Open Forum

Where is the Evidence Supporting Public Service Announcements Against Mental Illness Stigma?

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Abstract

Advocates and social marketers have used significant government resources to develop public service announcements (PSAs) as a lead strategy for public education and awareness campaigns meant to eliminate the stigma of mental illness. Evaluations of PSAs are needed to determine whether this is a good investment. Unfortunately, there are almost no data in the peer reviewed medical and psychological research literature addressing this question. Reports of government contractors suggest PSAs have some effect on population penetration but provide no meaningful evidence about impact; e.g., real-world change in discriminatory and affirming behaviors. Reasons for limited impact are considered. Targeted and local stigma change is proposed as a way for social marketing campaigns to enhance their impact.
Where is the Evidence Supporting Public Service Announcements Against Mental Illness Stigma?

Most advocates agree: life opportunities of people with serious mental illnesses are egregiously impeded by the stigma that corresponds with these illnesses. For example, stigma undermines vocational goals when some employers endorse it and hinders search for independent housing because some landlords agree with it. Advocacy groups have embraced a variety of strategies in order to erase stigma. Prominent among these are public service announcements (PSAs), issue-focused advertisements featured in television, radio, print, outdoor, online, mobile and other media. Typically, these are developed as part of a broader public service campaign, a multi-level program designed to tackle stigmatizing attitudes and discriminatory behavior. Some PSA campaigns require significant budgetary investments. They are comprehensive, multimedia campaigns sponsored by well-established non-profit organizations or national governments already available in many of the industrialized English speaking countries: Canada, Australia, England, New Zealand, Scotland, and the United States. Funding these campaigns encumbers resources that might be conceivably used for other public health communication efforts. Hence, these programs need to be evaluated to inform ongoing PSA development. I seek to briefly describe PSAs here and then to summarize the pulse of research on their influence. PSAs are then framed in terms of broader social marketing principles which are lead to recommendations for ongoing research and development.

Addressing the Stigma of Serious Mental Illness

Stigma has been described in terms of prejudice (agreement with stereotypic beliefs leading to hostile emotional responses like fear and anger) and discrimination (the behavioral
consequence of prejudice causing social distance and loss of opportunity (e.g., a good job or nice place to live)) (1). There has been opposition against the prejudice and discrimination of serious mental illness in America for more than a century with consumer groups having the most organized and strident voice during this time. Clifford Beers, founder of what was then called the National Committee for Mental Hygiene (now Mental Health America), authored *A Mind that Found Itself* in 1908, a summary of his experiences in psychiatric hospitals of the era and endemic abuse characteristic of the system (2). In 1977, Judi Chamberlin wrote *On Our Own*, widely recognized as the consumer manifesto for personal empowerment and against stigma (3). Advocacy against stigma’s pernicious effects has soared in the past decade with the energy and resources of professional groups (e.g., the American Psychiatric Association and the World Psychiatric Association), advocacy groups (NAMI and Mental Health America), pharmaceutical companies (Eli Lilly), and government bodies (in the U.S.: the Substance Abuse and Mental Health Services Administration (SAMHSA) and NIMH).

Based on a review of the social psychological literature, programs meant to eliminate the stigma of mental illness have been described as educational or contact-based (4). Educational programs provide information meant to challenge the prejudice and discrimination of psychiatric disorders. Some research has supported this hypothesis (5-7) though other studies suggest effects of education are relatively short lived (8). Stigma is further diminished when members of the general public have direct contact with people with mental illness who are able to hold down jobs or live as good neighbors in the community. Research shows that members of the community who meet and interact with people with mental illness as part of anti-stigma programs are less likely to show prejudicial attitudes and some proxies of discriminatory behavior (8-10). Although some PSAs fall neatly into these categories many combine education
and contact; they include a person who, in the process of telling his or her story, shares important facts about the illness.

**Examples of PSAs.** The U.S. government seemed to have actively pursued anti-stigma campaigns in a systematic way after the 1999 White House Conference on Mental Health. As a result, Tipper Gore and Alma Powell formed the National Mental Health Awareness Campaign in 2001 which, among its materials, were PSAs featuring adolescents forthrightly discussing their experience with major depression. The advertisements targeted teens with age-appropriate music and graphics, and were distributed to teen-friendly media outlets like MTV. SAMHSA has been a major force in anti-stigma efforts since then. In 2004, SAMHSA started the Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (http://www.promoteacceptance.samhsa.gov), a project designed to counter prejudice and discrimination associated with mental illness by sharing information and by providing technical assistance to help organizations design and implement anti-stigma initiatives. SAMHSA partnered with and the Ad Council to develop a campaign -- *What a Difference a Friend Makes* -- designed to encourage young adults to step up and support friends living with mental health problems. The PSAs launched nationally in December 2006 and incorporated television, radio, outdoor, print and web elements, including a printed brochure and new website. An especially poignant television PSA within the campaign (http://www.whatabdifference.samhsa.gov/site.asp?nav=nav00&content=6_0_media) had two young men sitting next to each other in a darkened room playing a computer game. They are seemingly frozen, not pushing the buttons on their controllers, appear uncomfortable stealing sidelong looks at each other. **Voice Over:** "It can be a little awkward when your friend tells you he's been diagnosed with a mental illness. But what's even more awkward is if you're not there
for him, he's less likely to recover.” **GUY 2 then says:** “I'm here to help, man. Whatever it takes.” The PSA fades to the website: [www.whatadifference.org](http://www.whatadifference.org).

This is actually SAMHSA’s second anti-stigma campaign with PSAs; the first was called the Elimination of Barriers Initiative (EBI) a 3-year pilot project begun with eight states in 2003. The scene in one of its PSAs showed “regular people” (a storeowner, a mother of two, and an honor student) with a voiceover that states all the people shown have “recovered from a mental illness.” It ended with the phone number of the National Mental Health Information Clearinghouse and its Internet address.

Another PSA, most recent at the time of writing this paper, had support from SAMHSA and NIMH. It was released on October 21, 2009 and featured film star Glenn Close ([bringchange2mind.com](http://bringchange2mind.com)). Set in a large train station, pairs of actors wore light colored t-shirts, half of them labeled in blue print with a mental illness. They were partnered with a person labeled as a loved one. For example, one man’s shirt says “schizophrenia;” next to him in a similar shirt is “mom”. Another was “bipolar” and paired with “better half.” Glenn Close’s shirt reads “sister;” standing next to her is real-life sister Jessie with “bipolar” on her shirt. There are definite benefits to this kind of PSA. Close’s star power, for example, had significant effects as evidenced by the news and online activity created by the PSA.

Evaluating PSAs

Although evidence is needed to determine PSA influence, a search for existing research is a bit disconcerting. There are few published studies on evaluation of American PSA efforts in the traditional research literature; e.g., what might be found via PsychInfo, google scholar, and PubMed. In fact, no data on PSA effects were found there. SAMHSA contractors provide data but these reports typically lack peer review. General considerations about PSAs from the public
health field do provide some interesting guidelines; e.g., they distinguish assessment of PSAs on penetration and impact (11-12). Penetration is the extent to which a targeted population is made aware of and otherwise informed about mental illness stigma. Impact is the degree to which penetration leads to important change in prejudice and discrimination.

Penetration might be viewed as a function of recall and recognition memory; can individuals remember seeing or hearing a specific PSA? Consider this self-test as one way to assess PSA effects. Ask how many people in a group of acquaintances recall seeing the Glenn Close PSA, "Change a Mind." The Ad Council does not measure recall of its advertising per se but provided a report with recognition scores for the tracking survey on the What a Difference campaign. An online tracking survey found that 31% of a sample of 18 to 25 year old adults recognized any PSA from the What a Difference campaign in March 2008, and 28% recognized any PSA in May 2009.

Impact is more difficult to assess. One way has been in terms of visits to websites listed at the end of many PSAs based on the rationale that viewers are seeking further information to better learn about and work against stigma. The Ad Council reported website traffic for the What a Difference campaign from the launch of the campaign in December 2006 through September 2008 with a monthly median of 64,098 visits. In the first month of the campaign, website visits increased to a high of 102,416 in September 2007. Average time spent on the website was almost 8 minutes. Findings were a bit different for EBI PSAs (13). Monthly visits to the site almost tripled from 2,743 to 7,627 during its eight month campaign beginning November, 2004, highly significant indeed. Size of effect, however, is quite small. U.S. Census data as of July 2008 reported 124 million residents in the eight pilot states. That means 0.000061% of people in these states visited the website. Of additional concern, however, was
the finding that 88% of visitors exited the website in less than one minute; less than 30% of
visitors returned to the site in the subsequent months.

Website visits is a limited indicator of impact. It does not show whether learning from
the website leads to any important change: whether employers are hiring more people with
mental illness or landlords renting property more to them. In some ways, addressing the stigma
of mental illness is more difficult than the goals of PSAs targeting other health goals where goals
are more discrete. The end product of smoking PSAs is to stop cigarettes and breast cancer
PSAs to get tested for the malignancy. What more or less is sought in the mental illness stigma
PSAs? Some social critics have argued that PSAs targeting nebulous social justice goals might
lead to slacktivism (14). It reflects feel-good measures requiring minimal effort in support of a
social cause, that has little meaningful effect other than yielding self-satisfaction. Examples
include signing internet petitions, wearing awareness ribbons for social justice, or joining a
Facebook advocacy group. So might a concern be about mental illness stigma. People
electronically voice a concern that translates to little effort for real change.

Consistent with the health examples above are PSA efforts meant to guide people in need
of psychiatric services into local treatments. Corresponding websites could be a clearinghouse
for this purpose. Unfortunately, data on this kind of impact are absent from the literature. In
sum, therefore, research on PSAs is mostly lacking, provides moderate support for penetration at
best, and fails to show meaningful impact at this time.

Social Marketing for Targeted and Local Stigma Change START for refs

Who should be the object of anti-stigma approaches? Program targets for many PSAs are
samples of the entire population (e.g., all American TV viewers). Contrast this to a strategy for
narrower, targeted anti-stigma efforts. Targets are important when they describe a power role
vis-à-vis people with psychiatric disability and might include employers, landlords, legislators, educators, and health care providers (15-17). Some employers, for example, agree, “People with serious mental illness are not able to do real work,” so they do not interview people with mental illness for job openings. Prejudice and discrimination specific to this targeted group is a good base for a social marketing campaign. For example, a goal of a social marketing effort aimed at employers would seek to replace myths with contact; i.e., “Most people with serious mental illness can work a regular job, especially with legal accommodations.”

Effective stigma change is not only targeted, but local, too. Anti-stigma programs are likely to be more effective when they target a power group living or working in a relevant and accessible community. For example, although generally targeting employers to change prejudice and discrimination is potentially beneficial, challenging the stigma of employers working in the Greater Lawn neighborhood of Chicago (a largely African American and low SES area) is even more potent. Describing a community in terms of diversity (e.g., by ethnicity and SES), economic opportunity (availability of jobs), and resources (available mental health or educational programs) will significantly advance corresponding anti-stigma programs.

A call for targeted and local anti-stigma programs seems to diminish the potential influence of population-focused PSAs. One of the strengths of the Glenn Close PSA, for example, was the tens of millions of people who first viewed it during the last months of 2009. Breadth of PSA penetration is narrowed when addressing targeted goals. Instead of distributing population-focused PSAs to all radio and television media in a market, approaches targeting employers might use social marketing plans in venues rich in business people. Service groups such as Rotary International, for example, may be excellent venues for targeting employers.
Note, that PSAs *per se* might seem cold and distant in such a relatively intimate setting. In these situations, actual contact with a person with mental illness may yield the best impact.

**Future Directions**

Given these findings, I propose three directions for future consideration. (1) Clearly resources for future public service and PSA campaigns need to include support of evaluation efforts examining not only penetration but whether the PSA yielded any tangible positive impact. (2) In some ways, PSAs presented in this paper were an anachronism; fewer and fewer people are using television and radio as major sources of the media (18-19). Many Americans, especially the younger, rely on a variety of online resources including social networking and relatively instant information via twitter. At this point, however, no systematized or widespread strategies have emerged to address internet phenomena. (3) Population-based approaches to stigma change need to be balanced with more targeted and local effects. Social marketing efforts need to be developed for individual power groups in order for the employer to interview and hire more people with mental illness and the landlord to rent to them. Funds may need to be diverted from PSA development to realize these kinds of programs. Considerations like these will help advocates partner with funders to develop programs that have the greatest impact on stigma and that further free up opportunities of people with mental illness.
References


