001a; Corrigan & Watson, 2002; Couture & Penn, 2003). Several initiatives are pursuing stigma-change processes built upon promoting personal contact because the single most important factor for influencing public attitudes and

behaviour towards people with mental health problems is reported to be personal contact with someone with mental health problems (Angermeyer & Matschinger, 1996; Corrigan et al., 2001b; Penn et al., 1994; Read & Law, 1999), a finding consistent with research on racial stereotypes (Desforjes, Lord & Ransey, 1991; Hamburger, 1994). A few 'real world' stigma-change educational programmes are also reporting successful short-term impacts on a target groups' awareness of mental illness, particularly where they involve working with young people (Rahman et al., 1998; Schulze, Richter-Werling & Matschinger, 2003b).

Method

Aims of mental health awareness in action programme

The aims of the MHAA Programme were to design and deliver mental health awareness programmes to target audiences in the community, and to evaluate the effectiveness of mental health awareness programmes on reported knowledge, attitudes and intended behaviour. The programme is part of the World Psychiatric Association (WPA) Global programme 'Open-the-Doors' (www.openthedoors.com). The non-governmental organization 'Rethink Severe Mental Illness' is a partner in the programme along with the Health Service Research Department of the Institute of Psychiatry at King's College London. Full details of the study methods are given elsewhere (Pinfold et al., 2003a; 2003b; 2003c), where information about the outcomes of the two main targets groups (police officers and 14 year old school children) are also provided. In this paper we present data from our police and school studies, and workshops with adults working with service users who have received no specific mental health training—housing officers, Citizen Advice Bureau (CAB) volunteers, school nurses and local council employees. Briefly, the MHAA programme started in 2000 by building a mental health awareness workshop programme to deliver to target audiences in the community. Alongside the practical training of volunteers were the preparation of workshop activities, liaison with target audiences to meet their training needs, and the project also developed tools to measure the impact of the programme. The programme development was supported by two focus group studies with service users, one with four groups involving 26 participants and the second with five groups and 33 participants, (Pinfold, Byrne & Toulmin, in press) and interviews with the volunteers participating in the programme as educational workshop facilitators.

Police intervention programme

The educational intervention for the police was delivered by service users (eight trainers), carers (four trainers) and people working in the field of mental health (three social workers and seven voluntary sector staff). The project team developed the intervention with assistance from the Kent police force. Key communication messages were identified in focus groups with mental health service users. Over a six-month period, 109 police officers attended two mental health awareness training workshops, each of two hours duration and completed the baseline and follow-up evaluation. Both sessions combined small group work and discussion opportunities with didactic presentations using power point and short talks based on an individual's personal experiences. Workshop one focused on 'What are mental health problems' including a hearing voices simulation exercise, talks by someone explaining how it feels to be psychotic and a session on recovery. Workshop two addressed 'How can the police support people with mental health problems' using case study examples and talks from carers and service users highlighting best practice principles.

Working adults intervention programme

The project team regularly provided mental health awareness sessions to community groups whose working lives brought them into contact with people with mental health problems though they received no formal training on how to engage effectively and support mental health service users. The structure of the sessions followed those delivered with the police force. There were two sessions, each of two hours duration, delivered by a facilitation team involving personal talks about living with mental health problems, group exercises exploring relevant issues to the group's job roles and informative power point presentations. A total of 78 adults took part in the workshop programme and evaluation.

Schools intervention programme

Schools participating in the pilot programme received two educational sessions, each lasting 50 minutes, within the Personal Social Health and Education curriculum for Year 10 pupils (students aged 14–15). A two-stage project was evaluated over four school terms in schools that were approached to participate in the programme. Two schools were girls' grammar schools and three were co-education comprehensives. All participating schools had identified concerns over the emotional well-being of their pupils and sought advice on developing educational

sessions to address the issue. A total of 472 pupils took part in the project evaluation. The first hour session concentrated on pupils' understanding of mental health and mental illness, including the viewing of a short video about people living with depression and schizophrenia. The second session concentrated on promoting a positive sense of well-being and challenging the use of stereotypical labels—'nutter', 'loony', 'mental', 'psycho'—language known to dominate young peoples' descriptions of mental illness (Bailey, 1999; Weiss, 1994).

Evaluation scales

Questionnaires to measure the impact of stigma-change programmes are being developed and piloted. The process began by collating assessment instruments employed in stigma-change research studies from across the world. The MHAA pilot instrument was based on the CAMI (Taylor & Dear, 1981), constructs assessed in most public attitude surveys (e.g., views on prevalence, causes, symptoms, treatments, prognosis, risk behaviour and personal traits) and the WPA programme pilot tool kit developed in Canada (WPA, 2000). This instrument has since been modified and new techniques are also being developed and piloted.

Results

We report here both qualitative and quantitative results from the MHAA study, focussing on those aspects, which informs the question: What are the active ingredients in effective anti-stigma interventions, using illustrative quotations where relevant.

'I don't know whether education works because I've been trying to educate my sister ever since I became ill and I have been in and out of hospital since I was 29. I'm 49 this year and I have only just given up trying. I don't hold out much hope that stigma can be removed'
(Participant in focus group study 2)

'We need to make it socially unacceptable—we need to educate people that it is not acceptable to call people psycho, nutter, loony and to assume people are going to be violent. It is wrong but people think that is what mental illness means and are afraid of it'
(Participant in focus group study 1)

Despite a general pessimism that stigma and discrimination are difficult problems to combat, (particularly among carer groups, service user forms and within the psychiatric profession) current research suggests that locally focused, targeted interventions can impact on general mental health awareness (Holmes et al., 1999; Kaminski & Harty, 1999; Read & Law, 1999; Wolff et al., 1996). We also

Table I. What works—views from workshop facilitators.

‘I think that it is important to do mental health awareness work in a way so that you normalise the experience of mental illness. We have to be very careful that we don’t scare people and when we do work with people with experience of mental distress we have to be careful that they don’t just reinforce the idea that ‘this is what I use to do when I was mad’. We need to emphasise recovery’.
‘In my experience of co-delivering ‘Beyond the Cuckoo’s Nest’, the most effective element has simply been offering a personal account of mental ill health. Because all three of our trainers have an equal role in delivering the workshop, but at the end when one of us says, ‘One of the reasons I’m here is to talk about my experience of manic depression . . .’ it comes as a real surprise to people. It challenges common perceptions of people with a mental illness and helps normalise mental illness. This in itself counteracts stigma, especially coupled with giving people the opportunity to ask questions about what it’s like to have an illness. We try to create a space where people feel its OK to ask questions without feeling stupid or worrying that they’ll be judged’.
‘Looking at the whole concept of what mental illness is and what mental health is with different community groups appears to be a good way of looking at attitudes to mental distress. It provides a forum for the participants to learn from each other and challenge each other around the issue of stigma and discrimination, and therefore raises awareness’.
‘The one most important factor that ‘works’ in delivering the message of the problems and issues surrounding the misunderstanding and stigma of mental health problems is someone speaking about their personal experiences. This is such a powerful message and also allows for a discussion to ensue. One person I know begins her talk, having already taken part as a facilitator, by standing up and stating ‘I have a diagnosis of manic depression’. She then talks openly about her life, family, her job etc. It is the unexpected that impacts. I also like to watch the audience when someone is talking about personal experience. It is always the case that everyone is totally attentive and quiet and respectful—something people with mental health problems do not often experience’.
‘In my experience, what really makes the difference to mental health awareness training is the inclusion of service users. Hearing a person share their experiences never fails to make a dramatic impact on a group. However, this impact is most effective when service users are also involved in the planning and delivery of the whole training session’.

found that that subjective feedback from educational workshops, addressing both use and effectiveness of the sessions, was positive.

A common theme emerging from facilitators’ feedback on ‘what works’ was the importance and power of personal testimonies for breaking down ignorance, fear and prejudice (see Table I). Several groups use a strategy based on the social model where mental health and mental illness are viewed as a continuum of health experiences thus emphasizing the commonality of emotional distress and the ‘normality’ of mental health problems. When facilitators share their own personal experiences of mental illness, the impact of the educational session is rated as observably greater by facilitators. The sharing of information within an environment that encourages discussion, and reflection was also noted as an important ingredient in ‘successful’ mental health awareness workshops.

The opinions provided by workshop facilitators are in part a reflection of the feedback they themselves have received from participants, and their managers. We supplemented a pre- and post-questionnaire study design with feedback rating forms completed at the end of any training session. For example, in the community adult group follow-up questionnaire 97% identified that the service user talks had been ‘very useful’ or ‘useful’, compared to 85% for the hearing voices exercise. From the training feedback forms involving 109 police officers only one officer reported they had learned nothing in the session, 76% rated the sessions ‘very useful’ or ‘useful’ for police work and 77% rated the service user presentation as a ‘useful/very useful’ component of the training. Police workshop participants were also

asked to share ‘what I will most remember from the workshop’.

Using content analysis these data have been coded and the emergent themes are reported in Figure 1. The comparison between workshop ratings and four-week follow-up ratings concur with the views of the facilitators. The personal experience talks are noted as an important and valuable part of the session, particularly on longer reflection. One officer wrote:

‘Most importantly I recall being able to discuss with service users how they felt personally about their illness and about how the police have treated them’

Both police officers and the working adult group showed significant, positive improvement in reporting key messages at follow-up (see Table II). Despite expected ceiling effects, the workshop interventions did have an impact on reported stereotyping of people with mental health problems indicating that even when ‘awareness’ within a group is high, educational sessions do make a difference. This is important evidence for mental health awareness groups, assisting the strategic planning of targeted interventions. In practice, groups need to plan and develop their training programme, and build confidence and expertise within the team to deliver stigma-change interventions to diverse audiences.

Despite the positive impact of short educational interventions on participants awareness of mental health issues, and participant reported attitudes, our results illustrate that actual behaviour-change, and thus discriminatory responses, may not be affected by short educational packages without

What will you most remember from the workshops?

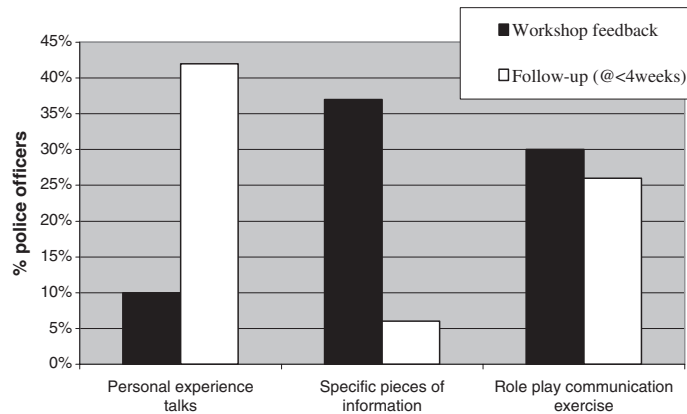


Figure 1. Police officer workshop feedback.

Table II. The communication of five key workshop messages: Police officer ratings of statements at baseline and follow-up.

	Message concept	Group	Baseline	Follow-up	McNemar
+We all have mental health needs	Connecting health and illness	Police (n = 109)	65 (60%)	86 (80%)	$p < 0.0001$
		CAG (n = 78)	68 (87%)	77 (99%)	$p = 0.004$
+People with mental health problems are far less of a danger than most people believe	Violence myth	Police (n = 109)	54 (49%)	73 (68%)	$p = 0.006$
		CAG (n = 78)	60 (77%)	75 (97%)	$p < 0.0001$
+Most people with mental health problems can with treatment get well and return to lead normal lives	Recovery	Police (n = 109)	62 (57%)	98 (91%)	$p < 0.0001$
		CAG (n = 78)	65 (84%)	76 (97%)	$p = 0.002$
*1 in 4 people will experience some form of mental health problems in the course of their lives	Prevalence	Police (n = 109)	29 (32%)	53 (56%)	$p = 0.002$
		CAG (n = 78)	35 (47%)	53 (68%)	$p = 0.018$
*Schizophrenia is like having a split personality (reverse scoring)	Split-personality myth	Police (n = 109)	32 (29%)	72 (67%)	$p < 0.0001$
		CAG (n = 78)	39 (50%)	65 (83%)	$p < 0.0001$

+Participants had a 'positive opinion' if they endorsed a statement on 1 or 2 points of a 1–5 Likert scale; *respondents answered yes or no to the statement; CAG, Community Adult Group including schools nurses; CAB, volunteers, local council employees and housing workers.

longer term follow-up (see Table III). Social-distance ratings have been used here as a proxy measure for intentional behaviour, and no improvement in scores is observable beyond police officers rating they would be more comfortable working with a person with schizophrenia post-training. Behaviour-change is an integral and essential part of stigma-change programmes, and more research is needed over longer periods of time to assess whether any group based educational activity with community audiences can promote behaviour change.

Participant's own experiences of mental health problems, or those of family and friends, are known

to influence attitudes (Corrigan et al., 2002b). In the school studies that MHAA undertook, young people identifying personal experience scored significantly higher attitude changes when compared to students that did not report knowing someone personally with a mental health problem (see Table IV). When we compared the impact of personal experience in the police and Community Adult Group (CAG) studies we found the CAG reported more personal experiences within the family than police officers — 49% compared to 27% ($\chi^2 = 9.8$, $p = 0.002$), and with other contexts (family, friends, work colleagues) — 76% compared to 46% ($\chi^2 = 16.5$, $p < 0.0001$). Importantly, however, in both the adult groups

Table III. Police officer and adult working group ratings of being able to interact with a person with schizophrenia.

Social-distance item	Group	Baseline	Follow-up	McNemar
Definitely would not be afraid to talk to	POLICE	52 (48%) (<i>n</i> = 108)	60 (55%) (<i>n</i> = 109)	NS
	CAG	29 (39%) (<i>n</i> = 78)	36 (48%) (<i>n</i> = 78)	NS
Definitely would not find it difficult to work with	POLICE	21 (21%) (<i>n</i> = 101)	35 (34%) (<i>n</i> = 102)	<i>p</i> = 0.007
	CAG	30 (41%) (<i>n</i> = 78)	35 (47%) (<i>n</i> = 78)	NS
Definitely would be able to be friends with	POLICE	21 (22%) (<i>n</i> = 96)	16 (16%) (<i>n</i> = 103)	NS
	CAG	22 (31%) (<i>n</i> = 78)	26 (36%) (<i>n</i> = 78)	NS
Definitely would not be embarrassed of family member	POLICE	60 (58%) (<i>n</i> = 103)	63 (59%) (<i>n</i> = 107)	NS
	CAG	52 (66%) (<i>n</i> = 78)	46 (61%) (<i>n</i> = 78)	NS

CAG, Community Adult Group.

Table IV. Impact of personal experience on student survey scores at follow-up.

Aggregate scores	No experience of knowing someone with mental health problems	Experience of knowing someone with mental health problems	
5 attitude statements	2.47	3.2	<i>F</i> = 15.724 <i>p</i> < 0.0001
5 knowledge statements	1.78	2.23	<i>F</i> = 12.446 <i>p</i> < 0.0001
4 social distance statements	1.59	20.4	<i>F</i> = 8.833 <i>p</i> = 0.003

*For attitude statements and further analysis please refer to Pinfold et al., 2003b.

personal experience of mental health problems did not impact on attitude change scores.

'An almost automatic response from users and service providers to evidence of discrimination on mental health grounds is to call for education, in schools or through the media'

(Diana Rose 1996, cited in Sayce, 2000, p. 205).

To supplement our understanding of the active ingredients of anti-stigma programmes, we also ran two focus group projects in which service users informed us about what they wanted to be done about psychiatric stigma and discrimination and as predicted by Rose (1996) most people identified the need to educate young people:

'We need young people to go into schools and tell their stories. A cool young pop star would be excellent—a bit like the AIDS thing'

(Focus group study 1)

'Don't you think we should be trying to get into schools and educate young people. Because I have written something and I am trying to get it published so I can go into schools, and hand out these pamphlets and talk to youngsters about it.'

(Focus group study 2)

In focus groups study two, when we asked what service users thought should be done to tackle the stigma of mental illness, interestingly the solution to counter stigma—being 'made to feel different', 'being isolated, labelled, unfairly treated', 'experiencing prejudice and others' ignorance' — went further than traditional public education work. Although school children and the media were targets for stigma-change studies, as reported elsewhere most of the participants rated 'reform to the psychiatric system' as the most important aspect for challenging psychiatric stigma (Pinfold et al. in press). Suggestions for psychiatric reforms included the improvement in doctor's attitudes — particularly in regard to 'listening' to the patient and structure of doctor-patient relationships, increased profile for psychiatry within the medical establishment, and reduced emphasis on the biomedical model including improved access for psycho-social interventions. The extracts below illustrate some of these themes for tackling stigma:

'Reform psychiatry. Remove the labels on building — have multi-functional buildings, and remove the 'them and us' attitudes within services. The first impact is important — ensure the voice on the phone is friendly, supportive. We deserve better treatment than we are

currently getting — being fobbed off, never being able to get an appointment. Not being listened to. All this generates stigma'.

'Improve treatments. Fewer drugs, then people would have more energy to tackle the editor of the daily mail newspaper'

Discussion

The question of 'what works' in school to reduce the stigma of mental illness, is a question that we are a long way from being able to fully answer. A recent review of 'what works' to reduce stigma and discrimination involving the research team was recently published by the National Institute of Mental Health England (NIMHE, 2004). Six core principles were identified:

- (1) Users and carers (experts by experience) involved throughout the design, delivery monitoring and evaluation of the programme as seen in New Zealand (www.lmlm.govt.nz);
- (2) Programmes should be appropriately monitored and evaluated;
- (3) National programmes should be supported by local grass roots initiatives as seen in the WPA programme (www.openthedoors.com) and Scotland (www.seemescotland.org);
- (4) Programmes should address behaviour change with solutions that adopt both 'stick' and 'carrot' strategies (Sayce, 2003);
- (5) Clear specific messages delivered in targeted ways to identifiable audiences; and
- (6) Long-term planning and funding underpinning programme sustainability.

Many of the programmes — both local and national — have insufficient budgets to carry out rigorous evaluation studies to build an evidence base in this under-researched area. Although the academic research literature on stigma and discrimination is expanding, the stigma and discrimination problem continues to impact on the daily lives of people with mental health problems. The recent UK government inquiry on mental health identified stigma as the biggest barrier to social inclusion for people with mental health problems, stifling employment opportunities, social participation activities and recovery (Social Exclusion Unit, 2004).

From MHAA we have some indication that face-to-face contact with a person, who can talk about their experiences of mental illness, is a key factor in mental health awareness work with adult groups. Those taking part in the research reported that listening to people telling their personal stories using relevant situations to the audience were

extremely useful. For example school nurses heard from people who had developed mental health problems at school and police officers heard from service users who had contact with the police. Facilitators also felt that the strength of their approach was working with mental health service users as co-facilitators who could share personal experiences but equally importantly were part of the core presentation team rather than the token guest speaker. Alongside listening to experiences, however, participants need to develop the skills and confidence to work with people in distress. This aspect of the workshop programme needs further development including support in supervision and follow-up training sessions.

From our research, personal experience was an important factor predicting attitude change among young people. Personal experience seemed to affect young people's interest in mental health and subsequent engagement with the lessons. We also found that service user talks in schools did not impact on young people's attitude change scores, though feedback from these talks was positive. However, involving a person with mental health problems in school talks was less important than actually raising 'the issue' of mental health and mental illness (Pinfold et al., 2003b). As emphasized by Schulze et al. (2003b) in their summary of the WPA stigma-change schools project in Germany, adolescence is known as the beginning of young persons' concern for their own well-being and the development of a sense of personal identity. Attitudes of young people may be more responsive to stigma-change education and, at a time when they are developing views on a range of topics that will impact on future adult behaviour, it is vital that emotional well-being and mental illness is on the school learning agenda (Department of Health, 2001).

The evidence base for involving mental health service users at the heart of stigma and discrimination programmes is rapidly expanding (Alexander & Link, 2003; Corrigan et al., 2001a; Couture & Penn, 2003). However, the stigma problem is complex and current evidence suggests that programmes to address public fears, ignorance and prejudices must be multi-faceted, long-term, targeted and address behaviour change alongside raising mental health awareness. Developing a robust evidence base in future years will greatly assist our understanding of what aspects of personal contact and personal experience, and in what context, has greatest impact on stigma change, building on the seminal work of Allport (1954). Short educational workshop sessions can be only one part of a larger programme to address mental health stigma and discrimination.

Acknowledgements

We are pleased to acknowledge the contributions of Maidstone Mental Health Awareness Group and the Sevenoaks and Area Mental Health Awareness Group. In addition the following partners offered invaluable support to this programme: Lambeth Mental Health Promotion Unit, 'Beyond the Cuckoos Nest' Surrey, and 'Beyond the Cuckoos Nest' Brighton and Hove. This project was supported by an unrestricted educational grant from Lundbeck UK.

References

- Alexander, L., & Link, B. (2003). The impact of contact on stigmatising attitudes towards people with mental illness. *Journal of Mental Health, 12*(3), 271–289.
- Allport, G. W. (1954). *The nature of prejudice*. New York: Addison-Wesley.
- Angermeyer, M. C., & Matschinger, H. (1996). The effect of personal experience with mental illness on the attitude towards individuals suffering from mental illness. *Social Psychiatry and Psychiatric Epidemiology, 31*, 321–326.
- Angermeyer, M., & Schulze, B. (2001a). Reinforcing stereotypes: How the focus on forensic cases in news reporting may influence public attitudes towards the mentally ill. *International Journal of Law and Psychiatry, 24*, 469–486.
- Angermeyer, M., & Schulze, B. (2001b). Reducing the stigma of schizophrenia: Understanding the process and options for interventions. *Epidemiologia e Psichiatria Sociale, 10*, 1–7.
- Bailey, S. (1999). Young people, mental illness and stigmatisation. *Psychiatric Bulletin, 23*, 107–110.
- Bhugra, D. (1989). Attitudes towards mental illness. A review of the literature. *Acta Psychiatrica Scandinavica, 80*, 1–12.
- British Psychological Society (2000). *Recent advances in understanding mental illness and psychotic experiences*. London: BPS.
- Byrne, P. (2001). Psychiatric Stigma. *British Journal of Psychiatry, 178*, 281–284.
- Corrigan, P., & Lundin, R. (2000). *Don't call me nuts! Coping with the stigma of mental illness*. Chicago: Recovery Press.
- Corrigan, P., River, L., Lundin, R., Penn, D. L., Uphoff-Wasowski, K., & Campion, J., et al. (2001a). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*, 187–195.
- Corrigan, P., Green, A., Lundin, R., Kubiak, M., & Penn, D. L. (2001b). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services, 52*(7), 953–958.
- Corrigan, P., & Watson, A. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 19*(1), 16–20.
- Corrigan, P., Watson, A., & Ottati, V. (2003). From whence comes mental illness stigma? *International Journal of Social Psychiatry, 49*, 142–157.
- Corrigan, P. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behaviour, 44*, 162–179.
- Couture, S., & Penn, D. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health, 12*(3), 291–305.
- Crisp, A., Gelder, M., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4–7.
- Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In Gilbert, D., Fiske, S. T. & Lindzey, G. (Eds), *The handbook of social psychology*. Boston: McGraw-Hill: 504–553.
- Department of Health (1999). *National service frameworks for mental health: Modern standards and service models*. London: HMSO.
- Department of Health (2001). *Making it happen: A guide to developing mental health promotion*. London: Department of Health.
- Desforges, K., Lord, C., & Ransey, S. (1991). Effects of structured co-operative contact on changing negative attitudes towards stigmatised groups. *Journal of Personality and Social Psychology, 60*, 531–544.
- Guimon, J., Fischer, W., & Sartorius, N. (Eds) (1999). *The image of madness*. Basel: Karger.
- Haghighat, R. (2001). A unitary theory of stigmatisation: Pursuit of self interest and routes to destigmatisation. *British Journal of Psychiatry, 178*, 207–215.
- Hamburger, Y. (1994). The contact hypothesis reconsidered: Effects of the atypical outgroup member on the outgroup stereotype. *Basic and Applied Social Psychology, 1*, 339–358.
- Hayward, P., & Bright, J. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health, 6*(4), 435–454.
- Holmes, P., Corrigan, P., Williams, P., Canar, J., & Kubiak, M. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin, 25*(3), 447–456.
- Kaminski, P., & Harty, C. (1999). From stigma to strategy. *Nursing Standard, 13*(38), 36–40.
- Link, B. G. (2001). Stigma: Many mechanisms require multi-faceted responses. *Epidemiologia e Psichiatria Sociale, 10*, 8–11.
- Link, B. G., & Phelan, J. C. (2001). Conceptualising stigma. *American Sociological Review, 27*, 363–385.
- McKenzie, H. (2002). *An evaluation framework for mental illness anti-discrimination. Report prepared for the mental health commission (June 2002)*. Hamilton, New Zealand.
- National Institute of Mental Health England (2004). Scoping review on mental health anti-stigma and discrimination. www.nimhe.org.uk/antistigma/whatworks
- Penn, D. L., Guynan, K., Daily, T., Spaulding, W., Garbin, C., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin, 20*, 567–578.
- Philo, G. (1996). *Media and mental illness*. London: Longman.
- Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H., Graham, T., et al. (2003a). Reducing psychiatric stigma and discrimination: Evaluating an educational intervention with the police force in England. *Social Psychiatry Psychiatric Epidemiology, 38*, 337–344.
- Pinfold, V., Toulmin, H., Thornicroft, G., Huxley, P., Farmer, P., Graham, T., et al. (2003b). Reducing psychiatric stigma and discrimination: Evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry, 182*, 342–346.
- Pinfold, V. (2003c). *How can we make mental health education work? Example of a successful local mental health programme challenging stigma and discrimination*. London: Rethink Severe Mental Illness.
- Pinfold, V., Byrne, P., & Toulmin, H. (In press). Challenging stigma and discrimination in communities: A focus group study identifying UK mental health service users' main campaign priorities. *International Journal of Social Psychiatry*.
- Porter, R. (2002). *Madness: A brief history*. Oxford: Oxford University Press.
- Rabkin, J. (1974). Public attitudes toward mental illness: A review of the literature. *Schizophrenia Bulletin, 10*, 9–23.
- Rahman, A., Mubbashar, M. H., Gater, R., & Goldberg, D. (1998). Randomised trial of impact of school mental-health

- programme in rural Rawalpindi, Pakistan. *Lancet*, 352, 1022–1025.
- Read, J., & Law, A. (1999). The relationship of causal beliefs and contact with users of mental health services to attitudes to the 'mentally ill'. *International Journal of Social Psychiatry*, 45(3), 216–229.
- Rose, D. (1996). *Living in the community*. London: Sainsbury Centre for Mental Health.
- Royal College of Psychiatrists (2001). Mental illness: Stigmatisation and discrimination within the medical profession. *Council Report CR91*.
- Sayce, L. (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. Basingstoke: Palgrave Press.
- Sayce, L. (2003). Beyond good intentions: making anti-discrimination strategies work. *Disability & Society*, 18(5), 625–642.
- Schulze, B., & Angermeyer, M. (2003a). Subjective experiences of stigma: Schizophrenia patients, their relatives and mental health professionals. *Social Science and Medicine*, 56(2), 299–312.
- Schulze, B., Richter-Werling, M., & Matschinger, H. (2003b). Crazy? So What! Effects of a school project on students' attitudes towards people with schizophrenia. *Acta Psychiatrica Scandinavica*, 106, 1–9.
- Social Exclusion Unit (2004). *Mental health and social exclusion*. Office of the Deputy Prime Minister. London: HMSO.
- Taylor, M., & Dear, M. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, 7(2), 225–240.
- Thompson, A. H., Stuart, H., Bland, R. C., et al. (2002). Attitudes about schizophrenia from the pilot sites of the WPA worldwide campaign against the stigma of schizophrenia. *Social Psychiatry and Psychiatry Epidemiology*, 37, 475–482.
- Thornicroft, G., & Maingay, S. (2002). The global response to mental illness. *British Medical Journal*, 325, 608–609.
- Wahl, O. (1999). *Telling is risky business: Mental health consumers confront stigma*. New Brunswick: Rutgers University Press.
- Weiss, M. (1994). Children's attitude towards the mentally ill: An eight-year longitudinal follow-up. *Psychological Reports*, 74, 51–56.
- Wilson, C., Nairn, R., Coverdale, J., & Panapa, A. (2000). How mental illness is portrayed in children's television. *British Journal of Psychiatry*, 176, 440–443.
- Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996). Public education for community care: A new approach. *British Journal of Psychiatry*, 168, 441–447.
- World Health Organisation (2001). *World Health Report 2001. Mental health: New understanding, new hope*. Geneva: World Health Organization.
- World Psychiatric Association (2000). *The WPA programme to reduce stigma and discrimination because of schizophrenia* [Vol. 1–5]. WPA: Geneva.