THE POWER OF CONTACT

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ABSTRACT

Stigma and discrimination associated with mental illness is an epidemic that impacts on peoples' lives in a chronic and severely debilitating manner.

Work to counter stigma and discrimination associated with mental illness is undertaken in a myriad of ways. This piece of work involved the review and analysis of available literature on different initiatives aimed at reducing stigma and discrimination. In particular, the focus was on the impact of education and training. However, the paper has relevance to other initiatives being used to counter stigma and discrimination associated with experience of mental illness, such as work with the media. In addition, the findings have significance for mental health service development, planning and review.

The literature identifies three overarching strategies for countering stigma and discrimination associated with mental illness. These are education, contact and protest. Through the research 'education' is defined as replacing myths about mental illness with correct information, 'contact' as challenging discriminatory attitudes and behaviour through direct interactions with people with experience of mental illness and 'protest' as actions which suppress discriminatory attitudes and behaviours towards people with mental illness.

Studies have found that 'contact' is the most effective strategy in countering stigma and discrimination associated with mental illness. However, a perplexing phenomenon is that mental health professionals, who have a great deal of contact with people with experience of mental illness, often still exhibit discriminatory attitudes and behaviours. This contradiction can be reconciled with the understanding that, in order for 'contact' to be effective, several conditions must be associated with it. These are:

- Equal status
- The opportunity for individuals to get to know each other
- Information which challenges negative stereotypes
- Active co-operation
- Pursuit of a mutual goal.

These conditions are often not present in mental health service settings.

Contact, which encompasses all the conditions that have been identified to be most effective in countering stigma and discrimination, can be facilitated through the development and delivery of structured education programmes. This approach has been taken by some groups, both internationally and in New Zealand, with positive results.

It is recommended that future anti-discrimination training and education initiatives are further developed to facilitate contact of the type which is most effective in countering stigma and discrimination. More broadly, the present paper should be used to inform all anti-discrimination work.

INTRODUCTION

The recently published 'Respect Costs Nothing' survey report reflects how people with experience of mental illness have faced discrimination and the impact such discrimination has had on their lives (Mental Health Foundation, 2004). Respondents to this survey identified discrimination associated with mental illness in all aspects of their lives. Through the report it is highlighted that fear of further discrimination often prevents people from participating in many activities. In addition, internalising stereotypes about mental illness discourages people from pursuing dreams or goals.

The Mental Health Commission has identified the diverse range of activities currently being undertaken in New Zealand to counter stigma and discrimination associated with mental illness:

> *antidiscrimination activities include legislation, complaints resolution, service standards and monitoring, EEO programmes in workplaces, mass media campaigns, activities engaging with the media, workshops and other learning situations, protests, publications, story-telling, arts and culture activities, research – the list goes on. A well as the formal programmes, anti-discrimination activities occur in a myriad of ways at the informal level through social interactions amongst and between service users/tangata whaiora, service providers, families and whanau, agencies and the general public* (Mental Health Commission, 2004).

Education and training is an important aspect of work to counter sigma and discrimination associated with mental illness. However, it is acknowledged that education and training cannot, and must not, stand alone:

> *what is needed is to bring different strands of work together. In particular it would be helpful to forge a stronger synthesis between, on the one hand, securing legislative improvement and enforcement, and on the other, promoting the universal benefits of a more inclusive society. Each complements the other* (Sayce, 2003).

People working in the anti-discrimination field tend to argue about attitude change and behaviour change in a manner that is comparable to a 'chicken versus the egg' debate. Liz Sayce provides some straight forward advice on this issue:

> *the debate on whether first to force changes in behaviour, from which flow attitudinal change, or whether first to change beliefs, from which flow changed behaviours, is not reducible to one solution or the other. Both are possible. The aim is to create virtuous circles of changed beliefs and behaviours, which gradually lead to changes in disabled people's experience* (Sayce, 2003).

Despite many anecdotal reports about the effectiveness of education and training, that is delivered through Like Minds, Like Mine (LMLM) – the New Zealand Project to Counter Stigma and Discrimination Associated with Mental Illness, there has never

been a strong theoretical or evidence base to support this aspect of the work. Recent evaluations of the overall project have identified this as an issue:

> *while there are indications of good impacts from many workshops, there is a need to review the focus, to ascertain or ensure the effectiveness of these activities. Consumer safety is also an issue. The uncertainty about their effectiveness needs to be considered in relation to the personal risk for consumers (eg, where workshop formats include the disclosure of the speaker's mental illness) according to BRC* [BRC Marketing and Social Research]*. Milburn also noted that the theoretical base supports the inclusion of people with experience of mental illness, but it does not necessarily endorse people speaking of their personal experience of mental illness* (Ministry of Health, 2003).

This paper provides a review and analysis of the available literature on different initiatives aimed at reducing stigma and discrimination. In particular, the focus is on the impact of education and training. Based on the findings of the present work, recommendations for the future delivery of education and training to counter stigma and discrimination associated with mental illness are proposed.

STRATEGIES TO COUNTER STIGMA AND DISCRIMINATION

Taylor and Dear (1981) undertook a project to develop and test a tool specifically designed to measure community attitudes toward people with experience of mental illness. This tool is titled Community Attitudes Toward Mentally Ill – CAMI. Many of the studies referred to in this paper have used CAMI to evaluate the effectiveness of strategies to address stigma and discrimination associated with mental illness. The four scales that make up the CAMI are:

> ➢ **Authoritarianism** - the attitude that 'people with severe mental illness are irresponsible, so their life decisions should be made by others'.

> ➢ **Benevolence** - the attitude that 'people with severe mental illness are childlike and need to be cared for'.

> ➢ **Social Restrictiveness** - the attitude that 'people with severe mental illness are dangerous and should be separated from society'.

> ➢ **Community Mental Health Ideology** – the attitude that 'the best therapy for many mental health patients is to be part of a normal community'.

Not all studies use the same CAMI scales and Couture and Penn (2003) note that the variety of different scales used for measuring attitudes make it difficult to compare the results between studies.

Researchers have grouped various approaches to countering stigmatising attitudes and discriminatory behaviour into three overarching strategies:

> *education (which replaces myths about mental illness with correct information), contact (which challenges public attitudes about mental illness through direct interactions with persons who have these disorders) and protest (which seeks to suppress stigmatising attitudes about mental illness)* (Corrigan, River, Lundin, Penn, Uphoff-Wasowski, Campion, Mathisen, Gagnon, Bergman, Goldstein & Kubiak, 2001).

EDUCATION

The anticipated favourable impact of education, on attitudes about mental illness, is generally based on the premise that:

> *persons who seem to be more knowledgeable about mental illness are less likely to endorse stigma and discrimination* (Corrigan, River et al*., 2001).

The results of some studies do provide support for this hypothesis with participants showing improved attitudes after completing courses on mental illness (Morrison & Teta, 1980; Penn, Guynan, Daily, Spaulding, Garbin & Sullivan, 1994; Penn,

Kommana, Mansfield, & Link, 1999; Holmes, Corrigan, Williams, Canar & Kubiak, 1999).

However, despite some positive results, education as a stand-alone strategy has met with only moderate success (Corrigan & Penn, 1999) and has been rated less successful than the strategy known as contact.

The type of information and concepts presented through education programmes significantly affect their effectiveness in countering stigma and discrimination (Read & Law, 1999; Read & Harre, 2001; Walker & Read, 2002). In particular, these studies highlight that bio-genetic causal explanations of mental illness result in more negative attitudes towards people with mental illness, whereas psychosocial or trauma-related explanations result in the general public responding with more empathy and less desire for social distance.

CONTACT

In relation to the contact strategy one study (Corrigan, Green, Lundin, Kubiak & Penn, 2001) specifically examined the relationship between familiarity with, and social distance from, persons with experience of mental illness. Respondents' familiarity with mental illness was assessed based on contact with experience of mental illness:

> least intimacy ("I have never observed a person that I was aware had a serious mental illness") to medium intimacy ("I have worked with a person who had a severe mental illness at my place of employment") to high intimacy ("I have a mental illness").

The participants in this study consisted of 208 local community college students. The students completed three written measures about familiarity, perception of dangerousness, fear and social distance. The study hypothesised that familiarity influences perceptions of dangerousness, which in turn influences fear and ultimately the social distance an individual will chose to take from persons with serious mental illness.

The study found that respondents in the sample group, who had greater levels of contact with mental illness, were less likely to perceive people with experience of mental illness as dangerous and less likely to avoid them.

In a similar study (Penn et al., 1999) participants who reported previous contact with a person with experience of mental illness, perceived a hypothetical male with a mental illness in a case vignette as less dangerous. Link & Cullen (1986) examined contact amongst two group types: voluntary (i.e. someone who works or volunteers with persons with mental illness) and involuntary (i.e. knowing someone who works in mental health, a relative who has been hospitalised). They found that both groups endorsed, to a similar extent, less stigmatising attitudes toward people with mental illness. Based on the results of two population surveys conducted in Germany during 1990 and 1993, a further study (Angermeyer & Matschinger, 1996) examined to what

extent contact might influence attitudes towards people with experience of mental illness. It was concluded that:

> *with increasing experience respondents tended to react more prosocially, develop feelings of anxiety less frequently and express less desire for social distance.*

John Read, who is currently the Director of Clinical Psychology at the University of Auckland, has attributed the success of the 'Like Minds, Like Mine' campaign to:

> *it's avoidance of biological and genetic causal theories and it's focus, instead, on exposure to, and contact with, people who have experienced mental health problems* (Read, 2002).

The research provides a consistent and constant message that contact with people with experience of mental illness has a significant positive impact on stigma and discrimination associated with mental illness. Given this, it should follow that people who work within mental health services are the least discriminatory given the amount of contact they generally have with people with experience of mental illness. However, this is actually not the case. Both anecdotal and research based reports have identified the prevalence of stigma and discrimination within the mental health sector.

CONTACT THROUGH MENTAL HEALTH SERVICES

The 2002-2003 Australian SANE Mental Health Report included a key recommendation that:

> *… stigma from health professionals needs to be recognised as a problem, and tackled at the initial training stage and through continued ongoing consultative engagement with consumers and carers about their experiences.*

More recently, of 785 respondents who completed a survey about their experience of discrimination 34% reported that they had been discriminated against when using mental health services (Mental Health Foundation, 2004). The survey report identifies that discrimination from mental health services takes many forms, including:

> *disrespect, physical abuse, not being taken seriously, being talked about rather than talked to, being degraded and ill-treated, being put down, ridiculed or discouraged, and being treated as incompetent. Some respondents felt abuse was often subtle and specific to an individual staff member; others reported it as being overt and endemic.*

Several studies have noted the ineffectiveness of various initiatives aimed at generating positive attitudes among mental health professionals. In one study the attitudes of Chinese nurses were measured after they had participated in psychiatric training (Callaghan, Shan, Yu, Ching & Kwan, 1997). Training did not result in more positive attitudes; moreover attitudes were not related to prior contact as measured by reported family history of mental illness. Arkar and Ekar (1992) also found that

participation in a 3-week psychiatry rotation did not influence the attitudes of Turkish medical students. A third study showed no significant differences in attitudes between Israeli nurses who had had either high, moderate or no contact with people with experience of mental illness (Weller & Grunes, 1998).

CONDITIONS REQUIRED FOR CONTACT TO BE EFFECTIVE

In his book *The Nature of Prejudice,* Allport (1954) formally proposed the *contact hypothesis*.

The 'contact hypothesis' provides that equal status contact with members of a stigmatised group, where both groups are working in a co-operative (rather than in a competitive) manner, will counter negative stereotypes and reduce prejudice. A number of studies provide support for this hypothesis (Islam & Hewstone, 1993; Kolodziej & Johnson, 1996).

Despite its success and appeal as an anti stigma and discrimination strategy, the 'contact hypothesis' (simply involving equal status and active cooperation) does not always receive great empirical support. In one of a series of influential experiments (Sherif, Harvey, White, Hood & Sherif, 1961) researchers tested the contact hypothesis by creating two hostile rival groups among boys at a summer camp and then endeavouring to counter the prejudices they had encouraged. The researchers discovered that creating equal status contact alone had no effect on the negative intergroup attitudes. Only when the groups were given a shared superordinate goal did the boys' prejudice lessen.

One group of researchers (Desforges, Lord, Ramsey, Manson, Van Leeuwen, West & Lepper, 1991) reviewed several studies and identified a number of conditions that must be associated with contact for it to be effective in countering stigma and discrimination:

- *[i]ntergroup interactions bring about more positive attitudes only when interactions are such that members of different groups have **equal status***

- *The interaction must afford **acquaintance potential**, or the opportunity to get to know the other person*

- *The information exchanged during the interaction must be of the type that might **disconfirm a negative stereotype***

- *The participants must **pursue mutual goals***

- *The participants must **actively cooperate** with each other.*

On the basis of these findings Desforges et al. (1991) conducted a study to explore the impact of contact with people with experience of mental illness, within a setting that afforded a measure of each of the identified conditions.

214 undergraduate students participated in the study by completing a computerised survey that measured attitudes towards, and perceptions of, what participants had identified as their concept of a 'typical person with experience of mental illness'. Approximately one month later these same students were asked to volunteer for a seemingly unrelated two-hour experiment on learning strategies. This involved participants working co-operatively with a partner who, they were informed through the exchange of self-essays, had experience of mental illness and was also a member of the student body. The study found that, after completing a co-operative task, students reported improved attitudes toward the partner.

Couture and Penn (2003) conducted a review of the literature to determine the effect of interpersonal contact on stigmatising attitudes associated with mental illness. They divided contact into two categories, retrospective (contact which occurred prior to the assessment of its effectiveness) and prospective (contact which was facilitated as part of the research assessing its effectiveness, with attitudes measured before and after the contact). The results of 10 studies of retrospective contact were summarised. These studies identified that experience of retrospective contact resulted in more positive attitudes, including less social distance, fewer negative emotions and less perceptions of dangerousness. From twelve studies of prospective contact, eight reported positive changes in attitude including an increase in perceived favourable traits, a decrease in negative impressions and perceptions of dangerousness. However, four studies found no significant differences. In regards to these four studies, Couture and Penn state:

> *contact reduces stigmatizing views, but it is unclear at this time why most studies find an effect and a few do not. The majority of studies finding that contact had no effect on attitudes involved contact in job training settings. An explanation for these non-significant findings could be the nature of contact, as contact in these studies took place in a psychiatric hospital with severely afflicted individuals and the important factors discussed previously (equal status, intimacy, etc.) are less likely to have occurred in these situations.*

HOW CONTACT CHANGES ATTITUDES

Desforges et al. (1991) considered how a positive attitude change, towards an individual of a stigmatised group, could generalise to more positive attitudes to the group as a whole. They identified that such attitude change is consistent with the three stages of the model of generalisation processes:

Stage 1. **Expectation:** Individuals who know they are about to interact with a member of a stereotyped group expect to interact with someone similar to a typical member.

Stage 2. **Adjustment:** Equal status co-operative contact with a member of a negatively stereotyped group elicits a more positive impression of that person than expected.

Stage 3. **Generalisation:** The unexpectedly positive impression of the specific group member generalises to a more positive portrait of the typical member and a more positive attitude toward the wider group.

CONCLUSIONS ON CONTACT

This review highlights that, whilst the strategy of contact can be very effective in countering stigma and discrimination, it is significantly dependant on the 'context' and 'nature' of the contact. Contact needs to involve more than simply encountering a member of a stigmatised group. Several conditions must be associated with the contact for it to be most effective. This helps to explain why mental health professionals can still express stigma and discrimination, despite having considerable interaction with people with experience of mental illness. Mental health services do not necessarily support interactions that are consistent with the identified favourable conditions.

It is contended that contact, involving the identified favourable conditions, can be most easily and effectively facilitated using the education construct (albeit in a different form to simply providing information on mental illness). Education can equate to the design and delivery of programmes that involve condition favourable contact between trainers and participants.

EFFECTIVE CONTACT WITHIN AN EDUCATION CONSTRUCT

Studies have identified and investigated two distinct ways that effective contact has impacted favourably on the provision of education:

1. Where people have had condition favourable contact with people with experience of mental illness prior to involvement in education (retrospective).
2. Where people have condition favourable contact with people with experience of mental illness as part of involvement in education (prospective).

One study attempted to determine whether or not the results of an education program, about stigmatising attitudes towards schizophrenia, would be mediated by previous knowledge about and contact with severe mental illness (Holmes et al., 1999). Eighty-three study participants were recruited through one of two courses taught at a Chicago community college.

The first course covered a range of topics specifically relevant to severe mental illness and rehabilitation for people with mental illness. This course included two sixty-minute lecture/discussions. One of these lectures was presented by a consumer and the other was presented by a family member.

The second course was a general psychology course which taught students only basic theory concerning human behaviour and contained no information about challenging stigma. Nor did it include the participation of a consumer.

Participants were assessed for their previous knowledge about, and contact with, severe mental illness:

> *a friend of the family has a severe mental illness"(rank order score = 9); I have watched a documentary on television about mental illness" (rank order score = 4); my job involves providing services/treatment to people with severe mental illness' (rank order score = 7).*

Although it was anticipated that some change in attitudes might result from involvement in the second course, it was expected that a greater improvement in attitudes would be shown by those students in the first course. In addition, it was hypothesised that people with previous knowledge of, and more contact with, severe mental illness would prove better able to embrace the education program and more readily take on board more positive attitudes towards persons with severe mental illness. It was found that students of the first course showed greater improvement in both benevolent♠ and social restrictiveness attitudes. Authoritarian attitudes were not affected through involvement with either course. In addition, it was found that pre-education knowledge and contact augmented benevolent attitude change. This effect was more pronounced for participants of the first course. A contrary result was found in respect of social restrictiveness with research participants, who had prior intimate contact with mental illness, showing less improvement in attitudes about social restrictiveness. Once again, this effect was found to be greater for participants involved with the first course.

It was concluded that future research needs to identify variables, such as the inclusion of consumers and family members, which enhance education effects in respect of attitude change.

Another study (Pinfold, Toulmin, Thornicorft, Huxley, Famer & Graham, 2003) examined the effectiveness of an intervention aimed at increasing mental health literacy and challenging negative stereotypes associated with severe mental illness with young people.

A total of 472 secondary school students attended two mental health awareness workshops delivered by members of the Mid Kent mental health awareness group: a partnership initiative involving people with experience of living with mental health problems and mental health professionals.

The schools participating in the intervention program had identified concerns about the emotional well being of their pupils and sought educational sessions to address the issue. The workshops involved two 1-hour sessions where students completed pre and post-questionnaires detailing knowledge, attitudes and behavioural intentions in respect of people with experience of mental illness. Lesson plans were designed to facilitate an interactive environment.

♠ Note: Benevolence in this context means the attitude that 'people with severe mental illness are childlike and need to be cared for'.

In phase one workshops were delivered by a facilitator who worked in the field of mental health. In phase two a speaker was introduced, in a co-facilitator role, to discuss their own personal experience of living with depression or schizophrenia.

The positive rise in attitudes was significant at both the 1-week follow-up and 6-month follow-up. Changes were marked for students who knew someone with mental health problems, and the inclusion of personal talks did have an independent and positive impact on social distance scores:

> *analysis of variance identifies that baseline social distance scores and the inclusion of a personal experience talk within the programme are two variables associated independently with a reduction in social distance at the 1- week follow-up.*

Another study investigated the impact of using consumers as trainers for mental health service providers (Cook, Jonikas & Razzano, 1995). Fifty-seven state mental health professionals participated in a two day training program:

> *designed to acquaint trainees with the knowledge and attitudes necessary for them to deliver assertive case management services.*

Participants were randomly assigned to one of two training conditions; one in which they received all their training from a non-consumer and the other where they received the second day of training from a consumer. The hypothesis of this study was that there would be significantly more positive attitudes among those trained by the consumer trainer than the non-consumer trainer. It was found that:

> *after controlling for baseline attitudinal levels, those trained by the consumer trainer showed more positive attitudes overall, felt more positive about consumers as service providers and trainers, and expressed more non-stigmatising attitudes than those trained by the non-consumer.*

The value of consumers in the role of trainers was highlighted by the fact that:

> *for many participants, the consumer trainer was the highest functioning person with a mental illness they had ever encountered. This led them to confront some of their own stereotypes about what was possible for persons with this disability, recognising for the first time the strengths and wellness of persons with mental illness.*

This lead the researchers to conclude that, as trainers, consumers can assume an expert role that directly contradicts commonly held stereotypes about people with mental illness.

Furthermore, the study noted that consumer trainers could address questions related to consumer perspectives on treatment and the value of consumer empowerment.

Based on earlier studies that had found that user involvement in training had resulted in favourable changes in students' perceptions of people with experience of mental

illness, Shor and Sykes (2002) evaluated the introduction of 'structured dialogue' into the training programme of social work students. The 'structured dialogue' involved a one and a half hour meeting where two people (both who had experience of mental illness) presented some background information on the philosophy underlying the approach, an introduction of themselves, and a personal story, relating particularly to: (a) how he/she experienced the difficulties related to the psychiatric disorder; (b) his/her experience of interactions with family, with helping professionals, and with society at large; and (c) what he or she has learned about the coping and recovery process. Time was made available, at the completion of the information presented, for questions to be asked and answered.

This approach was based on the premise that relationships, between consumers and providers, naturally involve a power differential between the participants and that this difference affects the perception that each party has of the other. The authors believed that the structured dialogue would create an encounter where the two parties met as equals. They hypothesised that this would result in professionals being able to discover the humanity and diversity of people with mental illness and that this would consequently affect their perceptions.

A measure of attitude found no difference in views expressed, that were non-judgmental toward people with mental illness, before and after the meetings. However, the evaluation of the structured dialogue provided some significant insight into students' own perceptions of the value of the approach:

> *the students 'discovered' the multidimensional facets of persons with mental illness (i.e., their humanity) along with the realization that mental illness could happen to anyone, and that there are more similarities than they had thought between themselves and persons with mental illness. Learning about these components could provide the opportunity, as some of the students indicated, to confront and correct their stereotypical perceptions.*

The authors conclude that their findings indicate the potential of the structured dialogue model and discuss the implications for training mental health professionals. In particular, they comment that such training must include experiential models that enable students to interact with, and learn from, people in an open, non-threatening situation as part of their academic learning experience.

A New Zealand education initiative, which involves the facilitation of condition favourable contact through training programmes, has also had positive results.

Speakers Bureau is an initiative of the Like Minds, Like Mine campaign. Speakers Bureau was established based on the belief that the provision of formal and structured presentations by people with experience of mental illness is one of the most effective strategies for combating stigma and discrimination associated with mental illness.

In 2002, the Wellington District Training Co-ordinator for the New Zealand Police contracted the Wellington Speakers Bureau to deliver education sessions on mental illness and working with people with experience of mental illness. This training was

organised in response to a need identified within the Wellington Police District to equip Police staff with the skills and understanding for more effective interventions when working with people with experience of mental illness, particularly in crisis situations.

It was determined that the best method to meet the identified training need was through people with personal experience of mental illness delivering the bulk of the training programme. This course of action was adopted because it was felt that perceptions and stereotypes were a major barrier to effective Police practice with people with experience of mental illness.

For the Police, the Wellington Speakers Bureau developed a 3-hour interactive training session.

This training was delivered to 134 frontline Uniform personnel in the Wellington region over a 5-week period and to a further 31 Criminal Investigation Branch members at a subsequent session.

To assess participants' prior level of awareness of people with experience mental illness a short Checkpoint was administered at the very beginning of the training sessions. Immediately following completion of each session, a standardised evaluation sheet was distributed and used to record participants' perceptions of the training. The results from the Checkpoint tool indicate that existing attitudes, reinforced by Police culture, were indeed a major factor in the way Police thought of, and interacted with, people with experience of mental illness.

The post-delivery evaluation tool questioned participants about their interest in the training that was delivered by Speakers Bureau. 57% responded that they were 'completely interested' in the session and 35% that they were 'interested in most' of the session. For participants the most effective presenter factor was their experience of mental illness.

Participants were also asked about their confidence in applying what they had learned from the session in future operational settings. 24% percent felt that they were 'totally confident', 52% that they were 'fairly confident', and 23% that they were 'confident but cautious'.

There was a strong correlation between the level of interest by participants and the reported confidence in applying the learning in future operational settings.

A similar training programme has been provided to the Kent Police in the United Kingdom (Pinfold, Huxley, Thornicroft, Farmer, Toulmin, & Graham, 2003). Those workshops were delivered by a group that involved service users, carers and people working in the field of mental health. Service user and carer involvement in the training was evaluated very highly by officers, and it was the talks based on personal experiences that officers most remembered at follow-up. Of particular note was:

> *being able to discuss with service users how they felt personally about their illness and about how the Police have treated them.*

One third of the officers involved in this training programme identified that it had had a positive practical impact on Police work, particularly with respect to communication between officers and people with experience of mental illness. In addition, 73% of the officers recommended that the same education should be delivered to other officers.

CONCLUSION

According to the most up-to-date research on the impact of strategies being used to counter stigma and discrimination, contact (which challenges public attitudes about mental illness through direct interactions with people with experience of mental illness) is more effective than education (which replaces myths about mental illness with correct information).

However, this seems incongruous with the fact that stigmatising attitudes and discriminatory behaviours still exist in the population that arguably has most contact with people with experience of mental illness – mental health professionals. Further investigation has revealed that, in order for contact to be effective in countering stigma and discrimination, several conditions must be associated with it. These are:

- Equal status
- The opportunity for individuals to get to know each other
- Information which challenges negative stereotypes
- Active co-operation
- Pursuit of a mutual goal.

The education construct can be used to facilitate condition favourable contact for the purposes of countering stigma and discrimination associated with mental illness. This model of education involves people who have experienced mental illness taking on trainer roles that afford **equal status**. The training is designed so that the participants and trainer/s **pursue mutual goals**, **actively cooperate** and **get to know each other**. The nature and method of information provided during the training is focused on **disproving negative stereotypes** that participants might hold about people with mental illness. Both international and New Zealand initiatives, that have taken this approach, have reported positive results. It is recommended that providers of education and training follow this model to achieve the most impact in reducing stigma and discrimination associated with mental illness.

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