



Countering the stigmatisation and discrimination of people with mental health problems in Europe



Research Paper



THE LONDON SCHOOL
OF ECONOMICS AND
POLITICAL SCIENCE



Directorate-General
"Employment, Social Affairs
and Equal Opportunities"

This paper has been produced for the European Commission by David McDaid from the Health and Living Conditions Network of the European Observatory on the Social Situation and Demography (run by the Directorate-General for Employment, Social Affairs and Equal Opportunities)

Countering the stigmatisation and discrimination of people with mental health problems in Europe

David McDaid

Poor mental health has substantial personal and economic impacts across the European Union. Stigma and discrimination exacerbate these impacts. Consistently, the evidence points towards strongly negative attitudes towards people with mental health problems: in particular there is an inaccurate view that they represent a danger to the community, a view strongly reinforced in the media. Negative attitudes are not only found among the general public and media, but even among mental health professionals. These and other elements of stigma increase social distance and lead to social exclusion: they, for instance, reduce the likelihood of an individual becoming employed or accessing health care services.

It is important that strategies to counter stigma are evidence-based. To date evidence on both their effectiveness and cost effectiveness is highly limited. Anti-stigma campaigns are difficult to evaluate but the limited evidence available suggests that campaigns targeted at specific population groups such as the police or school children may be more effective than those for the general population. Other measures to consider include investment in schemes to help individuals reintegrate into employment, schemes to increase the empowerment of people with mental health needs to choose the services that best meet their needs, and better enforcement and exchange of information on the use of legal instruments to tackle discrimination.

1. Introduction

Poor mental health can have a substantial adverse impact on the life of European citizens. One in four of us can expect to experience a mental health problem during our lifetimes. Around 9% of the European population experience depressive disorders in any one year, while the most severe psychotic disorders are much less common with a 12 month prevalence rate of 2.6% [1]

The economic costs of poor mental health are enormous, having been estimated at €386 billion (2004 prices) in the EU 25 plus Norway, Iceland and Switzerland [2]. The majority of these costs are incurred outside the health care system; the costs of lost productivity from employment can account for as much as 80% of all cost of poor mental health [3]. Other impacts include the deterioration of personal relationships and great strain on families[4-6], a higher-than-average risk of homelessness [7] and increased contact with the criminal justice system [8]. Moreover, almost uniquely, individuals with mental health problems may be involuntarily detained in hospital and/or treated without their consent, during times when they may lack insight into their condition and be a danger to themselves or others [9].

All of these non-health impacts are exacerbated by the social exclusion, discrimination and prejudice that people with mental health problems experience. Stigma can affect all aspects of life, limiting access to employment and housing, harming social relationships and reducing self esteem. Fear of being labelled as having a mental health problem also reduces the likelihood of individuals with mental health disorders seeking treatment [10, 11].

Stigma and prejudice contribute to the fundamental abuse of human rights that sadly continue to be seen in some of the outdated large psychiatric institutions and social care homes that remain the mainstay of mental health systems in some Member States [12]. This abuse manifests itself in many ways; even where community based care dominates, as in much of western Europe, individuals can be just as neglected and isolated within their communities as they were previously in institutions [4].

Stigma can also reduce the willingness of public policymakers to invest in mental health. Some public surveys have indicated that mental health is seen as a low priority when it comes to determining how to allocate health system funds [13, 14]. Several studies have also reported that the general public may believe that people with mental health problems cannot be treated within the health care system and instead should make use of complementary and alternative medicines [15].

Despite the importance of stigma, it has been the subject of comparatively modest analysis, although it was highlighted as one key issue within the health strand of the Greek Presidency of the EU in 2003. This briefing paper sets out to provide an overview of what is known about stigma. It begins by defining stigma and reflects on the attitude of the general public and other groups towards mental illness and some mediating factors, including the role of the media. It then looks at some of the practical implications of the discrimination and prejudice that arise out of stigma, particularly in respect of employment opportunities and use of the health care system. Finally, an overview is provided on what is known to date about the effectiveness of different approaches that have been adopted or might in future be adopted to tackle the terrible blight of stigma.

2. What do we mean by stigma and discrimination?

The word 'stigma' is of Greek origin and was used to describe a mark or scar left typically when branding animals. There is no clear consensus on the definition, but in everyday parlance it now can be described as 'a severe social disapproval due to believed or actual individual characteristics, beliefs or behaviours that are against norms, be they economic, political, cultural or social' [16]. It is characterised by a lack of knowledge about mental health, fear, prejudice and discrimination.

The stigmatisation of individuals with mental health problems is not new. For centuries individuals with mental disorders have long been viewed with fear and suspicion [17]. Many women burnt as witches in Europe and North America in the 16th and 17th centuries are now thought to have been suffering from mental disorders. In the 19th century *lunatic asylums* and *madhouses* were built to detain individuals often far away from local communities.

To this day the stigmatisation of people with mental health problems can lead to people being discriminated against in daily life, being denied access to goods and services or being treated unfairly. It is seen right across the globe regardless of differences in culture and context [18-20].

Why is this? Perhaps because negative attitudes to mental illness are firmly entrenched in individuals early in life: children are, for instance, exposed early to television programmes with ‘crazy, loony’ characters, ‘stereotypical, blatantly negative and served as objects of amusement, derision or fear’ [21]. Certainly by adolescence these views are well developed. In one survey 250 terms were used by 400 fourteen year olds in schools in England to describe mental illness; not one of these terms expressed people with mental health problems in a positive light while 116 were highly derogatory [22].

But what perhaps singles out the stigmatisation of people with mental health problems, from other potentially marginalised groups, e.g. women, ethnic minorities and people with disfigurements or physical disabilities, is the lack of voice that they often have in fighting against discrimination. They are among the most marginalised of groups within society: often service user organisations are poorly funded and reluctant to take any funding from industry. Stigma, discrimination and social exclusion do not end with people with mental health problems; there are also substantial impacts on family, friends and other individuals who come into contact with people with mental health problems, such as social workers and psychiatrists [23, 24].

3. What do we know about the attitude of the general population towards mental health problems?

Social perceptions of mental health problems are dominated by negative stereotypes. People with mental health problems are often thought to look strange and behave in a bizarre fashion. They might be seen solely in terms of their health problems, regardless of their overall contribution to society, and may be seen as incompetent and dependent on others. It was not that long ago after all that people with mental health problems were referred to in legal documents as being lunatics.

There have, of course, been some positive changes in general population attitudes over time - much of this research has been undertaken in Germany. For instance, one comparison of data from two representative population surveys found seeing a psychiatrist and psychotherapist being more readily recommended in 2001 than in 1990 for someone living with schizophrenia or depression [25]. Despite this improvement, the authors emphasised that much more needed to be done to change stigmatising attitudes. Another recent survey in Germany also indicates that the majority of the public now believe that depression can be prevented and more than half would participate in prevention programmes [26].

In Scotland, surveys of public attitudes on mental health have been conducted bi-annually since 2002. The 2006 survey indicated that 85% of participants agreed that ‘people with a mental health problem should have the same rights as anyone else’, 46% agreed that ‘the majority of people with mental health problems recover’ and 40% agreed that ‘people are generally caring and sympathetic to people with mental health problems’. The proportion of people agreeing with the statement, ‘If I were suffering from mental health problems, I

wouldn't want people knowing about it' continued to decline, from 50% in 2002 to 45% in 2004 and 41% in 2006. Willingness to provide support and interact with people with mental health problems when considering schizophrenia [27].

Not all recent trends are positive. The challenge in changing long held population attitudes about mental disorder should not be underestimated; a series of surveys in England since 1994 indicate that positive attitudes towards mental illness may be decreasing. In 2007 only 78% of individuals disagreed with the statement 'people with mental illness are a burden on society' compared with 84% in 2000, while the number of people agreeing with the statement 'We need to adopt a far more tolerant attitude toward people with mental illness in our society' was just 84% in 2007 compared with 92% in 1994 [28].

3.1 Mental disorders and violence

The single most perception by the general public of people living with mental health problems, particularly psychotic conditions, is that they are violent and represent a grave danger to the public. The misperception that most individuals with mental health problems are dangerous leads to more social distance (particularly for those with psychotic disorders), that is a reluctance on the part of the general public to engage with these individuals; ultimately this can lead to their social exclusion [29].

One German survey reported that 49.6% of the public expressed the belief that someone with a mental disorder was unpredictable, while violent and aggressive behaviour was associated with mental illness by about one quarter of respondents [25]. The public can also believe that people with mental health problems are more likely to engage in criminal violent acts than members of the general public [30-32]. Culture and ethnicity may also influence attitudes [33].

Despite these public perceptions, analyses in a number of high income countries suggest that the risks of violence by someone with mental health problems are no greater than those for the general population as a whole. Official homicides (murder, manslaughter or infanticide) statistics covering the period 1957 to 1995 were analysed in England and Wales [34]. Little change in the rate of homicide by people with a mental health diagnosis was observed over this time period; in fact this represented an annual decline of 3% in the overall number of murders. Further analysis suggested that the increase in stranger homicides over the period 1967 to 1999 indicated that these were less likely to be committed by people with mental health problems compared with the general population; these murders were more likely to be linked to harmful alcohol consumption and drug abuse [35].

A similar analysis in New Zealand reported that almost 9% of homicides between 1970 and 2000 were by people with mental health problems. Again the annual rate of such homicides did not fluctuate over this period, while as a percentage of all homicides the annual rate fell from almost 20% in 1970 to 5% by 2000. Most homicide victims were known to the perpetrator of the crime and the authors concluded that the process of desinstitutionalisation that had taken place in the country was not associated with any increase in the risk of murder by people with mental health problems [36].

One caveat about the conclusions of these studies is that their conclusions differ depending on the way in which mental disorder is identified. A more recent analysis of all homicides in England and Wales between 1996 and 1999 suggested that about 10% of homicides were by people with mental health problems at the time of the offence, the majority of whom had never come into contact with mental health services [37]. Some of these individuals were sent to prison rather than to mental health care facilities. The study also suggested that more than one third of those who committed murder had a lifetime history of mental health problems.

The critical role of the media

A long standing key contributor to the enduring difference between the public risk from people with mental health problems and the reality is the role of the media [38]. In particular the print media tend to place an emphasis on the reporting of rare but sensational tragic events involving people with mental health problems. For instance, analysis of the German tabloid BILD-Zeitung over the first nine months of 1997 found 186 articles related to mental illness, just 0.7% of all news items printed. Thus overall the readers of this newspaper received very little information on mental illness, but 51% of what they did receive was concerned with serious crimes made by people with mental health problems. Inflammatory language and inaccuracies concerning the judicial process were often used to sensationalise these stories [39]. In the United States analysis also indicates that the violence was the principal message in 39% of all articles; the majority of these articles were prominent in the main news pages of newspapers [40].

4. What about the attitude of professionals?

Recently attention has turned towards mental health professionals. Stigmatising attitudes towards people with mental health problems are also seen even within the mental health professions. Several surveys have indicated little difference between the attitudes of the general public and psychiatrists [41].

The police may be the first point of contact for people with mental health problems, particularly during crises, or in cases where they may have to enforce involuntary detention orders. Stigma within the police can be substantial; again the view that individuals are violent and predictable is strong [42, 43]. In Greece, one recent survey on the attitudes of police officers to people with mental health problems reported that 60% believed that people with mental health problems were more dangerous than the general population, 47% that they needed to be on continuous medication and 67% that they should be permanently hospitalised. More than 60% believed that people with mental health problems are rarely or never able to work, while more than 75% believed that they only were rarely capable of being married, having children and living independently [44].

A survey of the attitudes of staff at all psychiatric inpatient and outpatient facilities in the German speaking area of Switzerland was conducted and results compared with that for the general public [45]. Psychiatrists were found to have more negative stereotype views of people with mental health problems than the general public or other mental health professionals. There was also no distance in the degree of social distance towards people with schizophrenia between mental health professionals and the general public. The authors suggested more needed to be done to counter negative attitudes among mental

health professionals: this is of particular importance given that they are often involved in implementing or training other people to implement anti-stigma campaigns.

Mental health professionals can also have negative views on employment. One review of the links between social exclusion and mental health in England found that in addition to widespread stigma and discrimination, health professionals had a low expectation of what individuals with mental health problems can achieve, and that employment in particular is not seen as a key objective. It found that there was a lack of clear responsibility for promoting social and vocational outcomes, a lack of ongoing support to enable people to work and structural barriers to engagement in the community. The report called for more choice and empowerment of service users, help to retain jobs, return to employment and progress careers [46].

5. What are the consequences of stigmatisation?

5.1 Employment

Consistently research indicates that the majority of individuals with severe mental health problems want to work in regular employment settings. Research demonstrates that work increases their self-esteem and quality of life [47]. Users of psychiatric services in the UK reported that 90% wanted to enter (or return to) work [48]. Another study of patients with schizophrenia in three countries, Germany, US and Switzerland, reported the same subjective attitude towards work and employment, with those in employment reporting a better quality of life than the unemployed, in all three countries [49].

Despite this willingness to work, individuals with mental health problems have much lower rates of employment than the general population. This may be due to the greater levels of stigma and prejudice they face [50]. In Germany, for instance, strong negative responses to people with schizophrenia returning to their place of employment have been reported[51].

Data on employment rates for people with mental health problems are limited in most countries and in many instances the breakdown of employment statistics by health status is simply not available. But from the data that are available it is abundantly clear that people with mental health problems, particularly those with psychotic disorders have very low rates of employment. The majority of EU countries with data report employment rates of between 20% and 30%, although there are some outliers (See Figure 1) [52].

Recent analysis of data from the European Schizophrenia Cohort indicates that in Germany, for instance, the employment rate for people with schizophrenia is just 14% [53]. Research in England also suggests that individuals with mental health problems have up to a 40% lower chance of obtaining employment compared with other disability groups [54]. In countries in central and eastern Europe, where the economic climate remains challenging, rates of employment may be very low indeed. Data from Poland indicate that the employment rate for people with mental health problems was just 10.3% compared with 48% for the general population.

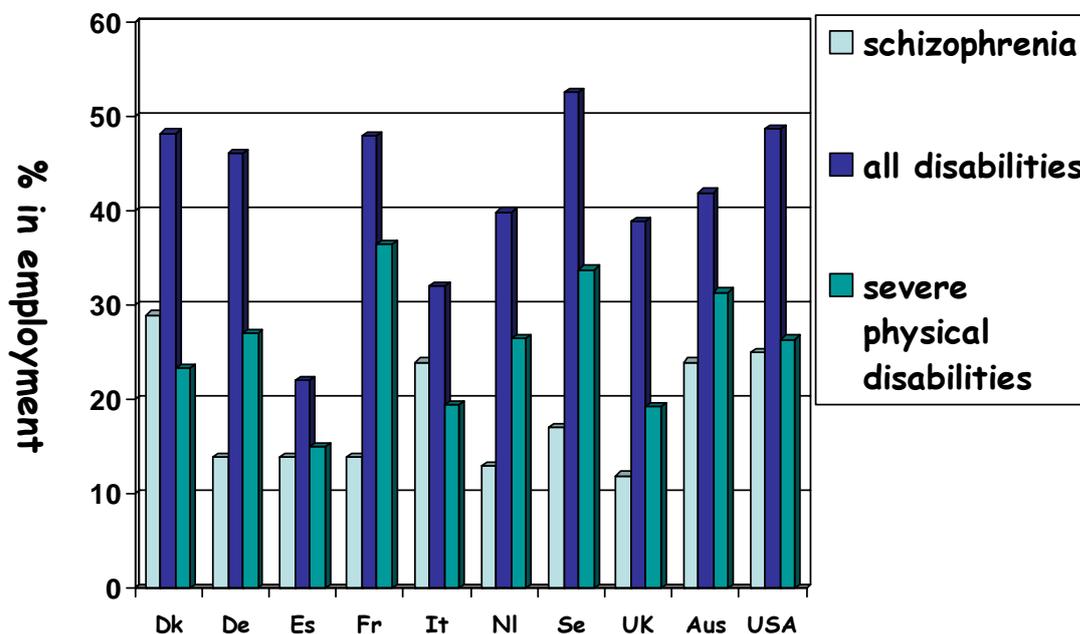


Figure 1: Employment rates for people with schizophrenia, severe physical disabilities and all disability in selected countries. Source: [52]

5.1.2 Barriers to employment

What then are the barriers to employment? Clearly, one major reason for the low rates of employment in some countries reflects differences in the structure of social welfare systems. The way in which social welfare benefit system may work in different countries may mean that an individual is financially better off staying on benefit rather than returning to work. In Italy, where access to benefits is poor, much higher rates of employment of 46.5% of all diagnoses compared with 18.4% in the UK [52]. Disability benefits typically are greater than unemployment benefits which may encourage individuals to withdraw from the labour market; moreover, in order to gain access to some specialist services in some countries it is necessary to be registered as disabled (McDaid et al 2005b).

Another structural barrier may be rules governing the participation in work of people receiving disability benefits. In some countries, individuals claiming disability benefits are explicitly banned from seeking work. For instance in Bulgaria, there are three benefit groups: (1) Loss of capacity for work greater than 90%, 2) loss of capacity between 50-90% and 3) loss of capacity less than 50%) Those in the second group (66.3% of the total registered disabled population) are only allowed to engage in a limited amount of work under a “labour contract” while those in the third group legally cannot work at all. Denmark, by contrast, has high rates of employment, which may in part be due to the promotion of flexible regulations on benefits and the promotion of active labour market inclusion policies [52].

There is also evidence that stigmatising views among employers have an impact. Employers are often reluctant to take on an individual with a mental health problem [55] [56]. In the EU funded Optiwork study, which looked at barriers to the return to work of people with disabilities, data from focus groups of employers in several European countries indicated that employers were reluctant to take on people with mental health problems, believing them to be less productive than people with physical disabilities [57]. In Ireland, a survey for the National and Economic Social Forum (NESF) found that one third of employers felt that people with mental health difficulties were less reliable than other employees. Over half of employers thought it was a considerable risk to employ someone with mental health difficulties.

In a Polish survey 95% of employers reported that they did not want to employ a person with schizophrenia for any position [58]. In another Polish survey, 63% of respondents indicated that they would accept a person with mental health problems as a collaborator, but 70% objected to them being given employment which involved any responsibilities, including childcare, physician or any governmental position [59].

People with mental health problems may also be reluctant to enter employment for fear of having to disclose their condition. One survey in Scotland found that 57% of those who had experienced mental ill health had concealed the fact when applying for a job. Some 43% had not gone ahead with a job application for fear of how their mental health history might be perceived [60]. In some countries, the fear of the loss of any job and the difficulty in reclaiming benefits also acts as a disincentive to seek work. In England, a governmental report noted that psychiatrists were often reluctant to encourage individuals to take paid employment specifically because of the delay in reclaiming benefits, which might cause undue hardship [46]. In Ireland, this fear of loss of welfare benefits has also been a powerful barrier to employment for people with mental health problems [61].

5.2 Access and utilisation of health care services

The majority of those with mental disorders do not come into contact with mental health services [62]. Recent analysis of data from the World Mental Health (WMH) surveys on the use of services for anxiety, mood and substance abuse disorders reported that overall only around one third of those who could benefit from treatment actually made use of services [63].

As indicated in Table 1 even for those individuals with the most severe of these mental disorders at least 39% (Belgium) and at most 60% (Germany) did not receive any treatment. Table 2 also indicates that of those who actually received services no more than 42% obtained what was deemed to be a minimally adequate level of treatment for their disorder. There were also substantial variations in the proportion of those with more severe disorders who received adequate treatment.

Table 1. 12-month service use by severity of anxiety mood and substance disorders in the WMH surveys (%)

	<i>Severe</i>	<i>Moderate</i>	<i>Mild</i>	<i>None</i>
<i>Belgium</i>	60.9	36.5	13.9	6.8
<i>France</i>	48.0	29.4	21.1	7.0
<i>Germany</i>	40.0	23.9	20.3	5.9
<i>Italy</i>	51.0	25.9	17.3	2.2
<i>Netherlands</i>	50.4	31.3	16.1	7.7
<i>Spain</i>	58.7	37.4	17.3	3.9
<i>USA</i>	59.7	39.9	26.2	9.7

Source: Adapted from [63].

Table 2. Minimally adequate treatment use for respondents using services in the WMH surveys in previous 12 months (% of people by degree of severity)

	<i>Any severity</i>	<i>Severe</i>	<i>Moderate</i>	<i>Mild</i>	<i>None</i>
<i>Belgium</i>	33.6	42.5	35.5	-	29.4
<i>France</i>	42.3	57.9	36.5	41.5	40.2
<i>Germany</i>	42.0	67.3	53.9	-	35.4
<i>Italy</i>	33.0	-	33.4	-	31.0
<i>Netherlands</i>	34.4	67.2	34.1	-	20.8
<i>Spain</i>	37.3	47.5	43.6	48.5	29.2
<i>USA</i>	18.1	41.8	24.8	4.9	-

Source: Adapted from [63]

The WHO Mental Health Survey Consortium (2004) previously reported that up to 85% of people with serious mental disorders did not receive treatment in a one year period [64]. Stigma surrounding poor mental health appears to be a major contributor to a lack of contact with services [65]. In Europe, this is not really connected to the availability of clinical services (although social and community care remains limited in some countries). Instead there seems to be a reluctance to come into contact with services because of anticipated discrimination [66]. Individuals may be fearful of being discriminated against if they are labelled as having a mental health problem. This under utilisation of services is reported even in those countries where there is no need to make out of pocket payments to access services. As members of the general population, they are also exposed to common misconceptions surrounding mental disorders – for instance that they cannot be cured or that drug treatments do not work.

Contact rates differ by mental health problem. They are highest for severe psychotic conditions such as schizophrenia but much lower for conditions perceived to be less serious conditions such as depression [1]. This may again be due to a lack of knowledge about mental health problems – while people with psychosis may be more likely to come to the attention of services during the acute phases of their condition, there is some

evidence to suggest that the general public do not believe conditions such as depression always require intervention from mental health services as they are caused by socio-environmental events or may reflect individual weakness – all that is needed is for individuals to ‘get a grip’.

Rates of contact with mental health services may be lower in specific population groups than in the general population. This may be due to a lack of cultural sensitivity in the provision of care, or taboo within the community. In England, for example, rates on contact with mental health services are lower in the Afro-Caribbean community compared to the general population, yet they have higher rates of involuntary detention and treatment [67]. The stigma of mental illness may be particularly acute in young people with mental health problems; one study reported that only 4% of these young people contacted their primary care practitioner about their problems [68].

6. What potential interventions are available to tackle stigma and discrimination?

What can be done to tackle stigma and discrimination? Certainly in recent years, as awareness of the issue has grown, a number of different initiatives have been undertaken at both an international level, e.g. the World Health Organization’s Closing the Gap Programme, and national level e.g. the See Me campaign in Scotland (<http://www.seemescotland.org.uk/>), Like Minds, Like Mine in New Zealand or the Italian Ministry of Health campaign (<http://www.campagnastigma.it/>).

It is critical that resources are allocated to interventions that have been properly evaluated: unfortunately however as some commentators have noted “some confusing and poorly drafted initiatives – expensive, heavily promoted, but lacking any firm evidence base – have been implemented over the last years” [69]. At a European level one way of overcoming this may be through the EU’s Social Protection and Social Inclusion Process. One of its core objectives is to build up an evidence-informed picture of policy and practice (See Box 1)

Box 1 - The European Union’s Social Protection and Social Inclusion Process

The inclusion of vulnerable groups is one of the key priorities of the European Social Protection Social Inclusion Process. In this context, Member States have committed to develop integrated and coordinated responses to the multiple disadvantages faced by disadvantaged groups and in meeting their particular needs.

The EU recognise that in order to overcome discrimination and increase the inclusion of vulnerable and marginalised groups, including people with mental health problems, it is vital to enhance access to mainstream services and opportunities, enforce legislation to overcome discrimination and, where necessary, develop targeted approaches to respond to the specific needs of each group.

In order to gain a clear picture of the situation and needs of each country in the field and measure the actual impact of policies targeting vulnerable groups, the European Union continues to work on the development of targets, objectives and common indicators, based on reliable data and concrete statistics

So what do we know about the effectiveness of existing strategies to date and what potential interventions might policy makers also wish to consider? The results of interventions to tackle stigmatisation and discrimination of people with mental illness are difficult to measure and interpret. In order to fully determine whether interventions make a difference it is important to have a long term follow up as part of any evaluation, but thus far there have been few such studies. From the available evidence, it would appear that broad anti-stigma campaigns have at best modest effects and require reinforcement if these effects are to endure. Targeted measures that can help reduce social distance between elements of the general public and people with mental health problems may be more appropriate [70]. These might include intervention in schools to raise awareness of mental health, more control over choice of treatment by people with mental health needs or constructive engagement with the media, who have socially reinforced stigma and social exclusion by sensationalist and inaccurate portrayals of mental health. We now look at some of evidence around some interventions.

6.1 Anti-stigma campaigns

Campaigns targeted at the general population, intended to counter negative stereotypes and attitudes towards people with mental health problems, do not appear to have much effect. There are few rigorous evaluations exist: qualitative evidence suggests they may have an effect but these are usually based on cross-sectional data rather than longitudinal data over time e.g. [71].

One of the more robust evaluations refers to the German version of the World Psychiatric Association's Open the Doors programme [72]. This is the first study to make use of a longitudinal dataset for an area based anti-stigma programme. The programme was implemented in a number of German cities from 2001 onwards and involved a whole range of anti-stigma interventions targeted at the general public, including lectures at adult education centres, art exhibitions, cinema events and charity concerts. Most events included panel discussions with mental health professionals, as well as with people who were affected by mental disorders as participants. Events were widely publicised beforehand and press workshops on schizophrenia were held to try and improve reporting.

Attitude surveys with the same study sample conducted before the introduction of the campaign in 2001 and afterwards in 2004 were used to assess longer term impact; this included two control cities that had not taken part in the anti-stigma campaign. Results indicated no difference in beliefs about the causes of schizophrenia and or the role for psychotropic drugs, but fewer people thought people with schizophrenia to be dangerous to the public. There was also a significant but small decrease in social distance towards people with schizophrenia in 2004 compared with baseline figures in 2001 – this reduction was not observed in the control cities where anti-stigma campaigns had not been run.

Despite this positive finding only 6.7% of those contacted in 2004 had heard of any anti-stigma campaign. The authors thus concluded that anti-stigma campaigns can have some (very small) effect on attitudes, but only if a reduction in social distance translates into a more inclusive approach towards people with mental health problems will the campaign

be successful. Improved direct social contact with people with mental health problems has been shown to reduce stigmatising attitudes and fear of violence in several studies [20, 70, 73, 74].

Targeted campaigns might be more effective, e.g. to try and address the attitudes of mental health professionals or to have more specific messages raising awareness about the symptoms of specific conditions such as anxiety and depressive disorders [16]. Target professional population groups may include social care professionals, teachers and the police. One recent survey in Greece indicated that 75% of police officers wished to receive more information about mental health problems [44]. In England a short term before and after study of the effectiveness of a mental health training intervention for the police suggested that there was an improvement in understanding of mental health issues and better communication between the police and people with mental health problems improved, although there was no change in the view that those with mental health problems were more likely to be violent [43].

Interventions might also be targeted at young people. Rose and colleagues have recommended that interventions to improve awareness about mental illness and to reduce negative emotional reactions towards people with mental health problems [22]. Evaluation in England suggests that in the short term at least interventions in school settings can improve attitudes towards people with mental health problems [75].

Elsewhere, a rigorous before and after evaluated of a multi-faceted community awareness campaign designed to improve mental health literacy and early help seeking amongst young people was carried out in Australia. The intervention, which included multimedia, a website, and the use of an information telephone service, was evaluated over a 14 month period using a before an after approach. It had a significant impact on awareness of mental health campaigns, self-identified depression, help for depression sought in the previous year, correct estimate of prevalence of mental health problems, increased awareness of suicide risk, and a reduction in perceived barriers to help seeking. The authors also suggested that the benefits of the campaign may be conservative as a small amount of print material was distributed in the comparison region used in the analysis [76].

6.2 Tackling discrimination in the labour market

Other key target groups include employers and trade union representatives. Improved understanding of mental health issues is critical in companies and among co-workers if efforts to reintegrate people with mental health problems into the workforce are to be successful; there can be strong opposition to working alongside people with mental health problems [51]. Employment has many benefits including a reduced need for health care services, increased levels of social inclusion and improved quality of life. The existence of active return to work policies across Europe is increasing (See examples in Table 3). These combine a range of regulatory measures and economic incentives for individuals and employers.

Table 3: Initiatives to help promote return to work in selected European countries

<i>Country</i>	<i>Initiative</i>
<i>UK</i>	The Department of Work and Pension's Pathways to Work Programme, provides support for people with mental health problems to find and retain jobs in the open labour market
<i>Ireland</i>	Localised initiatives including the PINEL Programme which offers a 20 week training course for people with mental health problems in Dublin to help access employment
<i>Sweden</i>	Social Insurance Agency will provide a rehabilitation programme for anyone receiving sick pay for sixty continuous days. The programme aims to stimulate people to return to work as soon as possible
<i>Poland</i>	Adaptation of a law allowing people with mental health problems the ability to work on the open market and to participate in various forms of rehabilitation. It further obligates that local governments organise professional training and provide sheltered workshops
<i>Norway</i>	New national strategic plan for mental health and employment covering the period 2007-2012 has strengthened the focus on employment. The aim is to prevent people with mental health problems from being expelled from employment and to reduce barriers to employment.

Recent analysis in Europe confirms what has been known for sometime in north America for some time, namely that interventions which seek to return individuals directly to open employment and then provide support and accommodation to help maintain individuals at work do appear to be much more effective and cost effective than the use of vocational rehabilitation schemes where individuals receive training within a sheltered environment [77-80]. Critical to the success of such programmes is the willingness of employers to participate and also of mental health professionals to be supportive of individuals seeking employment. As Box 2 illustrates anti stigma campaigns can include specific initiatives to raise awareness and illustrate the benefits to employers of helping to reintegrate people into work.

Box 2 – Examples of policy initiatives to tackle stigma in England

The need to tackle stigma and discrimination linked to poor mental health was acknowledged to be a key policy priority in 2004[46]. In response the National Institute for Mental Health in England (NIMHE) launched a strategic five-year programme to tackle stigma and discrimination (SHIFT) [81]. Different strategies were developed to reach different target audiences, e.g. young people or the media. Cross-sectoral collaboration between government departments, including education, justice, the department of work and pensions was highlighted.

NIMHE's National Social Inclusion Programme is responsible for taking forward the implementation of recommendations set out in a national report of social exclusion. Actions are underway in seven areas: employment, income and benefits, education, housing, social networks, community participation, and use of direct payments.

On World Mental Health Day 2006, the Department of Health launched 'Action on Stigma' [82] to tackle discrimination in the workplace. The initiative is being delivered jointly by SHIFT and the National Social Inclusion Programme. It sets out the benefits of helping an individual return to work and highlights principles of best practice that employers can adopt to promote mental well being and when problems do occur avoid discrimination. The Department of Work and Pension's Pathways to Work scheme, developed in conjunction with the National Social Inclusion Programme, also provides specialist advice and support to individuals to help them find employment.

6.3 Improving access to services that best meet needs

People with mental health problems can also be empowered to have more control over their services that best meet their needs. Attention is beginning to focus on the use of 'direct payments' where individuals are given cash to purchase services and support that they require, including help in vocational rehabilitation. The system has however only been introduced in a few countries including England, Scotland and the Netherlands for a few service users making it too early for formal evaluation.

Another continuing challenge is to improve access to information in order to help empower individuals to seek help. A lack of knowledge about conditions and treatment is one key reason for under-utilisation of services. Basic information could be provided on services available, and co-ordination improved between different service providers/funders. These approaches will be dependent on the level of resources available within countries. In high-income countries approaches that have been shown to be relatively effective include the use of assertive community treatment teams which among other things seek to contribute towards improving an individual's living conditions and work status [83]

Many service user organisations in Europe, e.g. in England and the Netherlands, (as well as other stakeholders) support the use of 'advanced directives', where an individual when well specifies how they wish to be treated if they become unwell [84, 85]. Such advance directives were thought to be empowering and potentially destigmatising, although it was recognised that many problems need to be overcome in their implementation. Another alternative to empower individuals to have more control over treatments are crisis cards which again state preferences in anticipation of a time when a person is too ill to express their views directly [86]. While these issues have been considered only in high-income countries, in principle such approaches might be used in all settings with some local adaptation.

6.4 Anti discriminatory legislation

There is also a role to be played by legislation, although to date its impact has not been well evaluated [87]. Legislative instruments from the UN, the Council of Europe, the EU and others are intended to protect the human rights of people with mental health problems. They can only promote social inclusion however if effectively monitored with adequate sanctions where required to effect change.

Legislation and regulations have an important role, in particular, to play in fighting discrimination in the workplace. The Mental Health Economic European Network (www.mheen.org) recently looked at the existence of legislation and policies that might have been in place that might tackle discrimination in the labour market. For the most part available legislative measures address mental health as a part of disability issues generally, rather than referring to specific legislation for people with mental health problems. These policies and legislative measures cover a number of specific themes, for example many countries have policies on employment quotas, directing the number of people with a severe disability that should be employed by companies over a certain size (they do not specify the type of disability – so those with mental health problems are often excluded).

There are also anti-discrimination laws and closely related laws to promote inclusion rather than prevent discrimination. In some countries, Germany and Portugal for example, some employers receive a tax rebate if they employ an individual with a disability. In other countries, grants are available to adapt workplaces to make them more amenable to people with disabilities. Governments may also finance sheltered employment: in Bulgaria, the Ministry of Labour and Social Affairs provides economic incentives to firms owned by disabled people.

As it is mandatory to have anti discrimination laws in the European Union there are also opportunities to share experiences between different countries. For instance how successful such laws have been to reduce discrimination against people with mental health problems and what might this mean for the drafting and implementation of new legislation [70].

Conclusions

Poor mental health has substantial personal and economic impacts across the European Union. Stigma and discrimination associated with poor mental health exacerbate these impacts. Consistently evidence points towards strongly negative attitudes towards people with mental health problems: in particular there is an inaccurate view that they represent a danger to the community, a view strongly reinforced in the media. Negative attitudes are not only found among the general public, but even among mental health professionals. This and other elements of stigma increases social distance: it for instance reduces the likelihood of an individual becoming employed or accessing health care services. It is important that strategies to counter stigma are evidence-based.

While there has been much research on stigma, particularly in Germany and the UK, evidence on effective and cost effective interventions remains highly limited and steps to plug this gap in our knowledge through careful evaluation of different interventions in different contexts would be well merited. Interventions need to be able to reduce the social distance that leads to the stigmatisation, prejudice and social exclusion of many of our fellow Europeans. Promising programmes include initiatives to help people return to work and education/awareness campaigns that are targeted at segments of the population most likely to come into contact with people with mental health needs.

References

1. Wittchen, H.U. and F. Jacobi, *Size and burden of mental disorders in Europe--a critical review and appraisal of 27 studies*. Eur Neuropsychopharmacol, 2005. **15**(4): p. 357-76.
2. Andlin-Sobocki, P., et al., *Cost of disorders of the brain in Europe*. Eur J Neurol, 2005. **12 Suppl 1**: p. 1-27.
3. Knapp, M., *Hidden costs of mental illness*. Br J Psychiatry, 2003. **183**: p. 477-8.
4. Thornicroft, G., et al., *The personal impact of schizophrenia in Europe*. Schizophr Res, 2004. **69**(2-3): p. 125-32.
5. van Wijngaarden, B., A.H. Schene, and M.W. Koeter, *Family caregiving in depression: impact on caregivers' daily life, distress, and help seeking*. J Affect Disord, 2004. **81**(3): p. 211-22.
6. Ostman, M. and L. Hansson, *Appraisal of caregiving, burden and psychological distress in relatives of psychiatric inpatients*. Eur Psychiatry, 2004. **19**(7): p. 402-7.
7. Anderson, R., R. Wynne, and D. McDaid, *Housing and employment*, in *Mental Health Policy and Practice Across Europe*, M. Knapp, et al., Editors. 2007, Open University Press: Buckingham.
8. All Party Parliamentary Group on Prison Health, *The mental health problem in UK HM Prisons*. 2006, House of Commons: London.
9. Dressing, H. and H.J. Salize, *Compulsory admission of mentally ill patients in European Union Member States*. Soc Psychiatry Psychiatr Epidemiol, 2004. **39**(10): p. 797-803.
10. Angermeyer, M.C. and H. Matschinger, *The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder*. Acta Psychiatr Scand, 2003. **108**(4): p. 304-9.
11. Corrigan, P.W., *How clinical diagnosis might exacerbate the stigma of mental illness*. Soc Work, 2007. **52**(1): p. 31-9.
12. Mansell, J., et al., *Deinstitutionalisation and community living – outcomes and costs: report of a European Study. Volume 1: Executive Summary*. 2007, Tizard Centre, University of Kent: Canterbury.
13. Matschinger, H. and M.C. Angermeyer, *The public's preferences concerning the allocation of financial resources to health care: results from a representative population survey in Germany*. Eur Psychiatry, 2004. **19**(8): p. 478-82.
14. Schomerus, G., H. Matschinger, and M.C. Angermeyer, *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, 2006. **41**(5): p. 369-77.
15. Lauber, C., C. Nordt, and W. Rössler, *Lay beliefs about treatments for people with mental illness and their implications for anti-stigma strategies*. Canadian Journal of Psychiatry, 2005. **50**: p. 745-752.
16. Lauber, C., *Stigma and discrimination against people with mental illness: a critical appraisal*. Epidemiol Psychiatr Soc, 2008. **17**(1): p. 10-3.
17. Porter, R., *History of mental illness*. 1998.
18. Thornicroft, G., *Shunned: Discrimination against people with mental illness*. 2006, Oxford: Oxford University Press.
19. Lauber, C. and W. Rössler, *Stigma towards people with mental illness in developing countries in Asia*. Int Rev Psychiatry, 2007. **19**(2): p. 157-78.
20. Angermeyer, M.C. and S. Dietrich, *Public beliefs about and attitudes towards people with mental illness: a review of population studies*. Acta Psychiatr Scand, 2006. **113**(3): p. 163-79.
21. Wilson, C., et al., *How mental illness is portrayed in children's television. A prospective study*. British Journal of Psychiatry, 2000. **175**: p. 440-443.
22. Rose, D., et al., *250 labels used to stigmatise people with mental illness*. BMC Health Serv Res, 2007. **7**: p. 97.
23. Corrigan, P.W., A.C. Watson, and F.E. Miller, *Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members*. J Fam Psychol, 2006. **20**(2): p. 239-46.
24. Gonzalez-Torres, M.A., et al., *Stigma and discrimination towards people with schizophrenia and their family members. A qualitative study with focus groups*. Soc Psychiatry Psychiatr Epidemiol, 2007. **42**(1): p. 14-23.
25. Angermeyer, M.C. and H. Matschinger, *The stigma of mental illness in Germany: a trend analysis*. Int J Soc Psychiatry, 2005. **51**(3): p. 276-84.
26. Schomerus, G., et al., *Public attitudes towards prevention of depression*. J Affect Disord, 2008. **106**(3): p. 257-63.

27. Braunholtz, S., et al., *Well? What do you think? (2006): The third national Scottish survey of public attitudes to mental health, mental wellbeing and mental health problems*. 2007, Scottish Government Social Research: Edinburgh.
28. TNS, *Attitudes to mental illness 2007*. 2007, Office of National Statistics: London.
29. Müller, B., et al., *Mental illness, stigma and social support: A longitudinal approach*. Social Science and Medicine, 2006. **62**: p. 39-49.
30. Link, B.G., et al., *Public conceptions of mental illness: labels, causes, dangerousness, and social distance*. Am J Public Health, 1999. **89**(9): p. 1328-33.
31. Phelan, J.C. and B.G. Link, *The growing belief that people with mental illnesses are violent: the role of the dangerousness criterion for civil commitment*. Soc Psychiatry Psychiatr Epidemiol, 1998. **33 Suppl 1**: p. S7-12.
32. Link, B. and F. Cullen, *Contact with the mentally ill and perceptions of how dangerous they are*. J Health Soc Behav 1986. **27**: p. 289-302.
33. Anglin, D.M., B.G. Link, and J.C. Phelan, *Racial differences in stigmatizing attitudes toward people with mental illness*. Psychiatr Serv, 2006. **57**(6): p. 857-62.
34. Taylor, P.J. and J. Gunn, *Homicides by people with mental illness: myth and reality*. Br J Psychiatry, 1999. **174**: p. 9-14.
35. Shaw, J., et al., *Mental illness in people who kill strangers: longitudinal study and national clinical survey*. British Medical Journal, 2004. **328**(7442): p. 734-7.
36. Simpson, A.I., et al., *Homicide and mental illness in New Zealand, 1970-2000*. Br J Psychiatry, 2004. **185**: p. 394-8.
37. Shaw, J., et al., *Rates of mental disorder in people convicted of homicide. National clinical survey*. Br J Psychiatry, 2006. **188**: p. 143-7.
38. Scheff, T., *The role of the mentally ill in the dynamics of mental disorder: a research framework*. Sociometry, 1963. **26**: p. 436-453.
39. Angermeyer, M.C. and B. Schulze, *Reinforcing stereotypes: how the focus on forensic cases in news reporting may influence public attitudes towards the mentally ill*. Int J Law Psychiatry, 2001. **24**(4-5): p. 469-86.
40. Corrigan, P.W., et al., *Newspaper stories as measures of structural stigma*. Psychiatr Serv, 2005. **56**(5): p. 551-6.
41. Lauber, C., et al., *Do mental health professionals stigmatise their patients?* Acta Psychiatr Scandinavica, 2006. **113**(Suppl 429): p. 51-59.
42. Ruiz, J. and C. Miller, *An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness*. Police Quarterly, 2004. **7**(3): p. 359-371.
43. Pinfold, V., et al., *Reducing psychiatric stigma and discrimination--evaluating an educational intervention with the police force in England*. Soc Psychiatry Psychiatr Epidemiol, 2003. **38**(6): p. 337-44.
44. Psarra, V., et al., *Greek police officers' attitudes towards the mentally ill*. International Journal of Law and Psychiatry, 2008. **31**: p. 77-85.
45. Nordt, C., W. Rossler, and C. Lauber, *Attitudes of mental health professionals toward people with schizophrenia and major depression*. Schizophr Bull, 2006. **32**(4): p. 709-14.
46. Office of the Deputy Prime Minister, *Mental Health and Social Exclusion: Social Exclusion Unit Report*. 2004, HMSO: Norwich.
47. Latimer, E.A., et al., *The cost of high-fidelity supported employment programs for people with severe mental illness*. Psychiatr Serv, 2004. **55**(4): p. 401-6.
48. Grove, B., *Mental health employment - shaping a new agenda*. Journal of mental health, 1999. **8**: p. 131-140.
49. Priebe, S., et al., *Employment, attitudes toward work, and quality of life among people with schizophrenia in three countries*. Schizophr Bull, 1998. **24**(3): p. 469-77.
50. Marwaha, S. and S. Johnson, *Schizophrenia and employment - a review*. Soc Psychiatry Psychiatr Epidemiol, 2004. **39**(5): p. 337-49.
51. Schulze, B. and M.C. Angermeyer, *Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals*. Soc Sci Med, 2003. **56**(2): p. 299-312.
52. Kilian, R. and T. Becker, *Macro-economic indicators and labour force participation of people with schizophrenia*. Journal of Mental Health, 2007. **16**(2): p. 211-222.
53. Marwaha, S., et al., *Rates and correlates of employment in people with schizophrenia in the UK, France and Germany*. Br J Psychiatry, 2007. **191**: p. 30-7.

54. Berthoud, R., *The employment rates of disabled people*. 2006, Department of Work and Pensions: London.
55. Manning, C. and P. While, *Attitudes of employer to the mentally ill*. Psychitric Bull, 1995. **19**: p. 541-543.
56. Rinaldi, M. and R. Hill, *Insufficient Concern*. 2000, London: Merton MIND.
57. McDaid, D. and T. Matosevic, *Analysis of focus group results from the Optiwork project*. . 2008, London School of Economics and Political Science.: London.
58. PFRON, *Postawy pracodawców wobec zatrudniania osób niepełnosprawnych*. 1999, State Disability Fund (PFRON): Warsaw.
59. Społecznej, C.B.O., *Polacy wobec chorób psychicznych i osób chorych psychicznie*”, komunikat z badań, . 2005, Lipiec: Warsaw.
60. See Me Scotland, *See me so far: a review of the first four years of the Scottish anti-stigma campaign*. 2006, See Me Scotland: Edinburgh.
61. NESF, *National Economic and Social Forum Report on Mental Health and Social Inclusion 2007*, National Economic and Social Forum: Dublin.
62. Thornicroft, G., *Stigma and discrimination limit access to mental health care*. Epidemiol Psychiatr Soc, 2008. **17**(1): p. 14-9.
63. Wang, P.S., et al., *Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys*. Lancet, 2007. **370**(9590): p. 841-50.
64. World Health Organisation World Mental Health Survey Consortium, *Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organisation world mental health surveys*. Journal of the American Medical Association, 2004. **291**: p. 2581-2590.
65. Schomerus, G. and M.C. Angermeyer, *Stigma and its impact on help-seeking for mental disorders: what do we know?* Epidemiol Psychiatr Soc, 2008. **17**(1): p. 31-7.
66. Corrigan, P.W. and A. Wassel, *Understanding and influencing the stigma of mental illness*. J Psychosoc Nurs Ment Health Serv, 2008. **46**(1): p. 42-8.
67. Keating, F. and D. Robertson, *Fear, black people and mental illness. A vicious circle?*. Health and Social Care in the Community, 2004. **12**(5): p. 439-447.
68. Potts, Y., M. Gillies, and S. Wood, *Lack of mental well-being in 15-year-olds: an undisclosed iceberg?* Family Practice, 2001. **18**: p. 95-100.
69. Lasalvia, A. and M. Tansella, *Fighting discrimination and stigma against people with mental disorders*. Epidemiol Psychiatr Soc, 2008. **17**(1): p. 1-9.
70. Thornicroft, G., et al., *Reducing stigma and discrimination: Candidate interventions*. Int J Ment Health Syst, 2008. **2**(1): p. 3.
71. Crisp, A., L. Cowan, and D. Hart, *The College's Anti-Stigma Campaign, 1998 -2003. A shortened version of the concluding report*. Psychiatric Bulletin, 2004. **28**(4): p. 133-136.
72. Gaebel, W., et al., *Evaluation of the German WPA "program against stigma and discrimination because of schizophrenia--Open the Doors": results from representative telephone surveys before and after three years of antistigma interventions*. Schizophr Res, 2008. **98**(1-3): p. 184-93.
73. Phelan, J.C. and B.G. Link, *Fear of people with mental illnesses: the role of personal and impersonal contact and exposure to threat or harm*. J Health Soc Behav, 2004. **45**(1): p. 68-80.
74. Corrigan, P.W., et al., *Three strategies for changing attributions about severe mental illness*. Schizophr Bull, 2001. **27**(2): p. 187-95.
75. Pinfold, V., et al., *Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools*. Br J Psychiatry, 2003. **182**: p. 342-6.
76. Wright, A., et al., *Development and evaluation of a youth mental health community awareness campaign - The Compass Strategy*. BMC Public Health, 2006. **6**: p. 215.
77. Burns, T., et al., *The Impact of Supported Employment and Working on Clinical and Social Functioning: Results of an International Study of Individual Placement and Support*. Schizophr Bull, 2008.
78. Catty, J., et al., *Predictors of employment for people with severe mental illness: results of an international six-centre randomised controlled trial*. Br J Psychiatry, 2008. **192**(3): p. 224-31.
79. Burns, T., et al., *The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial*. Lancet, 2007. **370**(9593): p. 1146-52.
80. Latimer, E.A., et al., *Generalisability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial*. Br J Psychiatry, 2006. **189**: p. 65-73.
81. NIMHE, *From here to equality: strategic plan to tackle stigma and discrimination in mental health*. 2004, National Institute for Mental Health in England: Leeds.

82. Department of Health, *Action on stigma: promoting mental health, ending discrimination at work*. 2006, Department of Health: London.
83. Thornicroft, G. and M. Tansella, *Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence*. Br J Psychiatry, 2004. **185**: p. 283-90.
84. Atkinson, J.M., H.C. Garner, and W.H. Gilmour, *Models of advance directives in mental health care: stakeholder views*. Soc Psychiatry Psychiatr Epidemiol, 2004. **39**(8): p. 673-80.
85. Varekamp, I., *Ulysses directives in The Netherlands: opinions of psychiatrists and clients*. Health Policy, 2004. **70**(3): p. 291-301.
86. Sutherby, K., et al., *A study of 'crisis cards' in a community psychiatric service*. Acta Psychiatr Scand, 1999. **100**(1): p. 56-61.
87. Parker, C., *Mental health and human rights*, in *Mental Health Policy and Practice Across Europe*, M. Knapp, et al., Editors. 2007, Open University Press: Buckingham.