The Time to Change Programme to Reduce Stigma and Discrimination in England and Its Wider Context

18

Claire Henderson, Sara Evans Lacko, and Graham Thornicroft

Introduction

Stigma and discrimination against people with mental illness have substantial public health impact in England as demonstrated by a range of health, social, and economic indicators: poor access to mental and physical health care (Mai et al. 2011), reduced life expectancy (Laursen et al. 2007; Gissler et al. 2013), exclusion from higher education (Suhrcke and de Paz Nieves 2011; Lee et al. 2009) and employment (Social Exclusion U 2004), increased risk of contact with criminal justice systems, victimisation (Clement et al. 2011a), poverty, and homelessness. Goffman's seminal definition of stigma written in the 1960s as 'an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one' is still relevant (Goffman 1968). More recent conceptualisations include labelling, stereotyping, separation, status loss, and discrimination (Link et al. 1989) and incorporate experiences of discrimination; traditionally work on stigma has tended to focus on public attitudes and knowledge about mental illnesses.

C. Henderson (✉) • S.E. Lacko • G. Thornicroft
Institute of Psychiatry, Psychology and Neuroscience, King's College London, Box P029, De Crespigny Park, London SE5 8AF, UK
e-mail: claire.1.henderson@kcl.ac.uk; Sara.Evans-Lacko@kcl.ac.uk; graham.thornicroft@kcl.ac.uk

W. Gaebel et al. (eds.), *The Stigma of Mental Illness - End of the Story?*,
DOI 10.1007/978-3-319-27839-1_18

Internationally, public attitude data suggest that there has been little spontaneous improvement over time (Schomerus et al. 2012); however there is growing evidence for the effectiveness in high-income countries of anti-stigma interventions, both national programmes and those targeted to specific groups (Stuart et al. 2014). As a result, more countries are investing in national anti-stigma programmes targeted at both the general public and specific target groups (Borschmann RG et al. 2014; https://www.time-to-change.org.uk/news/global-meeting-anti-stigma-programme--london 2013). The National Institute for Health and Clinical Excellence emphasises the inclusion of knowledge, attitude, and behavioural components when developing and evaluating behaviour change interventions (National Institute for H & Clinical E. Behaviour Change. NICE 2007). Applying this to anti-stigma interventions requires the evaluation of lack of knowledge and misinformation such as stereotypes, prejudicial attitudes and emotional reactions such as fear and anger, and discriminatory behaviour, as evidenced by the indicators listed above and by the experiences of people with mental illness (Thornicroft 2006; Thornicroft et al. 2007).

Key Current Issues

Surveys of mental health service users show that experiences of discrimination pervade many areas of life (Corker et al. 2013; Lasalvia et al. 2012; Thornicroft et al. 2009) and that anticipation of discrimination is even more frequent, leading people to avoid possible opportunities for employment and relationships (Ucok et al. 2012). In this chapter we focus on three areas of life in which the impact of discrimination has a significant public health impact: health care, employment, and citizenship.

Evidence from the first year of the Time to Change anti-stigma programme in England (Henderson et al. 2012a) showed significant improvements in life areas in which relationships are informal, i.e. family, friends, and social life. In some areas where discrimination may occur at a structural level, there were no improvements, including mental and physical health care and welfare benefits; in others including those in seeking and gaining employment, early improvements have since plateaued or been lost (Corker et al. 2013). This chapter therefore takes account of discrimination at both the structural (Schomerus et al. 1464, 2006) and the interpersonal level.

Population Level Interventions

A review from the National Institute of Mental Health England (Gale et al. 2004) identified six principles of an effective anti-stigma campaign:

1. Service users and carers should be involved throughout the design, delivery monitoring, and evaluation of the campaign.
2. Campaigns should be monitored and evaluated.
3. National campaigns should be supported by local grass-roots initiatives.
4. Campaigns should address behaviour change.
5. Clear specific messages should be delivered in targeted ways to identifiable audiences.

6. Long-term planning and funding should be in place to ensure campaign sustainability.

In a more recent consensus development study on effective types of messages to use in population-level campaigns, experts recommended messages which were recovery oriented and those which sought to remove the distance between 'us' and 'them' (Clement et al. 2010). Other research has demonstrated that enhancing public understanding of the biological correlates of mental illness is not accompanied by reduced levels of stigma (Schomerus et al. 2012; Mehta et al. 2015; Thornicroft et al. 2015; Semrau et al. 2015).

Several population-level programmes have shown evidence of effectiveness. Evaluation of the Nuremberg Alliance Against Depression (Hegerl et al. 2003, 2006; Dietrich et al. 2010) found a significant reduction in the number of suicidal acts over each of the 2 years of the campaign when compared to a control-comparison region. In Australia, survey respondents in states and territories which funded the beyondblue programme (Jorm n.d.) showed greater recognition of depression and more frequent recognition of depression in people they knew; this may be due to both greater awareness and greater openness on the part of those affected. In Scotland, the 'See Me' campaign was launched in 2002 (Mehta et al. 2009; Dunion et al. 2005). Since then, there has been a significant reduction (30 % vs. 19 %) in the proportion of survey respondents who agreed that people with mental illness are often dangerous and a significant increase in willingness to interact with someone who had a mental illness (Henderson et al. 2013). The proportion of people with a mental illness who reported experiencing discrimination also dropped significantly between 2002 and 2008 (Davidson. S et al. 2009). Survey data from 1993 to 2003 suggest that public attitudes in England worsened between 2000 and 2003, but changed less in Scotland (Laursen et al. 2007). In England, Time to Change (http://www.time-to-change.org.uk/), run by Mind and Rethink Mental Illness, is the largest ever programme to reduce stigma and discrimination against people with mental health problems; details are provided as a case study.

Interventions to Specific Target Groups

The three strategies most commonly used to address the stigma and discrimination related to mental illness at the individual level are (1) education (to replace preconceived myths and stereotypes with facts), (2) contact (direct interactions with persons who have mental illness), and (3) protest (to change behaviour and challenge attitudes) (Corrigan et al. 2001). A meta-analysis of studies in 2012 revealed that, while contact was more effective than education at reducing stigma in adults, the opposite was true for adolescents (Corrigan et al. 2012), while evidence for protest is weak and less well studied.

Health Care

While anti-stigma interventions with health-care students may have a positive short-term impact (Clement et al. 2011b), there is no evidence for longer-term behavioural change, either from targeted interventions for medical students

(Friedrich et al. 2013) or from the overall evaluation of Time to Change (Corker et al. 2013). This has shown no significant reduction in reported discrimination by mental health service users from either health professionals (30 % in 2008 and 29 % in 2011) or mental health professionals (34 % in 2008 and 30 % in 2011). The TTC social marketing campaign may be ineffective among health professionals, for example, because they do not recognise their role as stigmatisers (Schulze 2007) or because the 'clinical fallacy' means their attitudes and behaviour are resistant to change, as they most often see cases with the worst course and outcome. Medical students exposed to this bias during training may not benefit from anti-stigma training. Thus, initial treatment seeking for mental health problems may increase if public attitudes and behaviours improve, but negative experiences with health professionals may deter people from seeking further help.

Employment

A significant improvement in employment-related attitudes (a significant reduction in the proportion of employers who endorsed the view that people with mental health problems are less reliable than other employees and that employees with mental health problems are unlikely to ever fully recover) was observed between 2006 and 2010 (Henderson et al. 2012b). Employers also report the use of workplace accommodations for people with mental health problems with increasing frequency, and this can be important for facilitating openness and disclosure by employees (Evans-Lacko et al. n.d.). There was an initial improvement after the start of Time to Change in terms of frequency at which mental health service users reported unfair treatment in both finding and keeping work (Henderson et al. 2012c), but the magnitude of this change was no longer significant by 2011 (Corker et al. 2013). This may be due to economic problems; European data (Evans-Lacko et al. 2013a) suggest that the gap in unemployment rates between individuals with and without mental health problems significantly widened during the recent economic recession and that the disadvantage facing people with mental health problems was greater in countries with higher levels of stigmatising attitudes.

Citizenship

The 2013 Mental Health (Discrimination) Act removed sections from several pieces of legislation and abolished any common law rule which had disqualified people on the grounds of mental health from a number of offices and roles: member of parliament and membership of devolved bodies, jurors, and company

directors. Exclusion from jury service is now based on being currently detained under the Mental Health Act or residing in hospital. This legislation sends an important message, that no one should be automatically excluded from playing their part as a UK citizen due to having, or having had, a mental illness. However, in terms of the experiences of mental health service users' daily lives, there is no evidence that the ability to take part in any area of life besides contact with friends, family, and neighbours (Corker et al. 2013) has got any easier. Besides employment and health care, examples where no reduction in unfair treatment has been observed include welfare benefits, personal safety, and parenting. 'Unfair treatment' covers a range of experiences in these different life areas (Hamilton et al. 2014).

In the area of welfare benefits, this can include the behaviour of job centre staff and problems getting entitlements. Discriminatory experiences in terms of personal safety encompass disability hate crime and victimisation more broadly. A review (Choe et al. 2008) found 2–13 % of outpatient attenders with mental health problems had perpetrated acts of violence in the previous 6 months to 3 years, compared with 20–34 % who had been the victims of violence. The authors conclude that victimisation is a greater public health problem than perpetration, and focusing on perpetration may contribute to negative stereotypes. In the area of parenting, the problems most commonly reported are being assumed to be an unfit parent and a lack of understanding of how the mental illness could affect the parenting role (Jeffery et al. 2013).

The Time to Change Programme in England: Policy Framework

Reducing mental health-related stigma and discrimination is one of the six objectives of the government's mental health strategy, No Health Without Mental Health (https://www.gov.uk/government/publications/the-mental-health-strategy-for-england). This was launched in 2011, the same year as the UK Department of Health became the largest funder of the second phase of Time to Change (TTC) in England (2011–2015). The Department of Health requested that TTC include campaigns targeted at children and young people, so that the programme covers all ages. The outcomes dashboard for monitoring progress on No Health Without Mental Health (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265388/Mental_Health_Dashboard.pdf) uses the surveys undertaken to evaluate TTC (Corker et al. 2013) to track progress towards its objective to reduce stigma and discrimination. The importance of reducing discrimination is reiterated in 'Closing the Gap: Priorities for Essential Change in Mental Health' (Department of Health 2014). Anti-stigma programmes are also ongoing in Wales (Time to Change Wales/Cymru) and Scotland (See Me), but not in Northern Ireland.

Experiences of Discrimination Among Mental Health Service Users in England

Figure 18.1 presents findings from a national sample of service users on their reported experiences of discrimination across the areas of employment, health, and citizenship during 2012.

Trends in Public Stigma in England

Public Stigma in Relation to Employment

The majority of the public agrees that most people with mental health problems want to work and that they have equal rights to employment, and this trend seems to be improving slightly in recent years; however, more than 30 % of the population appear to question these statements (Fig. 18.2).

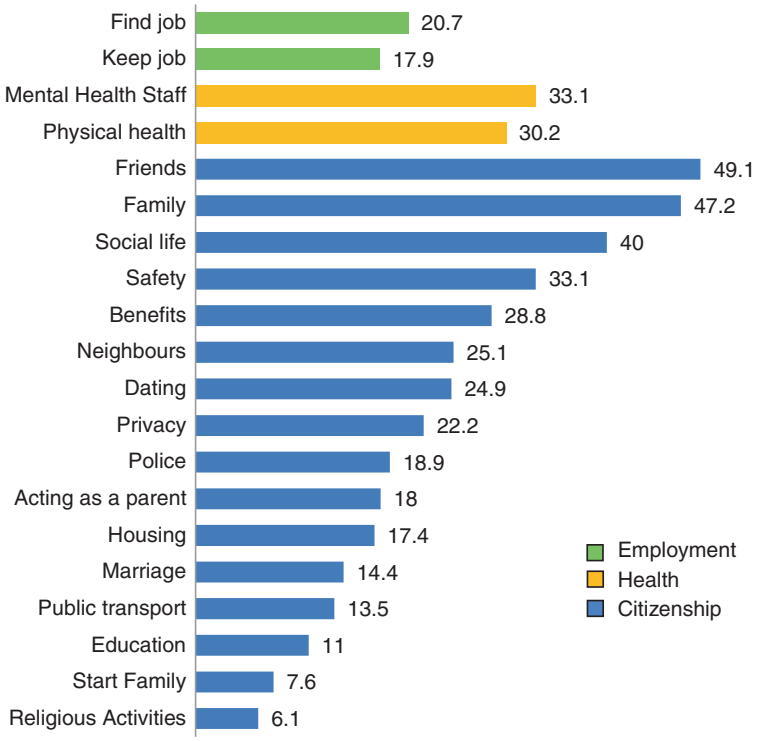

Fig. 18.1 Prevalence of experienced discrimination among secondary mental health service users across life domains of employment, health, and citizenship in England (2012) (Source: Henderson et al. 2014)

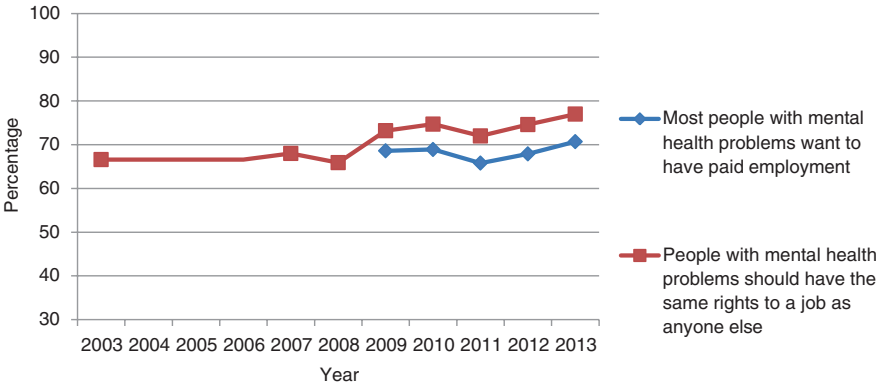

Fig. 18.2 Trends in public stigma in relation to employment (Source: Department of Health Attitudes to Mental Illness Survey. No data were collected from 2004 to 2006)

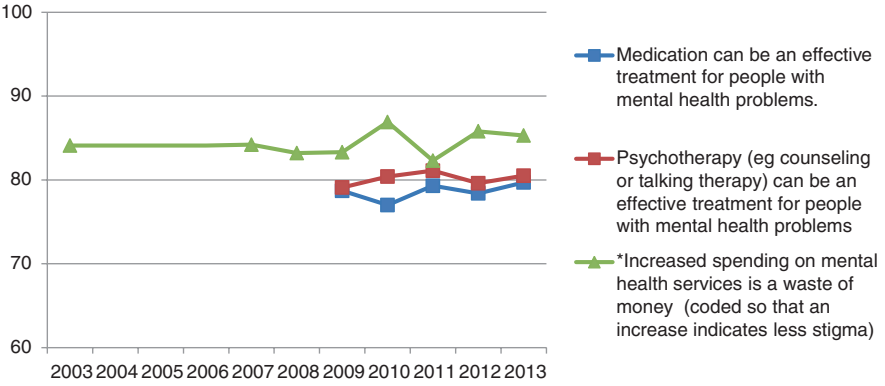

Fig. 18.3 Trends in public stigma in relation to mental health (Note: all items are coded so that trends going up indicate a favourable direction and less stigma) (Source: Department of Health Attitudes to Mental Illness Survey. No data were collected from 2004 to 2006. *Item was reverse coded so that all results could be calculated in a way where going up is the favourable direction)

Public Stigma in Relation to Mental Health

Figure 18.3 suggests that there is a high level of agreement that medication and psychotherapy are effective treatments for mental health problems and that spending on mental health services is not a waste of money; however, there was not much change in public views in relation to these statements. While agreement with these statements may be associated with increased likelihood of help-seeking for mental health problems and confidence in services, they may not directly

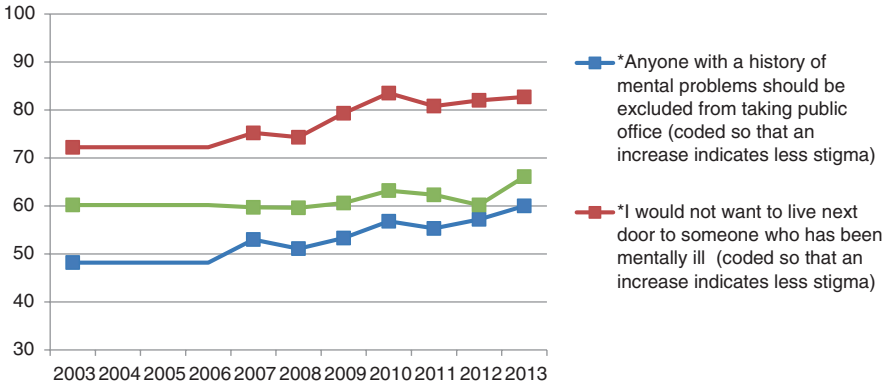

Fig. 18.4 Trends in public stigma in relation to citizenship (Note: all items are coded so that trends going up indicate a favourable direction and decreasing stigma) (Source: Department of Health Attitudes to Mental Illness Survey. No data were collected from 2004 to 2006. *Item was reverse coded so that all results could be calculated in a way where going up is the favourable direction)

translate to greater inclusion of people with mental health problems in other contexts (i.e. employment and citizenship) (Gissler et al. 2013; Suhrcke and de Paz Nieves 2011).

Public Stigma in Relation to Citizenship

The trends presented in Fig. 18.4 regarding public views of people with mental illness in relation to citizenship also seem to be improving in recent years. Although a clear majority responded positively about living next door to someone who has been mentally ill, indicators were less positive in relation to marriage and holding public office. In 2013, only one half to two thirds of respondents gave a positive (non-stigmatising) response to including people with mental illness in public office or when considering marriage.

Time to Change (TTC): Summary of Intervention and Evaluation

Question	Answer
What problem does TTC address?	Mental health-related stigma and discrimination in England; its impact on people with mental health problems and their supporters

Question	Answer
What is the intervention?	Phase 1 of TTC (2007–2011) consisted of several interventions, including a social marketing campaign, programmes for specific target groups including medical students and trainee teachers and head teachers and employers, local anti-discrimination initiatives, exercise programmes for people with mental health problems to promote social contact, social contact events organised by a range of stakeholders, and the use of social media such as Twitter and Facebook. Phase 2 (2011–2015) has built on the experience and evidence from phase 1 to deliver an even more evidence-based programme. Findings from phase 1 showed that, across England, there were significant improvements in intended behaviour and a positive (but nonsignificant) trend in attitudes towards mental illness (Evans-Lacko et al. 2013b); cumulative data including the first survey from phase 2 show further improvements such that the changes in both attitudes and intended behaviour are significant (Department of Health HMG 2013). There was a significant (3 %) increase in the proportion of service users who reported having experienced no discrimination during the previous year and a reduction in the median number of life areas in which discrimination was reported, from five to four (Corker et al. 2013). An improvement in employment-related attitudes (indicated by a significant reduction in the proportion of employers endorsing the view that people with mental health problems are less reliable than other employees and that employees with mental health problems are unlikely to ever fully recover) was observed among senior employers between 2006 and 2010 (Henderson et al. 2012b). Analysis of a sample of newspaper coverage showed 10 % proportional increases in articles coded as anti-stigmatising and in the use of people with experience of mental health problems as sources and a significant increase in the use of mental health charities as sources (Thornicroft et al. 2013). The TTC programme is innovative in terms of its long-term approach, use of evidence-based methods and significant investment in rigorous evaluation, use of social media both to amplify its message and empower people to tackle stigma, and involvement of people with lived experience at every level of both programme delivery and evaluation. The projected long-term benefits are improved quality of life for people with mental health problems and increased social capital as a result of better access to employment and services such as health care
How is TTC evaluated?	The evaluation comprises the following:
	Annual surveys of the general public, to assess mental health-related knowledge, attitudes, and intended behaviour; mental health service users, to assess experienced discrimination; responses to anticipated discrimination; perceived stigma; stigma coping responses; and social capital
	Content analysis of newspaper reporting on mental illness
	Awareness of each burst of the social marketing campaign; associations between campaign awareness and mental health-related knowledge, attitudes, and intended behaviour; and pre-post burst changes in these outcomes in the target population (aged 25–45 in middle income groups)
	Economic evaluation: costs of discrimination; costs of the campaign per point change in mental health-related knowledge, attitudes, and intended behaviour; return on investment

International Comparisons

In addition to higher rates of poverty and lower incomes, people with mental illness face a considerable employment disadvantage (Quinn et al. 2013). We know that the majority of people with mental illness want to work and that it is important for recovery; however, Fig. 18.5 demonstrates the significant disparity in employment rates between individuals with and without mental health problems. In the UK, although overall employment rates are relatively low, those with both moderate and severe disorders appear to have substantially lower rates of employment.

As employment rates are influenced by level of education, it is also important to investigate involvement among individuals in higher education. Figure 18.6 demonstrates that individuals with moderate and severe disorders tend to have much higher rates of stopping full-time education before age 15. Importantly, in the UK, overall rates seem to be higher, and the disparity between those with no mental disorder compared to those with severe mental disorder is greater than in any of the other high-income countries.

Economic Modelling

Epidemiological data demonstrates the adverse consequences for individuals with mental illness in terms of education and employment; however, there are limited data available on the economic costs of stigma (Evans-Lacko et al. 2014). The

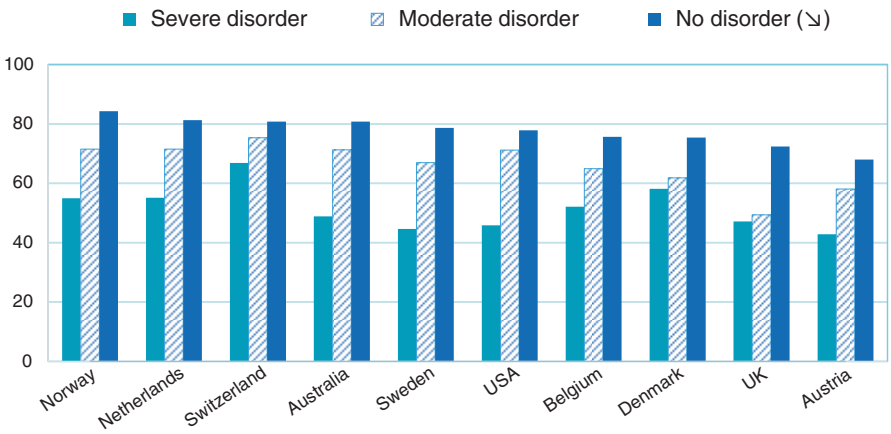

Fig. 18.5 Employment rates by mental health status across ten high-income countries. OECD (2012)

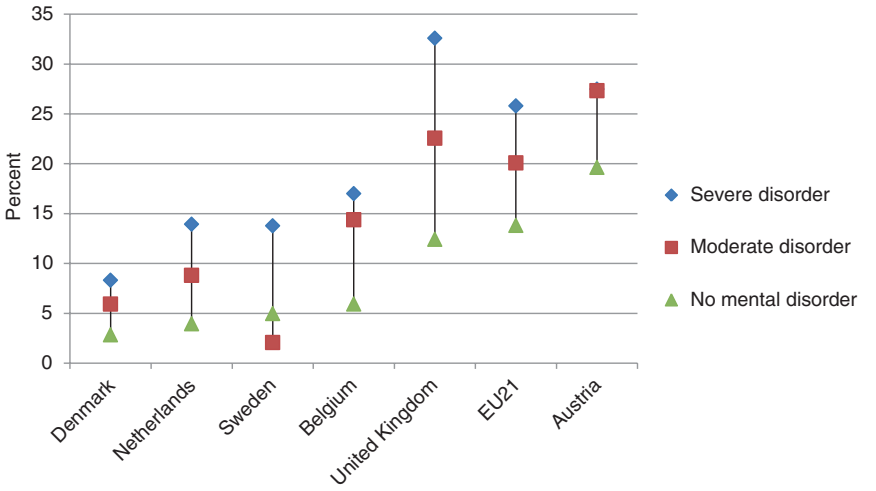

Fig. 18.6 Proportion of individuals who stopped full-time education before age 15 by mental health status across six high-income countries. Note: EU21 refers to all EU countries prior to the accession of the ten candidate countries on 1 May 2004, plus the four Eastern European member countries of the OECD, namely, Czech Republic, Hungary, Poland, and Slovak Republic (Source: OECD (2012)

economic evaluation of Time to Change builds on an evaluation of the See Me campaign examining the cost of the campaign in relation to the estimated number of people in the population with improved stigma outcomes (McCrone et al. 2010). Figures 18.7, 18.8, and 18.9 show that based on average social marketing campaign costs associated with Time to Change, and assuming that the campaign was only responsible for 50 % of the difference in responses to those who were aware vs. not aware of the Time to Change campaign, the cost for change in *knowledge* would be between £2.95 and £8.56. The cost for a change in *attitudes* would range from £2.50 to £10.96, and the cost for a change in *intended behaviour* would range from £2.24 to £3.86. Moreover, return on investment analysis suggested that the economic benefits of the campaign outweighed the costs even if the campaign resulted in only 1 % more people with depression accessing services and gaining employment if they experienced a health improvement (Evans-Lacko et al. 2013c).

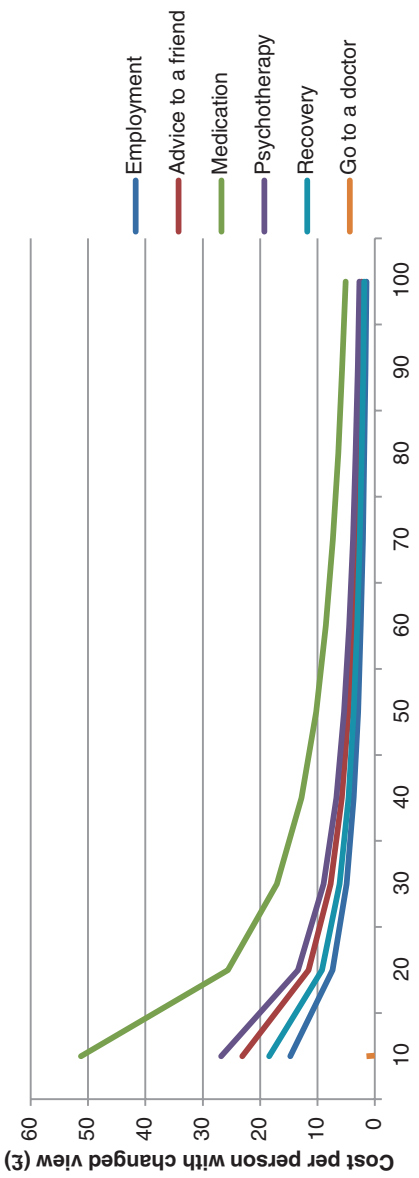

Fig. 18.7 Cost per person with changed knowledge associated with the Time to Change anti-stigma campaign. © [2013] The Royal College of Psychiatrists. Reference: (Evans-Lacko et al. 2013c) http://bjp.rcpsych.org/content/202/s55/s95.full

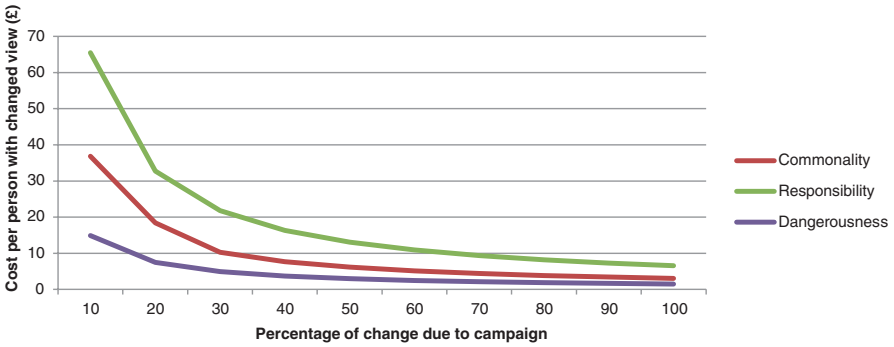

Fig. 18.8 Cost per person with changed attitudes associated with the Time to Change anti-stigma campaign. © [2013] The Royal College of Psychiatrists. Reference: (Evans-Lacko et al. 2013c) http://bjp.rcpsych.org/content/202/s55/s95.full

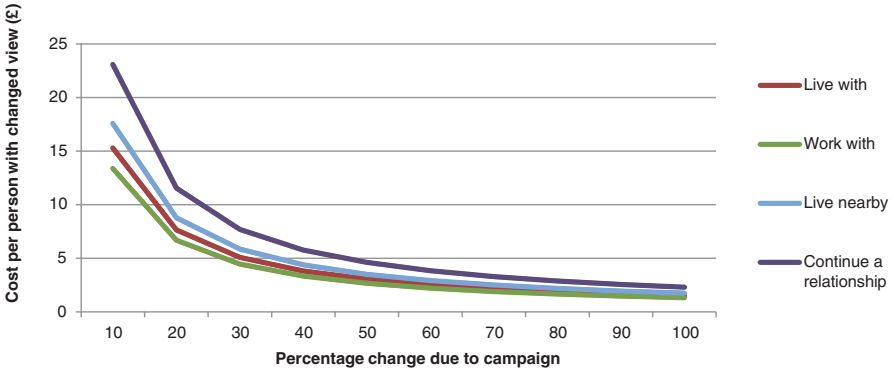

Fig. 18.9 Cost per person with changed intended behaviour associated with the Time to Change anti-stigma campaign. © [2013] The Royal College of Psychiatrists. Reference: (Evans-Lacko et al. 2013c) http://bjp.rcpsych.org/content/202/s55/s95.full

Conclusion

The following points are clear from this summary of the relevant evidence. Stigma and discrimination are major barriers to full citizenship in England. They reduce the opportunities for people with mental illness to gain employment, to receive the quantity and quality of mental and physical health care needed, and to form important social relationships. We therefore recommend the operationalisation of the Equality Act 2010 with respect to mental illness with respect to all areas of life, including the workplace, health and social care, education, the justice system, sports and leisure, and political participation. Significant, but modest, gains have been made in the reduction of stigma and discrimination during the period of the Time to Change programme, but most people with mental illness still experience these toxic reactions, and many then internalise these

forms of rejection in ways that diminish their life opportunities. Hence another key recommendation is to support and evaluate projects aiming to empower mental health service users to respond to stigma and discrimination. The evidence increasingly clearly shows that carefully delivered interventions, both local and national, do reduce stigma and discrimination, if sustained over a sufficiently long term; hence our third key recommendation is to develop evidence-based social contact programmes to reduce stigma and discrimination among target groups prioritised by mental health service users. It is clear that the progress made in stigma reduction in England, in which in many ways we now lead the world, needs to redoubled to ensure further progress to eradicate what some have called 'the last taboo'.

Summary

This chapter presents information to (i) define stigma and discrimination; (ii) present evidence on their severity and toxic impact on the lives of people with mental illness; (iii) describe population-level and target-group level interventions and their effects; (iv) examine the particular detrimental effects of stigma and discrimination on health care, employment, and citizenship; (v) compare progress in England with other similar countries; (iv) examine the relevant health economic evidence; and (vi) make recommendations for further stigma reduction in England in the future. Our key recommendations are to (1) operationalise the concept of reasonable adjustments as per the Equality Act 2010 with respect to mental illness with respect to all areas of life, including the workplace, health and social care, education, the justice system, sports and leisure, and political participation; (2) support and evaluate projects aiming to empower mental health service users to respond to stigma and discrimination, e.g. through addressing self-stigma, training in self-advocacy, and peer support; and

Key Points

1. In a survey of mental health service users across England in 2011, 87 % reported experiencing discrimination in at least one aspect of life in the preceding 12 months (Corker et al. 2013).
2. Three studies have found that about 70 % of mental health service users feel the need to conceal their illness (Corker et al. 2013; Lasalvia et al. 2012; Thornicroft et al. 2009).
3. An annual survey of mental health service users in England held 2008–2011 (Corker et al. 2013) found that while there was a significant fall in those reporting being shunned by others, this was still common, at 50 % in 2011 (down from 58 % in 2008).

4. Articles that contribute to stigma are the commonest type of newspaper article on mental illness, accounting for nearly half of all coverage (Thornicroft et al. 2013).
5. A review (Choe et al. 2008) found 2–13 % of outpatient attenders with mental health problems had perpetrated acts of violence in the previous 6 months to 3 years, compared with 20–34 % who had been the victims of violence.
6. National Labour Force Survey figures reveal that in 2003, employment in the whole adult population was about 75 %, for people with physical health problems about 65 %, while for people with long-term mental health problems, it was 24 % (Social Exclusion U 2004).
7. A survey of mental health service users in 2011 (Corker et al. 2013) found that 19 % reported experiencing discrimination in seeking work; 17 % had experienced discrimination while in employment; and 46 % reported not looking for work due to the anticipation of discrimination.
8. Legal analysis of cases brought to employment tribunals under the Equality Act 2010 shows failure to make reasonable adjustment is the commonest type of mental health discrimination claim (Lockwood and Thornicroft in press); this type of claim also has the highest win rate, at 72 %.
9. Legal analysis of cases brought to Employment Appeal Tribunals on the basis of mental health discrimination shows that 58 % were based on an error in the application of the law/procedure; such appeals also have the highest win rate at 60 % (Lockwood and Thornicroft in press). This reflects insufficient detail and quality of employment tribunal judgements.
10. An annual service user survey held 2008–2011 (Corker et al. 2013) showed no significant reduction in reported discrimination from either health professionals (30 % in 2008 and 29 % in 2011) or mental health professionals (34 % in 2008 and 30 % in 2011).

(3) develop evidence-based social contact programmes to reduce stigma and discrimination among target groups prioritised by mental health service users in surveys such as Viewpoint (Corker et al. 2013) and Stigma Shout (Change 2008) and summarise the evidence for the effectiveness of England's most recent anti-stigma programme, Time to Change.

Acknowledgements This research was supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South London at King's College London Foundation Trust. The views expressed are those of the author(s) and not necessarily those of *the NHS*, *the NIHR*, *or the Department of Health. GT is supported by the*

European Union Seventh Framework Programme (*FP7/2007–2013*) *Emerald project*. The authors acknowledge financial support from the Department of Health via the National Institute for Health Research (NIHR) Biomedical Research Centre and Dementia Unit awarded to South London and Maudsley NHS Foundation Trust in partnership with King's College London and King's College Hospital NHS Foundation Trust. This chapter draws upon material in Thornicroft G., Evans-Lacko S., & Henderson C. (2014) Stigma & Discrimination. In Davies, S., Mehta, N., Murphy O, ed. Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence. Department of Health, London.

References

Borschmann R, Greenberg N, Jones N, Henderson RC (2014) Campaigns to reduce mental illness stigma in Europe: a scoping review

Change Tt. Stigma Shout (2008). Time to Change. Stigma Shout. Mind and Rethink, 2008

Choe JY, Teplin LA, Abram KM (2008) Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns. Psychiatr Serv 59(2):153–164

Clement S, Jarrett M, Henderson C, Thornicroft G (2010) Messages to use in population-level campaigns to reduce mental health-related stigma: consensus development study. Epidemiol Psichiatr Soc 19(1):72–79

Clement S, Brohan E, Sayce L, Pool J, Thornicroft G (2011a) Disability hate crime and targeted violence and hostility: a mental health and discrimination perspective. J Ment Health 20(3):219–225

Clement S, van Nieuwenhuizen A, Kassam A, Flach C, Lazarus A, de Castro M et al (2011b) Filmed v. live social contact interventions to reduce stigma: randomised controlled trial. Br J Psychiatry 201:57–64

Corker E, Hamilton S, Henderson C, Weeks C, Pinfold V, Rose D et al (2013) Experiences of discrimination among people using mental health service users in England 2008–11. Br J Psychiatry 202:s58–s63

Corrigan PW, River LP, Lundin RK, Penn DL, Uphoff-Wasowski K, Campion J et al (2001) Three strategies for changing attributions about severe mental illness. Schizophr Bull 27(2):187

Corrigan PW, Morris SB, Michaels PJ, Rafacz JD, Rüsch N (2012) Challenging the public stigma of mental illness: a meta-analysis of outcome studies. Psychiatr Serv 63(10):963–973

Davidson. S, Sewel K, Tse D, Ipsos M, O'Connor R (2009) Well? What do you think? (2008). The fourth National Scottish survey of public attitudes to mental wellbeing and mental health problems. Scottish Government Social Research

Department of Health HMG (2014) No health without mental health: mental health dashboard. Department of Health, London gov.uk/dh. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

Dietrich S, Mergl R, Freudenberg P, Althaus D, Hegerl U (2010) Impact of a campaign on the public's attitudes towards depression. Health Educ Res 25(1):135–150

Dunion L, Gordon L (2005) Tackling the attitude problem. The achievements to date of Scotland's 'see me'anti-stigma campaign. Mental health today (Brighton, England) 22

Evans-Lacko S, Knapp M (in press) Importance of social and cultural factors for attitudes, disclosure and time off work for depression: findings from a seven country European study on depression in the workplace. PLoS ONE

Evans-Lacko S, Knapp M, McCrone P, Thornicroft G, Mojtabai R (2013a) The mental health consequences of the recession: economic hardship and employment of people with mental health problems in 27 European countries. PLoSONE 8(7):e69792

Evans-Lacko S, Henderson C, Thornicroft G (2013b) Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009–2012. Br J Psychiatry 202(s55): s51–s57

Evans-Lacko S, Henderson C, Thornicroft G, McCrone P (2013c) Economic evaluation of the anti-stigma social marketing campaign in England 2009–2011. Br J Psychiatry Suppl 55:s95–s101

Evans-Lacko S, Clement S, Corker E, Brohan E, Dockery L, Farrelly S et al (2015) How much does mental health discrimination cost: valuing experienced discrimination in relation to healthcare care costs and community participation. Epidemiol Psychiatr Sci. 2015;24(5)423–34

Friedrich B, Evans-Lacko S, London J, Rhydderch D, Henderson C, Thornicroft G (2013) Anti-stigma training for medical students – the Education Not Discrimination project. Br J Psychiatry 202;S55:s89–94

Gale E, Seymour L, Crepaz-Keay D, Gibbons M, Farmer P, Pinfold V (2004) Scoping review on mental health anti-stigma and discrimination: current activities and what works. National Institute of Mental Health England. NIMHE, Leeds

Gissler M, Laursen TM, Ösby U, Nordentoft M, Wahlbeck K (2013) Patterns in mortality among people with severe mental disorders across birth cohorts: a register-based study of Denmark and Finland in 1982–2006. BMC Public Health 13:834

Goffman E (1968) Stigma: notes on the management of spoiled identity. Penguin, Harmondsworth

Hamilton S, Lewis-Holmes E, Pinfold V, Henderson C, Rose D, Thornicroft G (2014) Discrimination against people with a mental health diagnosis: qualitative analysis of reported experiences. J Ment Health 23(2):88–93, 2014

Hegerl U, Althaus D, Stefanek J (2003) Public attitudes towards treatment of depression: effects of an information campaign. Pharmacopsychiatry 36(06):288–291

Hegerl U, Althaus D, Schmidtke A, Niklewski G (2006) The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. Psychol Med 36(9):1225–1234

Henderson C, Williams P, Little K, Thornicroft G (2012) The time to change programme against stigma and discrimination. Mental health problems in the workplace: changes in employers' knowledge, attitudes and practices in England 2006–2010. Br J Psychiatry 202(suppl 55): s70–s76

Henderson C, Corker E, Lewis-Holmes E, Hamilton S, Flach C, Rose D (2012b) Reducing mental health related stigma and discrimination in England: one year outcomes of the Time to Change Programme for service user-rated experiences of discrimination. Psychiatr Serv 63(5):451–457

Henderson C, Corker E, Lewis-Holmes E, Hamilton S, Flach C, Rose D et al (2012c) England's time to change antistigma campaign: one-year outcomes of service user-rated experiences of discrimination. Psychiatr Serv 63(5):451–457

Henderson RC, Evans-Lacko S, Thornicroft G (2013) Evidence for reducing discrimination in mental health: results of public awareness campaigns undertaken in the U.K. Seishin-Igaku. Clin Psychiatry (in press)

Henderson RC, Corker E, Hamilton S, Williams P, Pinfold V, Rose D et al (2014) Viewpoint survey of mental health service users' experiences of discrimination in England 2008–2012. Soc Psychiatry Psychiatric Epidemiol 49(10):1599–1608. https://www.time-to-change.org.uk/news/global-meeting-anti-stigma-programme-london 2013. Global Alliance Against Stigma

Jeffery D, Clement S, Corker E, Howard LM, Murray J, Thornicroft G (2013) Discrimination in relation to parenthood reported by community psychiatric service users in the UK: a framework analysis. BMC Psychiatry 20;13:120

Jorm AF, Christensen H Fau – Griffiths KM, Griffiths KM. Changes in depression awareness and attitudes in Australia: the impact of beyondblue: the national depression initiative. (0004-8674 (Print))

Lasalvia A, Zoppei S, Van BT, Bonetto C, Cristofalo D, Wahlbeck K et al (2012) Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. Lancet 381:55–62

Laursen TM, Munk-Olsen T, Nordentoft M, Mortensen PB (2007) Increased mortality among patients admitted with major psychiatric disorders: a register-based study comparing mortality in unipolar depressive disorder, bipolar affective disorder, schizoaffective disorder, and schizophrenia. J Clin Psychiatry 68(6):899–907

Lee S, Tsang A, Breslau J, Aguilar-Gaxiola S, Angermeyer M, Borges G et al (2009) Mental disorders and termination of education in high-income and low- to middle-income countries: epidemiological study. Br J Psychiatry 194:411–417

Link BG, Cullen FT, Struening E, Shrout PE, Dohrenwend BP (1989) A modified labeling theory approach to mental disorders: an empirical assessment. Am Sociol Rev 54(3):400–423
Lockwood GH, C, Thornicroft G (in press) Challenging mental health discrimination in employment: comparison of claimant win percentage. J Work Rights
Mai Q, D'Arcy C, Holman J, Sanfilippo FM, Emery JD, Preen DB (2011) Mental illness related disparities in diabetes prevalence, quality of care and outcomes: a population-based longitudinal study. BMC Med 1;9:118
McCrone P, Knapp M, Henri M, McDaid D (2010) The economic impact of initiatives to reduce stigma: demonstration of a modelling approach. Epidemiol Psichiatr Soc 19(2):131–139
Mehta N, Kassam A, Leese M, Butler G, Thornicroft G (2009) Public attitudes towards people with mental illness in England and Scotland, 1994–2003. Br J Psychiatry 194(3):278–284
Mehta N, Clement S, Marcus E, Stona A-C, Bezborodovs N, Evans-Lacko S et al (2015) Systematic review of evidence for effective interventions to reduce mental health related stigma and discrimination: medium and long-term effectiveness and interventions in low- and middle-income countries. Br J Psychiatry; In press
National Institute for H, Clinical E. Behaviour Change. NICE (2007)
OECD (2012) Sick on the Job?: Myths and realities about mental health and work, mental health and work, OECD Publishing, Paris
Quinn N, Knifton L, Goldie I, Van Bortel T, Dowds J, Lasalvia A et al (2013) Nature and impact of European anti-stigma depression programmes. Health Promot Int 29(3):403–413
Schomerus G, Lucht M, Holzinger A, Matschinger H, Carta MG, Angermeyer MC. The stigma of alcohol dependence compared with other mental disorders: a review of population studies. (1464–3502 (Electronic))
Schomerus G, Matschinger H, Angermeyer MC (2006) Preferences of the public regarding cutbacks in expenditure for patient care: are there indications of discrimination against those with mental disorders? Soc Psychiatry Psychiatr Epidemiol 41(5):369–377
Schomerus G, Schwahn C, Holzinger A, Corrigan PW, Grabe HJ, Carta MG et al (2012) Evolution of public attitudes about mental illness: a systematic review and meta-analysis. Acta Psychiatr Scand 125(6):440–452
Schulze B (2007) Stigma and mental health professionals: a review of the evidence on an intricate relationship. Int Rev Psychiatr 19(2):137–155
Semrau S, Evans-Lacko S, Koschorke M, Ashenafi L, Thornicroft G (2015) Mental health stigma and discrimination in low and middle income countries. Epidemiol Psychiatr Sci 24(5):382-94
Social Exclusion U (2004) Mental health and social exclusion. London Office of the Deputy Prime Minister, London
Stuart H, Chen SP, Christie R, Dobson K, Kirsh B, Knaak S et al (2014) Opening minds in Canada: background and rationale. Can J Psychiatry 59(10 Suppl 1):S8–S12
Suhrcke M, de Paz Nieves C (2011) The impact of health and health behaviours on educational outcomes in high-income countries: a review of the evidence. WHO Regional Office for Europe, Copenhagen
Thornicroft G (2006) Shunned: discrimination against people with mental illness. Oxford University Press, Oxford
Thornicroft G, Rose D, Kassam A, Sartorius N (2007) Stigma: ignorance, prejudice or discrimination? Br J Psychiatr 190:192–193
Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M (2009) Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. Lancet 373:408–415
Thornicroft A, Goulden R, Shefer G, Rhydderch D, Rose D, Williams P et al (2013) Newspaper coverage of mental illness in England 2008–2011. Br J Psychiatr 202(suppl 55): s-64–s69
Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D et al (2015) Evidence for effective interventions to reduce mental health related stigma and discrimination: narrative review. Lancet; In press
Ucok A, Brohan E, Rose D, Sartorius N, Leese M, Yoon CK et al (2012) Anticipated discrimination among people with schizophrenia. Acta Psychiatr Scand 125:77–83