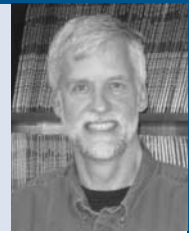## Editorial

Research and the elimination of the stigma of mental illness†

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Summary

Video-based and *in vivo* (face-to-face) contact have been shown to be effective ways to change stigmatising attitudes and behaviours. The two approaches reflect the strengths and weakness of sometimes conflicting priorities in anti-stigma programmes: broad audience *v.* grassroots control. Regardless of perspective, anti-stigma interventions have the greatest impact when contact is targeted, local, credible and continuous.

Declaration of interest

None.

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Stigma strikes like the Lernaean hydra of myth, a multiheaded serpent capable of attack and injury from many directions. Stigma robs people with mental illness of rightful opportunities in work, education, housing and healthcare. It leads to institutionalisation and coercion where empowerment and recovery are required. It promotes internalised prejudice and why try reactions: 'why should I try to live on my own; I am not competent!'. It creates structural inequities, for example government systems that fail to provide appropriate supports for mental health services. For these reasons, stigma is a major target of advocates who embrace strategies meant to eliminate its pernicious influence on society. Governments in most Western countries have joined with these groups to institute broad-based anti-stigma programmes. Australia rolled out Beyond Blue more than a decade ago with the UK joining the fray a few years later with Time to Change. The USA, Canada, and most member nations of the European Union have similar active programmes. Like many public health priorities, the zeal to rectify the problem sometimes gets ahead of the research examining the strategic impact. Fortunately, researchers are partnering with advocates to examine the impact of anti-stigma strategies, in the process yielding a portfolio of studies that begins to shed light on effective *v.* ineffective approaches to stigma change. The paper by Clement and colleagues (this issue) provides a nice example of a well-crafted investigation of approaches to eliminating stigma.[1]

Clement *et al* used experimental methods to contrast the effects of two contact-based approaches to changing stigma in the public with that of education;[1] by contact we mean anti-stigma programmes that rely on planned interactions between people with mental illness and the public. The two contact strategies were: (a) a film-based intervention where viewers observed a group of service users and carers telling their stories of illness and recovery and (b) the same kind of narrative but with users and carers live and engaged in the setting (an *in vivo* strategy). Findings were compelling, for example the investigators showed both contact conditions yielded significantly better effects on attitudes about mental illness compared with education. Mostly, no difference was found between film-based and *in vivo*

†See pp. 57–64, this issue.

conditions. These findings join a burgeoning collection of research on stigma change strategies. A recently completed meta-analysis uncovered 79 studies that examined anti-stigma programmes yielding more than 600 effect sizes.[2] Two results were especially relevant: consistent with Clements *et al*, contact yields significantly greater effects on attitudes and behavioural intentions than education. However, different from the findings of Clement and colleagues, *in vivo* contact seems to have a greater impact than video-based approaches.

In vivo v. media-based approaches to stigma change

Clement *et al*[1] juxtapose two important agendas in stigma-change programmes: broad audience *v.* grassroots control. Videotaped contact has the potential for a broad audience: disseminating the video via a variety of online platforms and television networks exponentially increases exposure of the anti-stigma effort compared with face-to-face approaches. Pursuit of a broad audience widens the domain of outcome assessment beyond a direct impact (how does the stigma-change programme diminish stigmatising attitudes and discriminatory behaviours?) to notions of market penetration (what percentage of a population is aware of and can recall an anti-stigma message?). The inherent strength of broad audience approaches is that they can have an impact on a sizeable proportion of a population, something much harder to achieve when using *in vivo* approaches. Video-based approaches can be distributed across networks or internet platforms with a conceivable impact on vast audiences. Distribution, however, is not sufficient. Viewers need to attend to the message and subsequently recall it for it to have an impact. This can be a difficult achievement in a media universe where the population is bombarded with public service messages. Effects can be further muted by the passive and seemingly repetitive nature of some social marketing approaches. Social networking sites like Facebook may promote the kind of active interaction that can enhance anti-stigma effects: discussion boards or the viral spread of anti-stigma messages among one's friends network may augment the anti-stigma message. Still, social marketing critics are concerned about the potential of 'slackeracy', a kind of slack advocacy that happens from mindlessly endorsing a position on a webpage (like a pink ribbon in solidarity with people with breast cancer) that does not lead to any meaningful action for the cause.

The use of a broad audience focus has been criticised as undermining grassroots control, i.e. the kind of resources needed

to produce social marketing campaigns are typically provided by governments or large non-governmental organisations partnered with advertising consortia. Government control centralises the effort and distances it from the mass of people with mental illness who are directly harmed by stigma, those likely to own the cause after a specific campaign runs its course. These large campaigns can be hijacked by government processes and agendas that lack the kind of flexibility needed to bring real change at the local level. Does this mean governments have no role in stigma change? After all, governments have been known to be potent forces for social justice. Opening Minds by the Canadian Mental Health Commission may have got it right. They built their programme on more than 75 user-based programmes distributed across the country's ten provinces and three territories.

Principles that promote a change in attitudes

Whether it be a broad audience or a grassroots focus, there are five principles that promote strategic stigma change defined by the acronym TLC3: targeted, local, credible, continuous contact.[3]

Contact with people with mental illness is fundamental to public stigma change

Several factors enhance contact and are incorporated into the remaining four strategic stigma-change principles.

Contact needs to be targeted

Rather than focusing on the population as a whole, contact is more effective when targeting key groups, typically people in positions of power like employers, landlords, healthcare providers, legislators, and media outlets. Targeting stigma not only suggests the 'who' of strategic contact but also the corresponding 'what'; what needs to be changed. These are affirming behaviours that seek to increase employer hires and landlord leases and the provision of quality health services to people with mental illness.

Local contact programmes are more effective

'Local' has several meanings but may include geopolitical and diversity factors. It seems reasonable, for example, to believe that target-group interests are shared within geographical regions, such as the UK or more narrowly within a country like Wales. Still Wales is more homogeneous than other UK nations, and surely more so than the diversity of the European Union where rural, urban, and suburban considerations may vary greatly. Sociopolitical factors within more narrowly defined areas are also important. Large cities will include neighbourhoods of differing socio-economic status that are likely to influence target-group interests; for example, employers in impoverished parts of a city will require different contact than peers located in wealthy suburbs. In addition, rural and urban resources differ calling for distinct contact programmes. Given research on health and healthcare disparities, consideration of ethnicity and religious background is additionally important for crafting local programmes.

Contacts must be credible

The contact person should be similar to the target. This could mean employers, landlords, healthcare providers and police officers with mental illness present to other employers, landlords, healthcare providers and police officers. A message in addition to 'people with mental illness recover!' needs to be provided by a member of the target group; 'The person in recovery can be successful'. For example, employers should tell peers that the person will be a good worker. Contact 'partnerships' are a good solution, combining consumers with representatives of the target group; think of the compelling civic group meeting where a person with mental illness talks about her recovery followed by the boss who discusses the success resulting from having hired her.

Contact must be continuous

One-time contact may have some positive effects but these are likely to be fleeting. Contact must occur multiple times with the quality of contact varying over time. This calls for different consumer and target partners, messages, venues and opportunities. It also reminds advocates that stigma change is not easily accomplished and requires not only ongoing efforts, but continual quality assessment of those efforts. Partnership with skilled investigators like Clement et al helps achieve this goal. Continuous and local priorities also call for participatory action research, investigations that are equally directed by advocates and researchers.

As advocates continue to partner with social marketers in order to erase the stigma of mental illness, they must continue to discern what works, from what does not, from what might actually result in unintended consequences. Many advocates wish to 'educate away' our problems, a principle that is largely not borne out by research. Face-to-face interchange with people with lived experience is essential. As we seek to disseminate these approaches to populations, we need to balance the benefits of media-based approaches with the strengths of grassroots interventions. Careful and rigorous research like that conducted by Clement and colleagues is a model for continued efforts in this regard.

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Acknowledgement

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