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Editorial

Evaluation of the Time to Change programme in England 2008–2011

Claire Henderson and Graham Thornicroft

Summary
Time to Change (TTC) is the largest-ever programme in England designed to reduce stigma and discrimination against people with mental health disorders. The TTC evaluation partner is the Institute of Psychiatry at King's College London. We give an overview of the TTC programme 2007–2011 and describe how it was evaluated, by introducing the seven interrelated papers in this supplement, which, taken together, describe a complex series of social interventions using a research design of hitherto unparalleled detail and comprehensiveness.

Declaration of Interest
G.T. has received grants for stigma-related research in the past 5 years from Lundbeck UK and from the National Institute for Health Research, and has acted as a consultant to the UK Office of the Chief Scientist.

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Time to Change (TTC) is the largest-ever programme in England designed to reduce stigma and discrimination against people with mental health disorders (http://www.time-to-change.org.uk/).[1] The first phase of this initiative was run by three charities: Mental Health Media, Mind and Rethink Mental Illness. It was funded in the first phase with £16 million from the Big Lottery Fund and £4.5 million from Comic Relief. The programme has also benefited from the secondment of two members of staff from the Department of Health to work on stakeholder management and policy. The Department of Health also funded the annual national Attitudes to Mental Illness survey.[2] The programme went on to run two sports-related programmes: the Sport and Mental Health Project (funded by the Department of Health with £83 000) and Imagine Your Goals (funded by Sport Relief and the Premier League with £620 000).

Evaluation of the Time To Change programme

The outcomes set by the Time To Change programme were:

(a) significantly increased public awareness of mental health (an estimated 30 million English adults would be reached), a 5% positive shift in public attitudes towards mental health problems and a 5% reduction in discrimination by 2012;

(b) 100 000 people with mental health problems to have increased knowledge, confidence and assertiveness to challenge discrimination by 2012;

(c) provision, through physical activity, of greater opportunities for 274 500 people with a range of mental health problems to come together, both to break down discrimination and to improve well-being, by 2012.

Time To Change was aimed both at the general population and at specific target groups (identified by people with experience of mental health problems) as well as at people with mental health problems themselves. To maximise its reach – and thus its value for money – it engaged individuals, communities and stakeholder organisations such as statutory health services and professional membership groups in distributing social marketing campaign materials, collaborating in staging public relations events and holding events to promote social contact between people with and without experience of mental health problems.[3–10]

Evaluation of the TTC programme was based on a conceptual framework that understands stigma as consisting of difficulties of knowledge (ignorance or misinformation), attitudes (prejudice) and behaviour (discrimination).[1,11] Changes in public attitudes were measured every year from 2008 to 2012 using the Department of Health's national Attitudes to Mental Illness general population survey in England.[2,12] Since its inception the survey has used a shortened list of items from the Community Attitudes toward the Mentally Ill (CAMI) scale and the Opinions about Mental Illness Scale,[13,14] providing data on attitudes from 1993. In collaboration with SHiFT, which commissioned this survey between 2008 and 2011, we also developed and from 2009 added the Mental Health Knowledge Schedule (MAKS) and the Reported and Intended Behaviour Scale (RIBS) to the pre-existing attitude questions,[15,16] in line with our conceptual model.

To assess progress towards the target of a 5% reduction in discrimination we conducted an annual survey from 2008 to 2011 of discrimination as experienced by people using mental health services across England ('Viewpoint'),[17,18] using the Discrimination and Stigma Scale.[19] The results are reported by Corker *et al* (this supplement).[20]Any impact of the social marketing campaign (budget £8 311 066) was likely to be influenced by concurrent reporting on mental health-related topics in the mass media.[21] The nature and balance of media coverage are of concern to anti-stigma campaigns internationally,[22,23] leading to increasing interest in methods of content analysis.[24] Analyses of English press coverage are presented by Thornicroft *et al* (this supplement).[25]

Employers were a specific target for stakeholder engagement, and were intended users of the Time to Challenge online resource (budget £196 049), which explained good practice in the field of employment and mental health, and the rights of employees with mental health problems. Henderson *et al* (this supplement) report evidence of changes in employers' knowledge, attitudes and practice in this field,[26] from the repeated survey in 2009 and 2010 of a survey originally undertaken by the Shaw Trust in 2006.[27,28]

Two aspects of the social marketing campaign are reported by Evans-Lacko *et al* (this supplement).[29] First, the national TTC

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social marketing campaign used bursts of mass media advertising and public relations exercises twice a year from 2009 to 2011. The key messages of the first two bursts addressed knowledge important in reducing stigma, i.e. that mental illnesses are common and that people with such disorders can lead meaningful lives. Bursts three and four addressed prejudicial attitudes, i.e. mental illness is our last taboo, such that the accompanying discrimination and exclusion can affect people in a way that many describe as 'worse than the illness itself'. The last two campaign bursts addressed behaviour change; i.e. we can all do something to help people with mental illness, such as maintaining social contact. Selected knowledge, attitudes and behaviour questions from the three measures used in the Attitudes to Mental Illness survey were used to evaluate the impact of each burst on the pre-identified targeted demographic group of people aged 25–45 years in middle-income groups, and this showed a positive impact on those aware of the campaign for five of the six bursts. Second, a strikingly original component of TTC involved the attendance of large numbers of people with experience of mental health problems at a series of one-day events designed to deliver social contact, addressing the second and third TTC targets (budget £1 077 214). Although the evidence for social contact in reducing prejudice towards people with mental health problems largely concerned its short-term impact,[9,30] these events also increased awareness of the social marketing campaign, and together this may have created a cumulative and more sustained effect. Our data suggest a positive relationship between the quality of social contact and a reduction in prejudice (both of improved attitudes and greater confidence to tackle stigma). Time to Change similarly delivered social contact through other programme components; 32 small-scale anti-discrimination initiatives ('Open Up', budget £1 407 243) aimed to empower people through awareness-raising and confidence-building groups and anti- discrimination projects, many of which involved the use of the creative arts. Another set of projects comprised exercise programmes for people with mental health problems in community leisure facilities delivered by local Rethink and Mind associations (budget £4 431 705).

For specific target groups (medical students, trainee teachers, trainee head teachers and social inclusion officers), the Education Not Discrimination (END) component of TTC again used social contact (budget £1 310 201).[9,10,31] Friedrich *et al* (this supplement) described the effect of END on the knowledge, attitudes and intended behaviour of medical students at four English medical schools.[32] We present the results for this target group only because it is of greatest interest to this journal's readership and because we were able to include a control group in the design, which was not the case for the other groups. The results suggest initial positive effects that were no longer present at the 6-month follow-up assessment.

It is vital that this investment has clear national economic benefits,[33,34] and so an economic evaluation was applied to most of the TTC components. In view of the high advertising costs of social marketing, Evans-Lacko *et al* (this supplement) present the results of an evaluation of the TTC social marketing campaign costs in relation to outcomes.[35] This applied an innovative model,[36] in conjunction with social marketing campaign evaluation data, to investigate the economic impact of the campaign, including the potential effects on the wider economy.

Strengths and limitations of the evaluation

One wholly innovative aspect of the TTC programme is its annual measurement of discriminatory experiences on the part of those using mental health services, rather than evaluating only public knowledge and/or attitudes.[37–39] Economic analyses have been lacking in previous campaign evaluations and analysis of changes in press coverage over time has been more limited.[22] The evaluation is thus relatively comprehensive, as well as informed by the involvement of people using mental health services in the development and administration of new measures.[15–17]

The main limitation of this evaluation was the inability to determine the exact contribution of TTC to the changes reported in annual survey results compared with other influences on public attitudes and behaviour, newspaper coverage and employers, owing to the lack of a control population.[2,20,25,26] Nevertheless, it is possible to be fairly confident that pre-burst to post-burst changes seen for the anti-stigma campaign bursts were due to the programme *per se*.[29] Further, the Viewpoint study suffered from low response rates.[20] However, after weighted analysis of the Viewpoint samples to take account of the overrepresentation of participants of White ethnicity, female gender and older age the main findings were unaffected.

Implications of the results

Among our assessments of knowledge, attitudes and behaviour, the most marked change between 2008 and 2011 was the significant overall reduction in the levels of experienced discrimination reported by people using mental health services.[20] This survey is the first of its kind so we cannot compare these findings with previous research. However, the results are in clear contrast to the lack of improvement in public attitudes found in England, Scotland and the USA during the previous 10–15 years.[12,40]

After the positive change between 2008 and 2010 there was a negative shift both in public attitudes and in some Viewpoint items.[2,20] The contemporaneous national economic problems might have exacerbated inequality in access to employment for people with mental health problems,[41] despite and/or since the improvements found in the survey of employers between 2006 and 2010.[26] There is also evidence that hostile and stigmatising behaviour towards groups with other disabilities has increased since 2010, for example towards people with cerebral palsy (http://www.scope.org.uk/news/attitudes-survey). This hostility might also affect people with mental health problems.[42] However, although reported discrimination in terms of safety, benefits and transport appears to have increased, these increases are not significant after allowing for multiple testing of Viewpoint items.

The patterns of changes in the Viewpoint items, taken with the positive effect of social contact on outcomes among the campaign target group, suggest that reducing stigma and discrimination might depend increasingly on more social contact, which should be explored in future work. Newspaper coverage changes also suggest such a polarisation, in that fewer articles in 2012 were neutral compared with 2008.[25] Journalists and editors may themselves have become more polarised and/or be catering for more polarised attitudes in their readership. These findings raise a key question for phase 2 of TTC: that is, whether individuals with lived experience of mental illness and those close to them can, through greater disclosure, contribute to higher levels of social contact at the population level with those with mental health problems, thus reducing public stigma. The results presented by Evans-Lacko *et al* (this supplement),[2] concerning greater levels of reported contact among the respondents of the Attitudes to Mental Illness survey, offer some support for this view.[7]

The lack of change in levels of experienced discrimination from health professionals among Viewpoint participants is of concern;[20] whereas initial help-seeking for mental health problems might

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increase if public attitudes and behaviours improved, a lack of reduction in the rate of negative experiences with health professionals might deter people from seeking further help. It may be that the campaign lacked market penetration among health professionals, or that the 'clinical fallacy' means their attitudes and behaviour are more resistant to change, i.e. the accumulated experience of staff is that they most often see people with the worst course and outcome. Medical students are also exposed to this bias, which may mitigate the impact of END.[32] In contrast with this finding, evaluation of the TTC programme components was on the whole positive, including the economic evaluation.[29,35]

Stigma and discrimination against people with mental illness are global challenges,[19,43] and the evidence of our evaluation of phase 1 of TTC is that they can be successfully tackled with a focused, determined and long-term approach.[44] With this *British Journal of Psychiatry* supplement we intend to communicate the results of the first phase (2008–2011) of the TTC programme to those who need to know how to intervene most effectively for the greater social inclusion of people with mental health problems worldwide.

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