

Workplace interventions can reduce stigma

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Stigma and discrimination towards people with mental health problems is a global issue, imposing a considerable public health burden in terms of social isolation, limited life chances, delayed help-seeking behaviour and stress. While numerous initiatives have been undertaken to address these issues, an evidence base for what works is still emerging. This paper explores the impact of 15 population-level awareness workshops delivered over a five-month period to 137 participants. These were employees drawn from workplaces identified as being important in the day-to-day lives of people with mental health problems. Evaluation approaches maximised specificity, sensitivity and anonymity and they assessed participant knowledge, attitude and behaviour. The workshops significantly improved participant knowledge. Attitude change was more complex with an overall significant improvement in attitudes, particularly in relation to unpredictability and recovery, but not dangerousness, which had more positive baseline attitudes. Social distance, a proxy for behavioural intent, had significant improvements in relation to 'moderate' social contact only. Qualitative feedback indicated that complex, unanticipated and positive messages had been absorbed by participants and influenced beliefs and behavioural intent. Service user narratives focusing on recovery were identified as the most valuable component of the intervention.

ANALYSIS

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The World Health Organization (2001) has estimated that one in four people will experience mental health problems at some point in their lifetime. The associated stigma and discrimination can lead to social isolation (Farina & Saul, 1968; Link *et al*, 1989), low self-esteem (Wright *et al*, 2000), and limited life chances in areas such as employment and housing (Link, 1982; Rosenfield, 1997). Further, there is evidence to suggest that stigma is also linked to delayed help-seeking behaviour (Link *et al*, 1997; Schomerus & Angermeyer, 2008). These negative outcomes are often interrelated and exacerbate people's mental health difficulties. Link and Phelan (2006) outline how people often experience high levels of stress as they live with the constant threat of being stigmatised.

Stigma and discrimination

Goffman (1963) describes stigma as an 'attribute that is deeply discrediting'. Link and Phelan (2001) more closely define stigma as the co-occurrence and

interrelatedness of five components: labelling, stereotyping, separation, discrimination and status loss. This process is mediated by power and influenced by cultural, social and environmental factors. This leads to the discrimination and inequalities associated with stigma (Corrigan *et al*, 2004). Various attitudinal studies have shown that stigma towards people with mental health problems is widespread (Byrne, 1997; Link *et al*, 1997; Jorm *et al*, 1999; Crisp *et al*, 2000) and includes benevolence, authoritarianism, fear, and perceptions of dangerousness (Brockington *et al*, 1993). We also find evidence of significant public discrimination. Individuals with mental health problems have been found to experience harassment in the workplace and community (Read & Baker 1996; Berzins *et al*, 2003).

What works in addressing stigma and discrimination?

Historical, structural discrimination has been challenged in many countries through legislation, mental health service reforms and affirmatory

action, often supplemented by public awareness programmes. Several authors have identified interventions that can be successful: Link and Phelan (2001), Penn and Martin (1998), Gale *et al*, (2004), and Corrigan *et al* (2007) provide a particularly valuable framework for analysing interventions at a population level, framing interventions as protest, education and contact.

Protesting against injustice through campaigns or media lobbying is resource intensive. It may serve to strengthen a sense of community among those discriminated against. However, its effectiveness among the wider population is very difficult to assess, and there is some indication of negative reactions (Penn & Corrigan, 2002), plus UK national campaigns have had limited success in changing media reporting trends (Knifton & Quinn, 2008).

Education interventions can be effective when messages are carefully targeted to key groups and use social models of mental health, framing symptoms as responses to circumstances rather than bio-medical education, which risks reinforcing pre-existing bias concerning capability and dangerousness (Read & Law, 1999; Byrne, 2000; Corrigan *et al*, 2001). Education interventions seem to be particularly promising when they are combined with positive personal contact, narratives or dialogue between the public and people who have experienced mental health problems (Pinfold *et al*, 2005; Quinn & Knifton, 2005). However, the evidence in this area requires strengthening and evaluations are often short term and focus on attitudes rather than behaviour change. It is not clear whether impact is due to emotional engagement, dispelling myths, or making educational messages more convincing.

Anti-stigma programmes

There are currently a number of international programmes in place to tackle psychiatric stigma (World Health Organization, 2001). Within Scotland, a national campaign that uses different approaches such as media lobbying, protest, and public awareness through targeted national campaigns including media, advertising and print, has been supplemented by regional approaches that focus on empowerment and partnerships of organisations who deliver face-to-face learning workshops, which have evaluated well (Quinn & Knifton, 2005). However, evaluations have relied on self-reported benefits that are subject to significant researcher effect and lack specificity in terms of forms of stigma and differences according to the nature of the mental health problem. A small number of studies have attempted to undertake

more structured approaches to evaluating the impact of short-term interventions on participant knowledge and attitudes. Pinfold *et al* (2005) investigated the effectiveness of mental health training interventions using pre- and post-training questionnaires to assess changes in attitude. While the design did not detect particularly negative attitudes at baseline, the results did indicate that there had been positive changes in attitudes post-training.

The complexities of evaluating attitudes

The relationship between knowledge and attitudes towards mental health problems is unclear. At a population level, we can identify correlations between greater knowledge and negative attitudes (Phillips, 1966), high rejection in affluent areas (Taylor & Dear, 1981), and greater fear and social distance among young, high income, educated groups (Wolff *et al*, 1996). However, these studies are mainly based on correlations rather than changes in response to targeted interventions, where knowledge gain may occur alongside other factors such as emotional engagement. This suggests that interventions aimed at tackling stigma should assess participant knowledge pre- and post-intervention to understand the importance of baseline knowledge on impact, and also the relationship between knowledge gain and attitudes. In addition, the components of stigma (such as dangerousness, blame and recovery) should be assessed independently as the relationships between these are complex. All measures of attitude are susceptible to social bias, and we also cannot assume that they generalise. There is also the problem that attitudes are vulnerable to change depending on the latest bad news item, despite training.

Method

The evidence presented in the review suggests that education and positive contact are the most effective components of anti-stigma programmes (Corrigan *et al*, 2007). Workshops provided an opportunity to combine these two elements in a structured intervention, which is both low-cost and has the potential to be scaled up to a population level. Social explanations of mental health, which challenge stereotypes and reframe mental health problems as a response to circumstances, show most promise in addressing stigma and informed the content of the workshops that were delivered. In order to have meaningful positive contact, service users were involved as trainers and as delivering personal narratives.

Workshop design

The workshop utilised a combination of service user narratives, experiential group learning, and didactic teaching approaches. The workshop was six hours and was divided into sections covering the following: mental health; mental health problems; stigma/public attitudes; recovery; personal narrative; responding to the DDA within the workplace; and how to support someone with mental health problems. The core purpose of this intervention was to increase knowledge of mental health and mental health problems, to promote positive attitudes and challenge negative stereotypes, and to create positive behavioural intent among targeted audiences. A consortium of organisations with different skills and values seconded staff drawn from various backgrounds to form a team who developed and designed workshops.

Service user involvement and narratives

Service users were involved as trainers and delivered personal narratives about their experience in relation to stigma and recovery. Service user trainers, who were chosen because they had existing experience of training, were identified by the different mental health organisations, who took into account support needs before and after the training. This was done to promote equality and there is evidence that this can be an empowering process (Quinn & Knifton, 2005). In addition, there is evidence that positive personal contact and dialogue between service users and the public is effective. It may be that this is due more to identification with the person involved than the content of the narrative. It is not possible to eliminate variables in training interventions, due to variation in trainers and participants. In this situation, narratives add another variable that need to be considered.

Sample

This study involved 137 participants across 15 workshops, taking place over a five-month period. Participants were drawn from workplaces that are of particular importance to people who experience mental health problems, who service users had identified in a needs assessment as being people with whom they came into frequent contact. The workshops targeted benefits, housing, employment and voluntary sector agencies. This group is not intended to be representative of the wider population. Indeed, there is some evidence that staff working with people with mental health problems may have more negative attitudes (Jorm *et al*, 1999),

and therefore, attitudes will be assessed before and after the intervention.

Evaluation design

This intervention is only one part of a much wider range of influences on participants, and we needed to take into account further factors, including the possibility that an intervention may have a contradictory impact on participant attitudes (that positive changes to one aspect of stigma, for example, dangerousness or social control may be accompanied by more negative attitudes such as pessimism about recovery) and the significance of social desirability effects. The challenge was to balance sensitivity, specificity and anonymity with the demand of being robust and simple enough to use in real-life situations. This meant triangulating different sources of evidence about changes in knowledge, attitudes and behaviour, incorporating a combination of structured questionnaires using scales and vignettes to provide specific and anonymous information, and semi-structured feedback to provide richer information and identify unplanned impact.

The study employed a pre- and post-questionnaire design to evaluate the effectiveness of the intervention. Participants received a baseline questionnaire prior to the training, and a follow-up questionnaire was sent back to the researcher in a stamped addressed envelope one week after the training. A questionnaire was chosen as the most effective way to minimise social desirability bias. It also allowed us to assess specific components of stigma that may not emerge in qualitative research and provide a standardisation that allows us to measure short-term change in attitudes among participants. Participants were not asked about the current national anti-stigma 'See Me' campaign, to further guard against social desirability bias, although you cannot ignore the possibility that participants may have been influenced by this campaign. Other approaches may yield richer data and provide opportunity for clarification, but since this context was more subject to researcher effect, the questionnaire was administered by a researcher who was not part of the training team. A short-term reference group was formed to review the questionnaire and to make suggestions for improvement, clarity for public use, and to review the language used. In addition, an anonymous, semi-structured questionnaire was employed immediately after the intervention to explore what participants felt about the intervention content, delivery approaches and perceived impact.

Measures

Pre- and post workshop questionnaires gathered information on participant socio-demographics, experience of mental health problems through a modified version of 'Level of Familiarity Questionnaire' (Holmes *et al*, 1999), mental health knowledge, attitudes, and behavioural intent.

The questionnaire was drawn from a range of sources. The attitudes section covered participants' views on the causality of depression and schizophrenia adapted from the Scottish Public Attitudes Survey (Braunholtz *et al*, 2004), and attitudes regarding recovery, dangerousness, and unpredictability. Items included: '*People who have recovered from mental illness may find returning to work too stressful*'. There are 10 attitude items in total; some were adapted from the Opinions about Mental Illness (OMI) scale of Cohen and Struening (1962) and others were developed by the local reference group. In addition, there were also five items looking at social distance, and these were used as a measure of behavioural intent, for example, '*I would feel comfortable moving next door to a person with mental health problems*'. All items were measured on a seven-point Likert scale, rated from 1 ('disagree') to 7 ('agree').

Analysis

To measure whether there were any significant differences between attitude scores pre- and post-training, paired-comparison t-tests were used. To ascertain whether there was any relationship between demographics and attitude scores, analysis of variance (ANOVA) was employed. Statistical analyses were performed using the Statistical Package for Social Sciences (SPSS). The qualitative feedback forms were analysed as a whole group and each statement was noted separately. The items were then grouped into common categories and themes. We employed a frame of reference against which to consider and analyse these responses comprising perceived knowledge change, attitudinal change, and behavioural intent.

Results

Sample characteristics and response rate

Baseline questionnaires were completed by 137 of the participants, and follow-up data at one week was collected from 63 participants (47%). **Table 1** shows that females comprised over 70% of the sample. The majority of participants were aged 45 to 54 years, next frequent was 35 to 44 years, and then 25 to 34 years. Participants had varied levels of education: 20% reported having standard grade level, but most

had continued their education to gain Highers, a HNC or a degree. Participants were most likely to earn between £10,400 and £26,000. Participants' reported experience of mental health problems ranged from those who had experienced difficulties themselves or a family member or friend who had experienced difficulties (both 29%), to those who had only seen a person with mental health problems being depicted through film or television (4%).

Comparisons of baseline data did not reveal any significant differences between participants who completed the follow-up questionnaire and those who did not with regards to demographics, however, at baseline, those who had experienced mental health problems (29%) accounted for 38% of the paired data, indicating that those who have experienced mental health problems were more likely to complete follow-up questionnaires. General attitudes and social distance ratings did not reveal any significant differences between participants who completed the follow-up questionnaire and those who did not (**Table 1**). Full participant data is available from the authors.

Impact

All the data analysis concerning impact of workshops presented in this paper is based on the paired data set and the evaluation feedback forms.

Raising awareness and improving knowledge

A comparison of the paired data showed that, overall, participants' knowledge of mental health problems had significantly increased from 72% to 85%. Analysis of variance did not indicate that there was any significant relationship between education and knowledge pre- or post-training.

Causality

The evaluation explores participants' attitudes regarding the causality of both depression and schizophrenia. At baseline, the participants identified the main causes of depression as being due to someone's personality, and a chemical imbalance in the brain, and the least likely cause as being the person's own fault. These results are slightly different to those published in the Scottish Public Attitudes Survey (Braunholtz *et al*, 2004), who reported stress as being a significant cause. Post-training, participants were more likely to believe that '*the way someone was brought up*' and genetics may play a role. However, they were slightly less likely to feel that a chemical imbalance and stress were causes.

At baseline, the participants identified the main causes of schizophrenia as being a chemical

Table 1: Baseline and impact Likert scale scores for recovery, dangerousness, unpredictability and social distance

Mean participant scores – paired data	Baseline	Post	P-Value (significance)
People who have recovered from mental illness may find returning to work too stressful	3.9	3.94	0.904 negative increase, not significant
It is possible to recognise someone who has a mental illness	2.69	2.85	0.486 negative increase, not significant
It is possible to have a mental health problem and lead a meaningful life	2.15	1.63	0.032 positive decline, significant
People who have experienced a mental illness could struggle to cope with bringing up children	3.78	3.41	0.13 positive decline, not significant
I would feel unsafe around a person with a mental health problem	2.79	2.57	0.343 positive decline, not significant
People who have had treatment for mental health problems are more dangerous	1.89	1.75	0.459 positive decline, not significant
People with mental health problems are unsafe, unless they have taken their medication	3.02	2.71	0.148 positive decline, not significant
People with mental health problems let their emotions control them	3.59	3.38	0.409 positive decline, not significant
I would feel uncomfortable allowing a person with a history of mental health problems to look after my child	4.75	4.08	0.003 positive decline, significant
People with mental health problems are more unpredictable	4.08	3.57	0.022 positive decline, significant
I would feel comfortable moving next door to a person with mental health problems.	4.27	4.73	0.056 positive increase, not significant
I would spend an evening socialising with a person with mental health problems.	5.24	5.79	0.013 positive increase, significant
I would make friends with a person with mental health problems	5.48	5.54	0.766 positive increase, not significant
I would feel comfortable with a person with mental health problems marry into the family	4.59	4.41	0.396 negative decrease, not significant
I would feel comfortable working closely with a person with mental health problems	5.06	5.29	0.366 positive increase, not significant

imbalance and stress, which is in line with the Scottish Public Attitudes Survey (Braunholtz *et al*, 2004). Again, the participants did not feel that a likely cause was the person's own fault. A comparison of baseline and follow-up data showed that participants were less likely to feel that schizophrenia was caused by a chemical imbalance, however they were more likely to think that it was caused by stress and 'the way someone was brought up'.

Challenging negative stereotypes

An essential part of the evaluation was to assess the impact of training on participants' attitudes. The evaluation looked at participant attitudes towards

recovery, dangerousness and unpredictability, all scored on a scale of one to seven (low score = positive attitude, high score = negative attitude).

At baseline, participants displayed a range of attitudes; mean rating across all attitudes (recovery, dangerousness and unpredictability) was 3.20. There were no significant differences between male and female attitude scores at baseline ($p=0.06$), nor at follow-up ($p=0.07$), however there was a trend in the data indicating less variability, and more positive and negative outliers in the female data.

Analysis of variance did not reveal that education ($p=0.44$) or income ($p=0.52$) was a significant predictor of attitudes at baseline, nor at follow-up; education ($p=0.42$); income ($p=0.09$).

There was no significant difference in baseline attitudes between participants who had and had not experienced mental health problems ($p=0.257$), similarly there was no significant difference between attitudes at follow-up ($p=0.945$).

Overall attitudes

At follow-up, overall attitudes (recovery, dangerousness, unpredictability) showed a significant improvement from 3.20 to 2.98 (sd 0.71) $t=3.12$, $p=0.003$. There were not an equal number of questions for each of the three themes, however, when the means for each of these three themes are combined, pre and post, the overall improvement remains significant from 3.27 to 3.00 (sd 0.10) $t=1.97$, $p=0.05$.

Attitudinal themes

Analysis of means at baseline showed considerable differences between the individual attitudinal themes. Overall, dangerousness was rated as having the least amount of stigma (mean 2.566), then recovery (mean 3.118), and finally unpredictability (mean 4.138). Further analysis of attitudinal themes using paired t-tests revealed a significant positive change in the unpredictability mean post-training (to 3.677, $p=0.002$), and positive shifts in the recovery mean (to 2.989, $p=0.27$) and dangerousness mean (to 2.344, $p=0.79$), with the latter two not significant as overall themes.

Individual recovery, dangerousness and unpredictability items

Paired t-tests comparing the difference between baseline and follow-up scores on individual items revealed that three items showed significant positive change post-training. Scores on the item 'People with mental health problems are more unpredictable' had significantly changed ($p=0.022$), indicating a positive shift in attitude. Further, the item 'I would feel uncomfortable allowing a person with a history of mental health problems to look after my child', also significant showed positive change in attitude ($p=0.003$). There was also significant ($p=0.032$) positive improvement in the belief that 'It is possible to have a mental health problem and lead a meaningful life'.

Of the remaining seven items, five showed a positive shift and two a negative shift post-training. The only negative shifts related to recovery items, for example, finding work too stressful, and were very small and not significant. All unpredictability and dangerousness items were positive shifts.

Social distance/behavioural intent

At baseline, the data revealed that participants expressed the greatest social distance in relation to someone with mental health problems 'moving next door', and 'marrying into the family'. Comparison of pre and post data did not indicate any significant differences in any of the social distance items except for a positive change in the item 'I would spend an evening socialising with a person with mental health problems' ($p=0.013$). Despite there being no significant changes in the other social distance items, all items saw a slight positive shift, except the item 'I would feel comfortable with a person with mental health problems marrying into the family', where participants reported greater social distance post-training.

Post-course feedback responses

All participants completed semi-structured feedback forms about areas of learning from the workshop. The categories are grouped by core themes.

Discussion

The findings show significant information gain across the sample about mental health problems. Improving this form of knowledge is a valid aim in itself, and may improve help-seeking behaviour. In addition, there is some evidence of linked reductions in stigmatising attitudes and discriminatory behaviour, although not as consistent (Wolff *et al*, 1996; Angermeyer & Matschinger, 2005). Indeed, knowledge about mental illness can make attitudes worse in relation to dangerousness, fear, unpredictability and social distance (Read *et al*, 2006). However, this intervention generated and discussed knowledge through positive personal contact, and further qualitative analysis reveals that participants did not just focus on specific 'psychiatric' knowledge about mental health problems, but instead identified themes such as the complexity of mental health problems and the fact that anyone can develop a mental health problem. We suggest that these encouraging results may reflect on the learning process where information was constructed and shared between facilitators and participants.

While there were significant improvements in knowledge, attitude change was more complex. There was an overall significant improvement in attitudes and significant improvements in relation to attitudinal themes including 'unpredictability' and also one item relating to recovery. Yet, several attitude items and beliefs seem much more resistant to short-term change. These positive attitude

Table 2: Qualitative feedback from participants organised within a knowledge, attitude, and behaviour framework

Broad theme	Grouped categories
Knowledge items <i>Mental health literacy</i>	Know about other organisations and websites Mental health problems not always negative Wide range of mental health problems Complexity of mental health problems Better recognition of symptoms Mental health problems can affect anyone
Belief items <i>Stigmatising attitudes</i>	Sceptical about media reports Challenged own assumptions Greater belief in recovery Strengthened belief in equal opportunities/rights Less judgemental Fewer preconceptions
Behaviour change items <i>Discrimination</i>	<p>Self: Respectful Acknowledge rights Supportive Treat people same Sensitive Open Empathy Tolerance Listen more Look after own mental health Will complain about media Be more confident about mental health problems</p> <p>Work: Will offer more support to colleagues/employees Will signpost staff better Will involve people more in discussions that involve them Will work with partner organisations more</p>

findings are broadly in line with those of other interventions (Holmes *et al*, 1999; Pinfold *et al*, 2005), which suggest that targeted workshops can have a limited but positive impact on participants' attitudes towards people with mental health problems. Given the wide range of factors influencing attitudes, small changes are most realistic; very large changes could indicate a strong social desirability effect. However, by doing a one-week follow-up rather than immediately post-training, it is likely that respondents would be less keen to please researchers than in the baseline study, so the positive changes identified are likely to underestimate impact. The qualitative feedback within this study provides important insights into participants' self-reported attitude and belief changes that enrich the standardised measures. In particular, participants report changes to beliefs that we did not measure through attitude scales, such as being 'sceptical about media reports' and having a 'greater belief in equal rights', which provides greater

confidence that the positive impact we identified was real.

More detailed analyses of the individual items that make up each theme showed some significant improvement in relation to beliefs about unpredictability and recovery, which is very encouraging, as they were key negative beliefs the intervention sought to change. While the overall theme of dangerousness did not improve significantly, the baseline attitudes were much more positive compared to unpredictability and there was, therefore, less scope for improvement. Further, several dangerousness questions link strongly to medication and treatment such as 'people are unsafe unless they have taken their medication', and may reflect some of the particular service user narratives that spoke about the value of medication, or it may reflect other aspects of stigma that the evaluation is not able to identify, such as compliance and social control, linked to increased knowledge (Read *et al*, 2006). The slightly negative trend for recovery items

such as 'returning to work too stressful' were not significant, and may be a consequence of particular narratives delivered within the workshops that focused on workplace stigma or discrimination that a particular narrator faced. This is one of the challenges in harnessing the strength of personally-delivered narratives in this context. When considering attitude change, the questions about causality may be significant. Beliefs that the way someone is brought up causes mental health problems increased after the workshops, and may indicate a more social model of mental health emerging among participants.

At both baseline and follow-up, the participants express consistent patterns in their attitudes between the stigmatising themes, with more positive attitudes in the following order: dangerousness; recovery; unpredictability. This reflects previous population studies (Braunholtz *et al*, 2004), where dangerousness, for example, was not a common reported belief compared to other themes. However, this finding should take into consideration the effect of social desirability bias, and the potential that it may reflect an awareness in the sample that saying 'people are dangerous' is socially unacceptable. The fact that participants express comparatively more negative beliefs about unpredictability and recovery, at both baseline and follow-up, could reflect a view that it is more socially acceptable to express these kinds of attitudes. On the other hand, it may also be attributable to the reality of the experiences of the sample, where many of those participating work with people with mental health problems at a point of crisis. In targeting this group of employees in order to tackle stigma, we acknowledge there is evidence of more negative attitudes among staff working with people with mental health problems (Jorm *et al*, 1999). The sample was not intended to be representative of the whole population and other population groups may well show different responses to the workshops according to their experiences. Given the nature of the participants being studied, we cannot generalise these findings to the wider population and further research should explore the issue of participant background in more detail.

Behavioural intent, or discrimination, was partially assessed by using social distance measures. There was an overall positive shift in social distance, and statistically significant improvement in the willingness of participants to 'spend an evening socialising with someone with a mental health problem'. However, more meaningful interaction was resistant to change, including marrying someone with a mental health problem and people with mental

health problems looking after children. Such resistance to major behaviour change has been seen in other studies and linked to deep-seated fears (Thompson *et al*, 2002). Some authors go beyond traditional social theorists, such as Haghghat (2001), who discusses stigma in relation to marriage, for example, as a defensive need to identify, label and avoid people based on perceptions that mental health problems are inheritable. The qualitative feedback about behavioural intent is particularly encouraging, as the bulk of items suggest that people will adopt more positive approaches across a range of situations in which they engage with people experiencing mental health problems. In addition, most items apply to conduct in participants' personal lives, and not just workplaces. In addition, there is evidence from the responses that participants have taken lessons from the workshops and been able to generate potential improvements to their work practice. Further studies should examine how effectively this is translated into real workplace changes.

While scales assessing attitudes can provide data that is very useful, anonymous and comparable, it does lack richness and contextualisation, and benefits from triangulation with more qualitative approaches. The qualitative data in this study has highlighted unexpected benefits in terms of attitude and behaviour change to build into future scales and evaluations, and questions whether scales can fully capture sensitive changes in attitude, and if baseline questions are free from social desirability bias.

Effective approaches that emerged from the participant feedback were positive personal contact and the use of service user narratives. This supports other research that shows that positive contact is an effective means of tackling stigma (Couture & Penn, 2003; Angermeyer & Matschinger, 1996; Pinfold *et al*, 2005). This applies beyond the mental health sphere where positive contact, particularly in conjunction with institutional support, can be more powerful than 'education' or 'protest', which can result in rebound effects (Corrigan & Penn, 1999). Historically, narratives have provided a way of communicating complex ideas, engaging and generating emotional responses. Crisp *et al* (2000) suggests that the public overwhelmingly perceive people with mental health problems as difficult to communicate and empathise with. This may help to explain why the narrative approach appears to be extremely powerful, as participants are forced to confront these stereotypes and reassess their attitudes based on their new experiences, rather than being influenced by indirect sources like the

media. However, defining 'contact' is complex and we cannot assume that all interactions will have similar impact. The nature of 'contact' prior to, within, and after interventions is a rich area for exploration.

As with much social research in complex areas, it is important to consider the limitations and context of the study. There was no control group, and we therefore cannot compare our quantitative findings to a non-intervention group. One concern was that the groups are self-selecting, attracting people with particularly positive or negative views; however, employers were effectively encouraged to be non-selective in identifying employees. A common experience among the participant groups was their familiarity with mental health problems within their working lives and often at points of crisis. We cannot assume that our baseline and follow-up findings will generalise to other social groups with less exposure to mental health problems. Moreover, some of the attitudes that did not change may be a reflection of the reality of these participants' prior experience and should be acknowledged and explored further through qualitative approaches.

In addition, the sample size within this study was quite modest (137, 63 post-data) and in particular had a smaller number of males (12). Therefore, we have to be quite tentative in our assertions about impact, and many of these findings are hypothesis-generating. Larger sample sizes over time will allow us to establish extent and patterns of attitude change much more robustly. Related to this is the issue of timeframe. Further evaluations should ensure that work is spread over a long timeframe to minimise the likelihood of a major incident in the media skewing the results. Unlike other studies (Braunholtz *et al*, 2004), participant knowledge, experience and demographic factors had no significant impact on attitudes at baseline or follow-up. There are several potential reasons for these findings; the short-term nature of the study may have prevented knowledge being translated into attitude change, or the small number of males making it difficult to identify gender differences. The finding that personal experience did not influence impact may be explained by the study exploring mental health in a homogenous way. It is likely that the high number of people who self-reported mental health problems are referring to depression, but they may very well be referring to another mental health problem, such as schizophrenia, when they formulate their responses.

We cannot be certain about the relative importance of workshop design and delivery in relation to impact on participants, although other studies have demonstrated the value of narratives in influencing participants' attitudes within a workshop setting (Quinn & Knifton, 2005). A development process was undertaken with stakeholders, including professional groups, service user groups, and previous participants, as a core purpose of this intervention was to encourage a range of individuals from different organisations and backgrounds to work together. This intervention reviewed the early stages of this work when facilitators and service user narrators were becoming familiar with one another, the training process and materials. Longer-term follow-up should help to clarify the importance of experience in terms of the workshops' effectiveness. In addition, for reasons of efficiency and practicality, workshops were delivered to workplaces where participants knew one another. It may have been more difficult for participants to discuss their attitudes freely, and group dynamics may have generated mutual reinforcement or denial of stigma.

The response rate of 47% was within the expected range given that we had to achieve three elements; anonymity, longer-term follow-up and self-completion (given that online questionnaires were not practicable for all workplace settings). One concern was that only more positive participants would respond and this would skew results, however baseline comparisons of non-respondents suggests that this did not occur. If further studies intend to apply the follow-up questionnaire at longer intervals, it is likely that response rates would be unacceptably low and approaches will need to be developed that track people yet retain anonymity.

The evaluation distinguished components of stigma, but did not differentiate stigmatising themes associated with different mental health problems. Different mental health problems can attract different forms of stigmatising beliefs (Gaebel *et al*, 2006) and the generic questions may have masked important findings. In particular, beliefs about schizophrenia can be particularly negative (Crisp *et al*, 2000) and could mask potential improvements in attitude toward more 'mild/moderate' mental health problems. This could be explored reasonably effectively in follow-up studies through extending the specificity of the questionnaire used, combined with using a more qualitative approach.

Conclusions and recommendations

This study supports wider recommendations about the development and implementation of anti-stigma interventions, particularly that more emphasis should be placed on a normalising, recovery approach, and that personal contact should be at the forefront. Future interventions should not be too ambitious in scope, but should build on what has been demonstrated to work. In particular, they should consider being more targeted to address differences between the components of stigma that are associated with different mental health problems, in line with findings from Thompson *et al* (2002), which support the effectiveness of a more specific focus.

As explored in this paper, attitudes can be entrenched and interlinked. In a brief intervention such as this, with short-term follow-up, sweeping changes in attitude across all scales would be an unrealistic expectation. Attitudes are subject to a wide range of influences that operate over many years and are mediated by a range of structural, cultural and social changes. This is but one intervention in a complex environment and should only realistically have a limited impact. However, small but significant improvements in attitudes, alongside increased knowledge, may shape how participants view subsequent influences such as media reports and have more measurable longer-term impact on behaviour. Longer-term analyses involving more participants should be undertaken to develop this evidence base, which would also allow greater focus on understanding intervention impact on behavioural change. Given that different mental health problems attract different forms and levels of stigma, future evaluations must be more targeted in order to address these differences, and should continue to be supported by the use of richer, qualitative approaches to understand and contextualise emerging issues.

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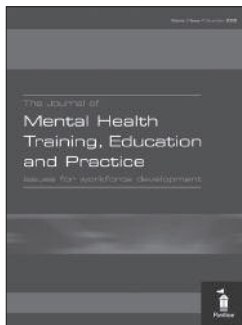
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