# Where Is the Evidence Supporting Public Service Announcements to Eliminate Mental Illness Stigma?

Patrick W. Corrigan, Psy.D.

**Advocates and social marketers have used substantial resources to develop public service announcements (PSAs) as a lead strategy in public education and awareness campaigns meant to eliminate stigma associated with mental illness. Evaluations of PSAs are needed to determine whether this is a good investment. The author notes that very few studies have been reported in the peer-reviewed medical and psychological research literature addressing this question. Reports of government contractors suggest that PSAs have some effect as measured by population penetration, but such data provide no meaningful evidence about the impact of PSAs, such as real-world change in prejudicial attitudes and discriminatory behaviors. The author considers reasons for the limited impact of PSAs and proposes that social marketing campaigns could enhance their impact by targeting local groups. (*Psychiatric Services* 63:79–82, 2012)**

Most advocates agree: life opportunities of people with serious mental illnesses are egregiously impeded by stigmatizing attitudes toward and beliefs about mental illness. For example, stigma undermines vocational goals when employers share these beliefs and attitudes and hinders the search for independent housing when landlords do so.

*The author is affiliated with the College of Psychology, Illinois Institute of Technology, 3424 S. State St., Chicago, IL 60616 (e-mail: corrigan@iit.edu).*

Advocacy groups have embraced a variety of strategies to erase stigma. Prominent among them 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 multilevel program designed to tackle stigmatizing attitudes and discriminatory behavior. Some PSA campaigns require significant financial investments. They are comprehensive, multimedia campaigns sponsored by well-established nonprofit organizations or national governments; such campaigns have been undertaken in many industrialized English-speaking countries, including Canada, Australia, England, New Zealand, Scotland, and the United States. Funding these campaigns encumbers resources that might be used for other public health communication efforts. Thus these programs need to be evaluated to inform ongoing PSA development. In this Open Forum, I briefly describe PSAs and then summarize evidence on their influence. PSAs are then framed in terms of broader social marketing principles, which 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, such as fear and anger) and discrimination (the behavioral consequence of prejudice, which leads to social distance and the loss of opportunity, such as a good job or nice place to live) (1). For more than a century in the United States, there has been opposition to prejudice and discrimination associated with serious mental illness, with consumer groups having the most organized and strident voice. In 1908 Clifford Beers, founder of the National Committee for Mental Hygiene (now Mental Health America), wrote *A Mind That Found Itself,* a summary of his experiences in psychiatric hospitals of the era, where he encountered the abuse that was 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 (for example, the American Psychiatric Association and the World Psychiatric Association), advocacy groups (for example, the National Alliance on Mental Illness and Mental Health America), pharmaceutical companies (for example, Eli Lilly), and government bodies (for example, the Substance Abuse and Mental Health Services Administration [SAMHSA] and the National Institute of Mental Health [NIMH]).

In the social psychology literature, programs meant to eliminate the stigma of mental illness have been described as educational or contact based (4). Educational programs provide information as a way to challenge prejudice and discrimination. Some research has supported this hypothesis (5–7), although other studies sug-

gest that 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 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 antistigma 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; for example, some PSAs feature a person who, in the process of telling his or her story, shares important facts about the illness.

## Examples of PSAs

After the 1999 White House Conference on Mental Health, the U.S. government seems to have actively pursued antistigma campaigns in a systematic way. As a result, Tipper Gore and Alma Powell formed the National Mental Health Awareness Campaign in 2001. 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 such as MTV.

SAMHSA has been a major force in antistigma efforts. In 2004, SAMHSA started the Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated With Mental Health (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 antistigma initiatives. SAMHSA partnered with 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 print brochure and new Web site. In an especially poignant television PSA in the campaign, two young men are sitting next to each other in a darkened room playing a computer game (www.whatadifference.samhsa.gov/site.asp?nav=nav00&content=6_0_media). They are seemingly frozen, not pushing the buttons on their controllers, and they 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." One of the young men then says, "I'm here to help, man. Whatever it takes." The PSA fades to the URL for the Web site (www.whatadifference.org).

This campaign is actually SAMHSA's second antistigma campaign with PSAs; the first was called the Elimination of Barriers Initiative (EBI) a three-year pilot project begun in eight states in 2003. One of its PSAs featured a scene with "regular people" (a storeowner, a mother of two, and an honor student) with a voice-over that stated that 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, the most recent when this Open Forum was written, received support from SAMHSA and NIMH. It was released on October 21, 2009, and features film star Glenn Close (bringchange2mind.com). Set in a large train station, pairs of actors wear light-colored T-shirts, half of them labeled in blue print with a mental illness. Each is partnered with another person labeled as a loved one. For example, one man's shirt says "schizophrenia," and next to him in a similar shirt is "mom." Another man wears a shirt with "bipolar," and paired with him is "better half." Glenn Close's shirt reads "sister," and 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, has had notable effects, as evidenced by the news coverage and online activity created by the PSA.

## Evaluating PSAs

Evidence is needed to determine the influence of PSAs, but a search for published studies is a bit disconcerting. There are few on the evaluation of U.S. PSA efforts in the traditional research literature—for example, in searches using via PsycINFO, Google Scholar, and PubMed. In fact, no studies on the effects of PSAs were found in such searches. SAMHSA contractors collect data, but their reports are typically not peer reviewed. General considerations about PSAs from authors in the public health field provide some interesting guidelines. For example, they assess PSAs on the basis of 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 of a PSA's 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 it provided a report with recognition scores for the tracking survey on the campaign "What a Difference a Friend Makes." An online tracking survey found that 31% of a sample of young adults age 18 to 25 recognized any PSA from the campaign in March 2008, and 28% recognized any PSA in May 2009.

Impact is more difficult to assess. One approach is to examine visits to Web sites listed at the end of many PSAs; this is based on the rationale that viewers are seeking further information to learn more about stigma and to work against it. The Ad Council reported Web site traffic for the "What a Difference" campaign from its launch in December 2006 through September 2008, with a monthly median of 64,098 visits. From the first month of the campaign to September 2007, Web site visits increased to a high of 102,416. Average time spent on the Web site was almost eight minutes.

Findings were a bit different for PSAs from EBI (13). During its eight-month campaign that began in November 2004, monthly visits to the site almost tripled, from 2,743 to 7,627—a highly significant increase. The effect size, however, is quite small. U.S. Census data as of July 2008 reported 124 million residents in the eight pilot states, which means that .000061% of people in these states visited the Web site. Of additional concern, however, was the finding that 88% of visitors exited the Web site in less than one minute; less than 30% of visitors returned to the site in the subsequent months.

Measuring Web site visits is a limited indicator of impact. It does not show whether learning from the Web site leads to any important change: whether employers are hiring more people with mental illness or landlords are more likely to rent property to them. In some ways, addressing the stigma of mental illness is more difficult than targeting the more discrete health goals of other PSAs. The goal of antismoking PSAs is to stop cigarette smoking, and the goal of breast cancer PSAs to persuade more women to get tested. 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). This term refers to feel-good measures that require minimal effort in support of a social cause and that have little meaningful effect other than yielding self-satisfaction. Examples include signing Internet petitions, wearing awareness ribbons for a social justice cause, or joining a Facebook advocacy group. Concern about mental illness stigma may fall into this category. People use their "electronic voice" to express a concern that translates to little effort for real change.

Consistent with the health examples above are PSA efforts that are designed to guide people in need of psychiatric services to seek treatments. A Web site included in such a campaign might be a clearinghouse for this purpose. Unfortunately, data on this kind of impact are absent from the literature.

In sum, 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 change

Who should be the target of antistigma campaigns? For many PSAs, targets are samples of the entire population (for example, all TV viewers in the United States). This can be contrasted with a strategy for narrower, targeted antistigma efforts. Targets are important when they play a power role vis-à-vis people with a psychiatric disability; such targets might include employers, landlords, legislators, educators, and health care providers (15–17). Some employers, for example, agree with the statement, "People with serious mental illness are not able to do real work," and therefore they do not interview people with mental illness for job openings. Prejudice and discrimination specific to this targeted group provide a good base for a social marketing campaign. For example, a goal of an effort aimed at employers would be to replace myths with contact—"Most people with serious mental illness can work a regular job, especially with legal accommodations."

Effective stigma change is not only targeted but also local. Antistigma 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 targeting employers as a group to change prejudice and discrimination may be beneficial, challenging the prejudice of employers working in the Greater Lawn neighborhood of Chicago (a largely African-American area, with residents of low socioeconomic status) is even more potent. Describing a community in terms of diversity (for example, by race-ethnicity and socioeconomic status), economic opportunity (availability of jobs), and resources (availability of mental health or educational programs) will significantly advance corresponding antistigma programs.

A focus on targeted and local antistigma programs might diminish the influence of population-focused PSAs. One of the strengths of the Glenn Close PSA, for example, was that tens of millions of people viewed it during the final months of 2009. Breadth of PSA penetration is narrowed when targeted goals are addressed. Instead of distributing population-focused PSAs to all radio and television media in a market, approaches that target employers might use social marketing plans in venues that are rich in business owners and employers. Service groups such as Rotary International, for example, may be excellent venues for targeting employers. PSAs by themselves may seem cold and distant in such a relatively intimate setting as a Rotary meeting. In these situations, actual contact with a person with mental illness may have the best impact.

## Future directions

Given these findings, I propose three directions for future consideration. First, funders of public service and PSA campaigns clearly need to include support of evaluation efforts not only to examine penetration but also to determine whether the PSA yields any tangible positive impact. Second, the PSA campaigns described here are in some ways an anachronism; fewer and fewer people are using television and radio as major sources of the media (18,19). Many Americans, especially younger people, 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. Third, population-based approaches to stigma change need to be balanced with more targeted and local efforts. Social marketing efforts should be developed for individual power groups, so that employers will interview and hire more people with mental illness and landlords will rent to them. Funds may need to be diverted from PSA development to advance these kinds of programs. Considerations such as these will help advocates partner with funders to develop programs that have the greatest impact on stigma and that create more opportunities for people with mental illness.

### *Acknowledgments and disclosures*

This work was supported in part by grant MH085981-01 from the National Institute of Mental Health.

The author reports no competing interests.

### *References*

1. Corrigan P: On the Stigma of Mental Illness: Practical Strategies for Research and Social Change. Washington, DC, American Psychological Association, 2005
2. Beers C: A Mind That Found Itself. Oxford, England, Longmans, 1908
3. Chamberlin J: On Our Own. New York, McGraw-Hill, 1977
4. Corrigan P, Penn D: Lessons from social psychology on discrediting psychiatric stigma. America Psychologist 54:765–776, 1999
5. Corrigan P, River L, Lundin R, et al: Three strategies for changing attributions about severe mental illness. Schizophrenia Bulletin 27:187–195, 2001
6. Keane M: Contemporary beliefs about mental illness among medical students: implications for education and practice. Academic Psychiatry 14:172–177, 1990
7. Penn DG, K, Daily T, Spaulding W: Dispelling the stigma of schizophrenia: what sort of information is best? Schizophrenia Bulletin 20:567–578, 1994
8. Corrigan P, Rowan D, Green A, et al: Challenging two mental illness stigmas: personal responsibility and dangerousness. Schizophrenia Bulletin 28:293–309, 2002
9. Pinfold V, Toulmin H, Thornicroft G, et al: Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. British Journal of Psychiatry 182:342–346, 2003
10. Schulze B, Richter-Werling M, Matschinger H, et al: Crazy? So what! Effects of a school project on students' attitudes towards people with schizophrenia. Acta Psychiatrica Scandinavica 107:142–150, 2003
11. DeJong W, Wolf R, Austin S: US federally funded television public service announcements (PSAs) to prevent HIV/AIDS: a content analysis. Journal of Health Communication 6:249–263, 2001
12. Goldman L, Glantz S: Evaluation of antismoking advertising campaigns. JAMA 279:772–777, 1998
13. Bell J, Colangelo A, Pillen M: Final Report of the Evaluation of the Elimination of Barriers Initiative. Arlington, Va, James Bell, 2005
14. Feder B: They weren't careful what they hoped for. New York Times, May 29, 2002
15. Link B, Phelan J: Conceptualizing stigma. Annual Review of Sociology 27:363–385, 2001
16. Farina A, Felner R: Employment interviewer reactions to former mental patients. Journal of Abnormal Psychology 82:268–272, 1973
17. Bordieri J, Drehmer D: Hiring decisions for disabled workers: looking at the cause. Journal of Applied Social Psychology 16: 197–208, 1986
18. Brandtzaeg P, Lüders M, Skjetne J: Too many Facebook "friends"? Content sharing and sociability versus the need for privacy in social network sites. International Journal of Human-Computer Interaction 26:1006–1030, 2010
19. Vasalou A, Joinson A, Courvoisier D: Cultural differences, experience with social networks and the nature of "true commitment" in Facebook. International Journal of Human Computer Studies 68:719–728, 2010

## Submissions for Datapoints Column Invited

Submissions to the journal's Datapoints column are invited. Datapoints encourages the rapid dissemination of relevant and timely findings related to clinical and policy issues in psychiatry. National data are preferred. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. The analyses should be straightforward, so that the figure or figures tell the story. The text should follow the standard research format to include a brief introduction, description of the methods and data set, description of the results, and comments on the implications or meanings of the findings.

Datapoints columns, which have a one-page format, are typically 350 to 400 words of text with one or two figures. Because of space constraints, submissions with multiple authors are discouraged; submissions with more than four authors should include justification for additional authors.

Inquiries or submissions should be directed to column editors Amy M. Kilbourne, Ph.D., M.P.H. (amy.kilbourne@va.gov), or Tami L. Mark, Ph.D. (tami.mark@thomsonreuters.com).