
PROMOTING SOCIAL CHANGE TO OVERCOME THE STIGMA OF MENTAL DISORDERS: ASPIRATIONS, COOPERATION AND COMMITMENT TO COLLECTIVE MENTAL HEALTH ADVOCACY

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DECLARATION

This thesis represents my own work developed during my Doctor of Philosophy (Clinical) candidature at the Department of Psychology at the Australian National University. Although it contains jointly authored papers, this thesis contains, unless otherwise indicated, my arguments developed and based on data collected and analysed by me with the guidance and support of my supervisors. This thesis has not been submitted for a higher degree at any other institution.

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THESIS ABSTRACT

A significant body of research demonstrates that people with mental disorders face prejudice and discrimination from other people in society and the health professions as well as systemic and structural disadvantage. Although this structural stigma is recognised as a significant problem for people with mental disorders in the psychological literature, the methods for reducing stigma overwhelmingly focus on changing the attitudes and behaviours of *individuals*, thereby failing to address the structural disadvantage that perpetuates that stigma. In this thesis, I argue that in order to develop methods that will be effective in reducing stigma, these methods must also produce movement towards positive *social change* to overcome systemic disadvantage. I propose this change can be achieved by cooperation between people who support mental health advocacy and in particular cooperation between people with mental disorders (and carers), health providers and other members of the public (including government officials) who hold a shared group membership, in what we have termed a cooperative community.

This thesis presents five studies to explore aspirations for cooperation among people committed to the aims of mental health advocacy. Studies 1, 2 and 3 (Chapter 4), utilising nominal supporters of the aims of mental health advocacy, demonstrate there is strong commitment to mental health advocacy among people who are not active advocates for mental health but who nonetheless identify as members of this group based on shared opinion. Additionally, this opinion-based group identity is strongly associated with an ideology of endorsing cooperation as the most desirable and effective method for reducing stigma and achieving positive change. This ideology adds unique prediction to non-stigmatizing individual practices (positive beliefs and social interaction intentions) and intended socio-political action.

Studies 4 and 5 (Chapters 6 and 7) then explored aspirations for cooperation among active advocates for mental health. Document analyses and interviews with members of two different mental health advocacy organizations demonstrate that advocates strongly value partnerships in the mental health sector, work to develop collaborations to advance mental health advocacy and view cooperation between people with mental disorders and carers, health providers, members of the public and government officials as vital collaborations in making a positive difference for people with mental disorders and the mental health sector. Findings are therefore consistent with those of Studies 1–3 in indicating that people committed to the aims of mental health advocacy, whether nominal or active supporters, strongly aspire to a cooperative community.

Taken together, results of the research presented in this thesis provide evidence to support the proposal that (a) social identification as a supporter of mental health advocacy (i.e., an opinion-based group identity) and (b) a shared group ideology that endorses aspirations for cooperation are both strong drivers for stigma-reducing practices to advance the cause of people with mental disorders. The current research also adds to understanding about opinion-based group identities in mobilising collective action and the role of group-based ideology in providing a shared orientation for group actions. Implications for training and community programs are discussed.

CHAPTER 1

THE NEED FOR SOCIAL CHANGE TO OVERCOME THE STIGMA OF MENTAL DISORDERS: INTRODUCTION AND OVERVIEW

Although a controversial figure, Thomas Szasz has been instrumental in bringing the injustices experienced by people with mental disorders to the fore as well as sparking social debate on how mental disorders are, and have historically been, defined, conceptualised, criminalised and treated as a social problem. In considering the legal injustices experienced by people with mental disorders, Szasz (1974) argued:

> … mental patients in the United States suffer widespread and grievous violations of their constitutional rights. I believe that today these people, more than members of particular racial or religious groups, are the principal scapegoats of our society. Unless we wish to foster this state of affairs, it devolves upon us to mobilize adequate social action to correct it. (p. 190)

The legal disadvantage faced by people with mental disorders is symptomatic of wider structural disadvantage faced by this stigmatized group (e.g., see Corrigan, Watson, Heyrman et al., 2005). Indeed, the problems referred to by Szasz (1974) remain a significant issue today, with the negative effects of the stigma that occurs at many levels of society now well established in the literature. For example, as well as discrimination in receiving adequate health care, housing and employment, people with mental disorders are often ostracised from and avoided in the community (e.g., Holmes, Corrigan, Williams, Canar & Kubiak, 1999; Markowitz, 1998; Schulze & Angermeyer, 2003; Wahl, 1999). People with mental disorders can themselves come to develop the stigmatizing attitudes perpetuated by the community in which they live (Watson, Corrigan, Larson & Sells, 2007).

In this thesis, I provide a framework for understanding how the social action referred to by Szasz (1974) to overcome this multi-level stigma can be mobilised. Specifically, I propose that stigma can be reduced when people with mental disorders (and carers), health service providers and members of the public (including government representatives) cooperate for the purpose of achieving positive change. I will present five studies that help map out a plausible social scientific basis to underpin that cooperation. Arguably this work helps to provide a framework that exists implicitly but is lacking explicitly. The aim is to provide a framework that is analogous to the social scientific frameworks that have been developed (and exist in various forms) for the global environment movement and the global fight against poverty. Given the nature of mental disorders as psychological phenomena and processes it is unsurprising that unlike those other movements for which the details of the frameworks are drawn from environmental, political and economic sciences I will present a framework drawn largely from psychological science: chiefly social and clinical psychology.

I begin with an overview of research that demonstrates the effects of stigma and investigates the most widely used methods to reduce it (Chapter 2). This review concludes that, although stigma is recognised as a significant interpersonal and structural problem, much of the research addresses only the interpersonal manifestations of stigma. I then introduce the systemic or collective aspects: specifically, the mental health advocacy movement which I interpret in terms provided by the social identity perspective on group relations (Tajfel & Turner, 1979/1986; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) in order to provide the context for which approaches to reduce structural disadvantage can be considered (Chapter 3).

In the first of the empirical chapters, Chapter 4 presents three studies that explore this social identity and a related ideology. Study 1 examines a scale designed to reflect aspirations for changes that are consistent with the creation or existence of a cooperative community. Study 2 further examines the properties of this scale in a wider sample of people who are nominal supporters of mental health advocacy and in comparison to social and community identification measures that are often utilised in action research. Both studies explore the predictive qualities of aspirations for attitudes and behaviours indicative of a commitment to reducing stigma. Study 3 explores a pictorial measure representing cooperation between people with mental disorders, health professionals and members of the public to measure the perceived desirability of this approach for producing change in comparison to other types of intergroup relations.

After presenting empirical explorations of the social identity reflecting support for mental health advocacy, and the ideology for aspirations which partially defines it, Chapter 5 further develops the theoretical basis for this ideology. In that chapter, I consider how the aspirations ideology differs from other group-based prejudice reduction strategies and explore practical applications and implications of developing cooperative communities for positive change.

In Chapters 6 and 7, I present two studies conducted with mental health advocacy organizations to investigate advocates' aspirations for cooperation and their views about the potential of this approach for achieving positive change. These studies provide an analysis of the documentation of each of the organizations as well as interviews with members in order to tap into the richness provided by advocates' knowledge, experience and views about change.

Finally, Chapter 8 provides a general discussion about the current findings and implications for future research, training and community programs and advocacy in the mental health sector.

Note that this thesis contains papers that have been submitted for peer-review, are in preparation for submission or were prepared for other purposes. Some of these papers, presented in Chapters 4, 5, 6 and 7, have joint authorship. However, as the lead author, the data collection, analyses, arguments and written content in these papers and in the thesis as a whole, were conducted and developed by me with guidance and input from my supervisors (the joint authors), unless otherwise indicated. Despite minor formatting changes (e.g., numbering of tables, numbering of studies, and references to other chapters for the convenience of readers), the content of the chapters presented in this thesis reflects the versions under review at the journals or organizations they were submitted to. The papers presented in this thesis are:

Gee, A. (2010). *The stigma of mental disorders: Problems, methods and implications for clinical practice.* Manuscript in preparation for submission for peer-review. The Australian National University, Canberra, Australia. (Chapter 2)

Gee, A., & McGarty, C. (2010). *Aspirations for a cooperative community and support for mental health advocacy: A shared orientation of an opinion-based group*. Manuscript submitted for peer-review publication. (Chapter 4)

Gee, A., & McGarty, C. (2010). *Developing Cooperative Communities to Reduce Stigma: Learning How to Be Part of the Change*. Manuscript in preparation for submission for peer-review. (Chapter 5)

Gee, A., McGarty, C., & O'Kearney, R. (2009). *What Does the ACT Mental Health Consumer Network Do and Why? A Big Picture Explanation for Making Advances in Mental Health Reform and Building an Inclusive Community*. Report based on research findings. The Australian National University, Canberra, Australia. (Chapter 6) http://www.actmhcn.org.au/cms/media/documents/actmhcn_making_advances_and_building_an_inclusive_community_gee_mcgarty_okearney2009.pdf

Gee, A., McGarty, C., & O'Kearney, R. (2009). *The [Advocacy Group's] Approach to Mental Health Reform: Highlighting the Importance of Genuine Participation and Working Relationships for Creating Positive Change*. Unpublished report. The Australian National University, Canberra, Australia. (Chapter 7)

This thesis also cites a published paper for which I was lead author:

Gee, A., Khalaf, A., & McGarty, C. (2007). Using group-based interaction to change stereotypes about people with mental disorders. *Australian Psychologist, 42,* Special Issue "Lay conceptions of mental disorder", 98–105.

That paper briefly presents an earlier study conducted by me during my Doctor of Philosophy (Clinical) candidature from which the cooperative community approach was developed. That paper introduces the cooperative community approach for reducing stigma (a section of the paper authored by me) and is presented in Appendix A of this thesis for the convenience of readers.

CHAPTER 2

THE STIGMA OF MENTAL DISORDERS: PROBLEMS, METHODS AND IMPLICATIONS FOR CLINICAL PRACTICE

CHAPTER OVERVIEW

The purpose of this chapter is to present an overview of the stigma of mental disorders. In examining the problem and impact of this social and clinical problem, I will review research that examines the most common negative beliefs and behaviours towards people with mental disorders and the negative effects that may result. I will then review research that reveals that members of the public, health providers and even people with mental disorders themselves can hold these prejudices. Finally, interventions frequently utilised to reduce the negative attitudes and behaviours that characterise stigma are reviewed and some guidelines for clinical practice are provided. The stigma of mental disorders is an issue that has attracted a considerable body of research, however the findings of this research are generally consistent even across different countries. The review in this chapter therefore presents findings with the strongest evidence base and includes research from a range of geographic sources.

Note that this chapter presents a manuscript in preparation for peer-review. The manuscript functions as a comprehensive current review of research investigating the stigma of mental disorders and methods for reducing it. Throughout this chapter, additional statements will be provided in [square brackets] for the convenience of readers of this thesis where additional contextual statements will provide clarity or orient the reader to remaining thesis content. The reference for this manuscript is:

- Gee, A. (2010). *The stigma of mental disorders: Problems, methods and implications for clinical practice.* Manuscript in preparation for submission for peer-review. The Australian National University, Canberra, Australia.

This chapter expands on some material contained in a published paper, for which I was the lead author and provided the review of stigma research. The reference for that paper is:

- Gee, A., Khalaf, A., & McGarty, C. (2007). Using group-based interaction to change stereotypes about people with mental disorders. *Australian Psychologist, 42*, 98–105. (This paper is presented in Appendix A.)

UNDERSTANDING THE PROBLEM AND IMPACT OF STIGMA

Stigma refers to a process that involves labelling, stereotyping, separation, and status loss resulting in discrimination and power disadvantage (Link & Phelan, 2001). The term stigma refers to both prejudice – negative attitudes and beliefs about people based on their membership of a social category or group – and its behavioural expression (a distinction outlined by Allport, 1954). Although there may be some physical cues triggering a person's social categorization as having a mental disorder (such as being labelled, behaviours and appearance, Corrigan, 2000) this information, unlike skin colour or physical disability, can be hidden from others and thus having a mental disorder is a *concealable stigmatized identity* (Quinn & Chaudoir, 2009).

Prejudice About People with Mental Disorders

Common negative attitudes about people with mental disorders are that they are dangerous, unpredictable and of weak character (e.g., Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein, 2003; Griffiths et al., 2006; Phelan, Link, Stueve & Pescosolido, 2000; Taylor & Dear, 1981). Many negative attitudes seem to reflect views that are authoritarian (decisions should be made for people with mental disorders because they are irresponsible), (paternalistically) benevolent (people with mental disorders need to be cared for because they are childlike) or are based on fear and a desire for exclusion (Holmes et al., 1999). Such negative views have implications for how people with mental disorders are treated by society and the health system.

Discrimination Against People with Mental Disorders

People with mental disorders report experiences of discrimination that are said to reflect individual and structural discrimination. Individual discrimination occurs in one-on-one interactions, for example, denial of opportunities for jobs or housing, or a loss of social networks due to having a mental disorder (Baldwin & Marcus, 2006; Corrigan, 1998; Hocking, 2003; Link, 2001; Schulze & Angermeyer, 2003; Wahl, 1999). Structural discrimination occurs as a product of the systems relating to mental health and include, for example, difficulty gaining access to adequate services, lack of funding from government and health/community systems, inadequate crisis intervention services, public communications that promote stigma, the poor quality of mental health services, legislation that offers little protection from discrimination (e.g., parental rights), legal definitions that treat people with a mental disorder as indistinguishable from people deemed incompetent and mental health policy that allows the forced treatment of "capacity-competent adults" (Corrigan, 1998; Corrigan, Watson, Gracia et al., 2005; Corrigan, Watson, Heyrman et al., 2005; Fulford, 1998, p. 666; Link & Phelan, 2001; Schulze & Angermeyer, 2003).

The prevalence of people who will experience stigma is difficult to determine. Structural discrimination is considered to be ingrained on a number of societal levels and thus research attempting to understand this cites examples and analyses of legislation, media portrayals and health policies (e.g., Corrigan, Watson, Gracia et al., 2005; Corrigan, Watson, Heyrman et al., 2005; Sieff, 2003). A number of studies investigate reported instances of individual discrimination experienced by people with mental disorders. Generally, these yield similar percentages across samples.

For example, approximately 50% of Markowitz's (1998) sample of consumers receiving outpatient and consumer-run self-help services reported previous discrimination such as employment/work difficulties, social exclusion, verbal derogation, denial of rights and adverse treatment by service providers. Similar numbers were reported by people with mental disorders receiving outpatient care in Hong Kong, with 36–46% of the sample reporting workplace stigma (e.g., negative comments from employers, not being offered a job after they revealed their disorder) and 27–68% reporting stigma from family, friends or partners (e.g., they received negative comments, others distanced themselves or disliked the individual, perceived them as highly likely to be violent or wanted to maintain the secrecy of the individual's disorder; Lee, Lee, Chiu & Kleinman, 2005).

Reported experiences of stigma were much higher in a sample of males with a mental disorder, history of substance abuse and prior hospitalisation, with 94% reporting some type of stigma experience, most often being avoided or having their history of hospitalisation held against them (Link, Struening, Rahav, Phelan & Nuttbrock, 1997). Link et al. recruited their sample through hospitals, treatment clinics, shelters for the homeless and criminal justice systems. This study serves as a stark reminder that stigma is more marked among people experiencing severe disadvantage.

Often, the discrimination experienced by some people with mental disorders represents a combination of individual and structural discrimination. For example, Baldwin and Marcus (2006) found that approximately 20% of their sample of people with mental disorders who reported they were limited in the kind or amount of work they could do reported discrimination in the workplace due to their disorder (e.g., difficulty changing or advancing jobs, unfair termination of employment). Reports of workplace discrimination were supported by findings that this group of workers earn just two-thirds the wage of people without mental disorders of comparable skill and ability (Baldwin & Marcus, 2006).

Stigma is therefore a significant problem for people with mental disorders, however it is not only the stigmatized group who are affected. Relatives of people with mental disorders may also be stigmatized. This is known as *courtesy* stigma and relatives have reported they have experienced, or anticipate they will experience, social exclusion, difficulty navigating overly complex and under-resourced health care systems, assignment of guilt for their family member's disorder and criticisms of parenting style (Angermeyer, Schulze & Dietrich, 2003; Koro-Ljungberg & Bussing, 2009; Norvilitis, Scime & Lee, 2002).

It is important to note that some people with mental disorders may not encounter discrimination or may not be affected by stigma (Camp, Finlay & Lyons, 2002; Corrigan & Watson, 2002). Indeed, not all participants in the reviewed studies have personally experienced outright discrimination. For example, 47% of Wahl's (1999) participants reported they had never been turned down for a job they were qualified for because they had a mental illness and 60% reported they had never had difficulty renting an apartment. In comparison to these examples of outright discrimination, Wahl's participants reported more incidents of subtle stigma manifestations. For example, 89% of the sample reported they had heard people say unfavourable/offensive things about consumers and mental disorders, 80% reported they had been shunned/avoided and 86% reported they had been treated as less competent when it was revealed they have a mental disorder. Thus, although not every consumer will experience discrimination, a substantial proportion does. We must therefore balance knowledge about the existence and potential consequences of stigma with knowledge that overemphasising stigma may unintentionally worsen its effects, which will be discussed next.

Effects of Stigma

Clearly, the presence of discriminatory practices will result in people with mental disorders facing limited opportunities. Research shows that these negative attitudes and behaviours can also result in difficulties relating to psychological and social health. Such effects may include lowered self-esteem and self-efficacy, loneliness, sadness and depression, hopelessness, distress, discouragement/disappointment and social isolation (Hocking, 2003; Markowitz, 1998; Wahl, 1999). These effects lead some people with severe mental disorder to state that the prejudice associated with their illness is as distressing as the symptoms themselves (Hocking, 2003).

A significant proportion of people with mental disorders anticipate they will encounter stigma if they reveal their disorder, with 48–72% of samples reporting this (e.g., Kleim et al., 2008; Lee et al., 2005; Markowitz, 1998). This anticipated stigma can also bring about some of the negative psychological and social effects for people with mental disorders identified above (Graf et al., 2004; Green, Hayes, Dickinson, Whittaker & Gilheany, 2003; Kleim et al., 2008; Markowitz, 1998; Quinn & Chaudoir, 2009). For example, holding the belief that people with a mental disorder are devalued by society, or perceiving discrimination against people with mental disorders (i.e., being aware of prejudice), is correlated with reduced self-esteem, self-efficacy and empowerment (Corrigan, Watson & Barr, 2006; N. Rüsch, Hölzer et al., 2006), increased secrecy about their disorder and social withdrawal in order to avoid the potential direct effects of stigma (Kleim et al., 2008). These effects appear to be particularly marked if the perceived discrimination is seen as legitimate (N. Rüsch, Lieb, Bohus & Corrigan, 2006). This research suggests that, although stigma should be recognised as a significant problem, over-emphasising stigma should be avoided because this in itself may be enough to result in negative consequences (Green et al., 2003).

The individual and structural manifestations of stigma nonetheless raise important clinical implications. Some have argued that the stigma of mental disorders makes it difficult for some people with mental health issues to seek and cooperate with the services they require (Hocking, 2003), perhaps because stigma can cloud accurate knowledge and understanding about mental disorders and potential treatments (e.g., Jorm & Kelly, 2007). Common views are that people with a mental disorder can "talk it over" or use alternative and self-help treatments instead of seeking professional assistance (e.g., Hugo et al., 2003, p. 718; Jorm, 2000).

These attitudes are in line with other findings which show that approximately 29–44% of a general public sample reported they would feel embarrassed about seeking help for a mental health issue, 14–20% expected negative reactions from professionals (e.g., condescending attitudes, being perceived as neurotic/unbalanced) and 21–46% believed that other people would think less of them for receiving professional help; these attitudes are associated with being less likely to seek professional help (Barney, Griffiths, Jorm & Christensen, 2006). Thus, public views about mental disorders and mental health services can have an effect on the ability of people to seek, and thus access, appropriate services.

Stigma may also have implications for the ability of an individual to engage in mental health treatments over a sufficient period of time. Fung, Tsang and Corrigan (2008) demonstrated that people with schizophrenia who mirror the negative attitudes about people with mental disorders found in some members of the public are significantly less likely to attend and engage in psychosocial treatments to manage the disorder. Thus, the effects of stigma clearly highlight it as a significant social and clinical problem.

Coping with Stigma

In order to manage stigma, people with mental disorders have reported using a number of coping strategies. These include strategies that may unintentionally contribute to their stigmatized status and social isolation, such as secrecy about their disorder, selective disclosure, avoiding social contacts and even delaying seeking treatment (Edwards & Timmons, 2005; Holmes & River, 1998; Kleim et al., 2008; Lee et al., 2005; Link et al., 1997; Vauth, Kleim, Wirtz & Corrigan, 2007; Wahl, 1999). Relatives of people with mental disorders have also reported using avoidance as a way to cope with courtesy stigma (Koro-Ljungberg & Bussing, 2009). The effectiveness of these coping strategies in guarding against the effects on psychological distress, however, is questionable. While reports from people with mental disorders indicate they find these strategies helpful, Link, Mirotznik and Cullen (1991) found that seeking to educate individuals and attempts to avoid stigma were not effective in decreasing psychological distress while secrecy about the disorder was associated with higher distress (e.g., sadness, low self-esteem, helplessness).

Alternatively, some people with mental disorders experience anger, seek social support, challenge attitudes, engage in advocacy or join consumer groups to manage stigma (Corrigan & Watson, 2002; Edwards & Timmons, 2005; Holmes & River, 1998; Wahl, 1999). Relatives too have reported using active participation strategies as well as seeking additional information and social/service support (Koro-Ljungberg & Bussing, 2009). Thus, again, we should be careful not to assume that the negative effects of stigma, or the use of unhelpful strategies, are inevitable for all people belonging to the stigmatized group.

SOURCES OF STIGMA

It is not surprising, given that stigma occurs on individual and structural levels, that negative attitudes and discriminatory practices against people with mental disorders are found in several sections of society. Research has identified that stigma occurs amongst members of the public, health providers and even people with mental disorders themselves.

Measuring Stigma Amongst Members of the Public

Negative attitudes from the public have probably received the most attention by researchers interested in the stigma of mental disorders and a large body of research investigates these attitudes over several decades (e.g., Brockington, Hall, Levings & Murphy, 1993; Griffiths et al., 2006; Holmes et al., 1999; Hugo et al., 2003; Sarbin & Mancuso, 1970; Taylor & Dear, 1981; Wolff, Pathare, Craig, & Leff, 1996; F. Wright & Shrader, 1965).

Recent research investigating negative attitudes about people with mental disorders most frequently measures attitudes about psychosis (e.g., schizophrenia) and depression. In addition to the authoritarian, benevolent and fear and exclusion (i.e., dangerousness) views discussed earlier in this paper, this research investigates attitudes about causes of mental disorder, degree of blame/personal responsibility assigned to people with mental disorders, helpful treatments and other perceived characteristics, such as laziness (Corrigan et al., 2002; Holmes et al., 1999; Jorm, 2000; Taylor & Dear, 1981). Perceived dangerousness has received significant attention, particularly in measuring attitudes about people with psychosis. For example, research on the attitudes of Australian, American and Japanese public samples revealed that approximately 11–19% of the samples believed people with depression are dangerous compared with the 20–38% who believed people with schizophrenia are dangerous (Griffiths et al., 2006; Jorms & Griffiths, 2008; Phelan et al., 2000). Attitudes of the public are said to be reinforced by negative media portrayals of people with mental disorders that present them as laughable, dangerous, incompetent, narcissistic or dangerously seductive (e.g., Corrigan, Watson, Gracia et al., 2005; Coverdale, Nairn & Claasen, 2002; Hyler, Gabbard & Schneider, 1991; Sieff, 2003; Wilson, Nairn, Coverdale & Panapa, 1999).

Of course, attitudinal responses are only part of the stigma puzzle. Researchers are also interested in how people behave towards a person with a mental disorder. Some research has utilised behavioural measures to demonstrate that people with more positive views towards people with mental disorders gave more sizeable donations to a mental health advocacy organization (Corrigan, Rowan et al., 2002). In earlier research (Farina, Holland & Ring, 1966), participants believed they were administering electric shocks to a person to assist learning. Participants chose to 'administer' more intense and longer electric shocks to a person who revealed they had a mental disorder (but who was actually an actor).

Measures of behavioural intentions have typically focused on intended social distance towards a person with mental disorder, for example how comfortable the individual would be having a person with a mental disorder living in their street, as a work colleague or employee, or in their social circle (e.g., Corrigan., 2002; Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999). Research by Link et al. (1999) demonstrated that 47% of their sample reported being unwilling to interact with people with depression and this jumped to 63% when reporting unwillingness to interact with people with schizophrenia. Another study by Mond, Robertson-Smith and Vetere (2006), in which participants read about a fictitious teenage girl who met the criteria for Anorexia Nervosa, demonstrated that despite generally understanding attitudes, 49.6% of participants reported having "mixed feelings" (p. 526) about interviewing the person for a job and 14.4% reported they would be unwilling to do so. Thus, people with mental disorders may experience discrimination from members of the public despite relatively positive attitudes. These outcomes are important to measure as these are the behaviours reported by consumers and family members as examples of discrimination they have encountered.

Stigma Amongst Health Providers

Consumer and carer reports of stigma experiences reveal that the attitudes and behaviours of some health professionals are another source of stigma (Schulze & Angermeyer, 2003; Wahl, 1999). Relatives of people with mental disorders have reported witnessing such stigma where their relative is treated badly by professionals and the health system (Angermeyer et al., 2003). Research has investigated the attitudes of health officers who are frequently involved in providing treatment to people with mental disorders, including psychologists, psychiatrists, general practitioners, pharmacists, nurses and hospital staff (e.g., Parker et al., 2001; Üçok, Polat, Sartorius, Erkoç & Atakli, 2004; Vibha, Saddichha & Kumar, 2008).

This body of research tends to examine the prejudices found in professional samples. For example, 58% of a sample of pharmacists agreed that people with depression should "pull themselves together", however 70% also disagreed that depression would get better without treatment (Scheerder, De Coster & Van Audenhove, 2009, p. 246). In relation to perceived characteristics of people with schizophrenia, 47% of a sample of general practitioners agreed they are untrustworthy and, relating to social distance, 66% agreed they would oppose a relative marrying someone with schizophrenia (Üçok et al., 2006). In another study, vignettes depicting a person admitted to a forensic hospital, a person with an active substance-use disorder and a person with schizophrenia who engaged in parasuicidal behaviour were perceived more negatively by mental health providers than people in vignettes depicting a previous substance-use disorder or a brief psychotic episode (Rao et al., 2009).

Some research demonstrates that health professionals can have more negative attitudes than the general public on some dimensions, particularly in judging expected prognosis (Jorm, Korten, Jacomb, Christensen & Henderson, 1999). Caldwell and Jorm (2001) extended these findings to reveal that a sample of mental health professionals generally expected a person with schizophrenia would be more likely to be violent, abuse drugs and alcohol and have poor friendships than did a sample from the public. The presence of highly negative expectations based solely on a diagnosis ignores the reality that many people with a mental disorder can effectively manage their symptoms and experience fulfilling lives with the appropriate support.

As a result, some professionals hold an unfair expectation of negative outcomes and subsequently, these expectations may be conveyed to people with mental disorders who may be treated as less competent by mental health providers and encouraged to set smaller goals than they are potentially able to achieve (Frese & Davis, 1997; Wahl, 1999). This is supported by reports of people with mental disorder who state that a negative prognosis is often given as an adjunct to their diagnosis, for example "you've got schizophrenia, you will be ill for the rest of your life" (Schulze & Angermeyer, 2003, p. 304). In line with this problematic negative view, some argue that the careless use of diagnostic labels also contributes to stigmatization and this often involves the communication of diagnoses to other workers who are not familiar with the intended implications and definition of the term (Sartorius, 2002).

The use of medications to treat mental disorders has been identified as another example of stigma in the health system. A chief concern of people with mental disorders is that mental health providers seem to disregard personal circumstances and adopt "one standard psychiatric treatment for everyone of 'experimenting with the type and dosage of drugs'" (Schulze & Angermeyer, 2003, p. 304). The prescription of medications responsible for producing visible side effects is also viewed as a stigmatizing act, a point now recognised by providers, as these serve as cues for the public to the person's mental health, which may then have behavioural consequences that contribute to lowered self-esteem, social avoidance and exclusion (Chaplin, 2000; Sartorius, 2002; Schulze & Angermeyer, 2003). Additionally, a study indicated that a number of pharmaceutical advertisements for antipsychotic medications in three leading psychiatric journals negatively portrayed people with mental disorder (McKay, 2000). Thus, even advertisements of pharmacological therapies can reinforce unfair negative views of schizophrenia.

The presence of stigma amongst professionals may result in some people with mental disorders not receiving adequate health care. For example, consumers and health providers have argued that non mental health providers (such as specialists) dismiss somatic complaints, do not investigate physical symptoms and impose unusually lengthy waiting periods for mental health consumers, not surprisingly this results in reluctance to address physical health concerns (Schulze & Angermeyer, 2003). This is consistent with research investigating the attitudes of general practitioners, which revealed that 86% of respondents reported they do not typically examine a patient with schizophrenia (Üçok et al., 2006) and many were less happy to have a patient with schizophrenia on their patient list compared to a person with diabetes or depression (Lawrie et al., 1998). Thus, stigma may result in some people with schizophrenia not receiving the comprehensive health care required (cf. Lawrie et al., 1998), however this may improve with training about the course and treatment of schizophrenia and the role of general practitioners in the care of people with schizophrenia (Üçok et al., 2006).

Relatives of people with mental disorders report experiencing courtesy stigma from mental health professionals. Their concerns reflect two issues in particular.

First, relatives report they receive attributions of blame for their relative's disorder and are perceived by providers as an "additional burden" and "source of irritation", thus having their competence, experience and concerns devalued (Angermeyer et al., 2003, p. 595). These views are somewhat supported by research. For example, a study investigating mental health providers' attitudes towards family members revealed that relatives can be perceived as cooperative supporters of their relatives in addition to unsupportive and inconsistent contributors to mental health issues or uninformed and unequal partners in treatment planning and programs (Riebschleger, 2001).

Secondly, relatives report they are excluded from the treatment process and not given the information about their relative's disorder and treatment relevant to their caring role (Angermeyer et al., 2003). Research has shown that mental health providers see the primary role of family members in treatment as providing education, encouragement for compliance and obtaining support from social services (Castaneda & Sommer, 1989). Thus despite research demonstrating many clinical, social, family and economic benefits to implementing structured family interventions into treatment programs for individuals with mental disorder (Falloon, Held, Coverdale, Roncone & Laidlaw, 1999), it appears that family members are either not included (Angermeyer et al., 2003; Glick & Dixon, 2002) or their role is limited to support and encouragement for the individual to seek and follow treatment (Castaneda & Sommer, 1989).

The Nature and Effects of Self-Stigma

Even some people with mental disorders hold the prejudices found in some members of the general and professional communities. Self-stigma is the process by which a person agrees with these negative beliefs, applies them to the self, devalues him or herself for supposedly having these qualities and subsequently demonstrates behaviour similar to discrimination, such as not pursuing their interests or seeking employment (Corrigan & Watson, 2002; Watson et al., 2007). An important part of this process is that negative views of the self are associated with lowered self-esteem, self-efficacy and quality of life factors such as psychological and physical well-being and social relationships (Corrigan et al., 2006; N. Rüsch, Hölzer et al., 2006).

I reviewed research earlier in this paper that showed that anticipated stigma (i.e., stereotype or stigma awareness) is associated with lowered self-esteem and self-efficacy for some people. Self-stigma differs from anticipated stigma because it also involves the person taking on these negative attitudes as applying to him or herself. A scale designed to reflect self-stigma for people with mental disorders (Corrigan et al., 2006) reflects awareness of prejudice (i.e., the extent to which the person perceives stigma in the community), agreement with those prejudices and concurrence with those prejudices as applying to the self. Research utilising this scale to investigate the effects of these components has demonstrated that lowered self-esteem may result from either prejudice awareness or self-concurrence (Corrigan et al., 2006; N. Rüsch, Hölzer et al., 2006) and perhaps prejudice agreement (N. Rüsch, Hölzer et al., 2006). Lowered self-efficacy beliefs, however, are associated with self-concurrence (Corrigan, et al., 2006; N. Rüsch, Hölzer et al., 2006) and perhaps prejudice awareness (Corrigan et al., 2006) but not prejudice agreement. Finally, lowered sense of empowerment is associated with prejudice agreement and self-concurrence (N. Rüsch, Hölzer et al., 2006). Measures of self-stigma, therefore, provide some clarity regarding who may experience lowered self-esteem, self-efficacy and empowerment beliefs as a result of stigma.

However, as with experiencing discrimination, not all people with mental disorders will self-stigmatize. Some will remain unaffected and some will engage in collective action to systemically influence positive change (Corrigan & Watson, 2002; Wahl, 1999). [Note for readers: collective action by mental health advocacy groups will be reviewed in the next chapter.] Members of a stigmatized group will therefore have different responses to stigma and some of the effects for those that self-stigmatize parallel those for stigma from the public: lowered self-esteem, social withdrawal and limited opportunities.

INTERVENTIONS FOR THE REDUCTION OF STIGMA

Given the substantial body of evidence demonstrating that stigma can have a range of detrimental effects for some people with mental disorders, reducing the stigma surrounding mental disorders is an important social goal. [Note for readers: Recall that stigma involves prejudice and discrimination towards people based on their membership of a social category or group (i.e., having a mental disorder). This understanding enables us to draw more widely on research investigating methods of overcoming prejudice, such as those interventions that take into account the existence of group memberships and intergroup relations. This is seen as a vital part of the approach proposed in this thesis and frameworks for understanding group relations and group processes will be introduced in Chapter 3, with these group-based techniques for prejudice reduction reviewed in Chapter 5]. This paper focuses on providing a review of interventions specifically developed to minimise the presence and impact of the stigma of mental disorders. These methods focus on ways to reduce the stigma held by individuals. Generally, they fit into three broad categories thoroughly investigated in research: education, contact, and protest (see also Corrigan & Penn, 1999; Corrigan & O'Shaughnessy, 2007; Watson & Corrigan, 2005, for reviews). After reviewing each, I will then review clinical practices and therapeutic programs that health providers can utilise in working with individual clients who may be affected by stigma.

Education About Mental Disorders and Treatments

Education strategies were developed to provide information that would increase awareness, understanding and knowledge in members of the public and counteract widely held false beliefs (Corrigan & Penn, 1999; Jorm, 2000). Overall, research on education has demonstrated mixed results as to the effectiveness of this method (see Corrigan & Penn, 1999). Some of these inconsistencies may be due to the type of information presented. For example, information about the symptoms of schizophrenia may be detrimental to stigma reduction (Penn et al., 1994). Others have warned against the use of information that focuses solely on the biological basis of mental disorder and does not take into account multiple causal factors (e.g., Hinshaw & Cicchetti, 2000; Read, 2007). Nevertheless, studies suggest that short education programs can be effective in producing some immediate positive changes in attitudes (e.g., Corrigan, River et al., 2001) although these effects have been found to dissolve just one week later (e.g., Corrigan et al., 2002).

Similar findings are revealed for education programs delivered to medical professionals. For example, Mino, Yasuda, Tsuda and Shimodera (2001) demonstrated that a one hour lecture (covering access to mental health care and providing a case example) produced improvements in some attitudes of Japanese medical students (e.g., perceived independence in social life, less social distance in some circumstances), however some attitudes about the role of psychiatric services did not improve significantly (e.g., that people with mental disorders should stay in psychiatric hospitals all their life, that early treatment will not aid recovery and that long-term stays in psychiatric hospitals will not lead to difficulties living in the community). A different study demonstrated that a training session provided to general practitioners about the course and treatment of schizophrenia, the impact of stigma and a description of the role of general practitioners in the treatment of people with schizophrenia improved attitudes towards people with schizophrenia in a number of domains (e.g., dangerousness, trustworthiness and potential for recovery; Üçok et al., 2006).

Longer education programs also have mixed results. For example, Holmes et al. (1999) investigated the effect of a 16-week psychology course exploring mental disorders and their treatment on the attitudes of university students. Although there were improvements in some attitudes for these students compared to those participating in a general introductory psychology course, these did not meet statistical significance. It is not clear which elements of the training may have contributed to more positive attitudes. Nonetheless, this does suggest there may be benefits to longer education programs.

Regarding the education of mental health professionals, Richmond and Foster (2003) demonstrated those who had completed postgraduate education reported less moral judgements and more optimism about treatment for substance misuse than undergraduates/non-graduates, regardless of chosen field. However, the presence of stigma among health professionals who have received education and training have led some to question whether changes to these training programs could produce more positive attitudes about working with people with mental disorders.

In Australia, recommendations for these changes were provided by the *National Practice Standards for the Mental Health Workforce* (National Mental Health Education and Training Advisory Group, 2002), which emphasised the need for training courses to provide consumer perspectives. Consumer-educators appointed to provide input and teaching in training programs for psychiatric nursing (Happell & Roper, 2003) and pharmacy (Bell, Johns, Rose & Chen, 2006) have resulted in more positive attitudes and primarily positive feedback from students. Specifically, the programs produced lower social distance intentions, more positive attitudes and greater awareness of issues than students believed could be offered by traditional education. Van Zelst (2009) suggests training programs should also provide information about the effects of stigma directly to assist professionals in learning to differentiate between the consequences of stigma and other symptoms of the person's mental disorder and to better understand the coping strategies of their clients. Additionally, being aware of the impact that providers' attitudes can have on clients and the potential attitudes that clients may encounter, particularly when in contact with multiple services, are important in assisting clients to access comprehensive care.

Contact with Persons with Mental Disorders

Although providing accurate information is important, research suggests that education alone may not be enough. A second method to reduce the stigma of mental disorders involves meeting people with personal experience of mental disorder to provide a unique perspective, break down unfamiliarity and disconfirm negative beliefs. Research has examined the effect of contact on attitudes towards people with mental disorders with both retrospective and prospective studies (for an excellent review see Couture & Penn, 2003).

Research indicates that contact generally has a positive effect. Retrospective studies indicate prior contact with a person with a mental disorder is associated with more positive attitudes relating to perceived dangerousness, fear, and social distance (Alexander & Link, 2003; Angermeyer, Matschinger & Corrigan, 2004; Corrigan, Edwards, Green, Diwan & Penn, 2001; Corrigan, Green, Lundin, Kubiak & Penn, 2001; Penn et al., 1994).

Regarding the effect of contact for health professionals, a study by Roth, Antony, Kerr and Downie (2000) demonstrated that medical staff who had previous contact with people with mental disorders held more positive attitudes towards medical students with mental health issues. These positive attitudes were held whether the previous contact was due to personal experience (e.g., by self, family or friends having a mental disorder) or contact as a mental health professional. Similarly, another study demonstrated that nursing staff who reported prior contact attributed less blame to people with schizophrenia and were more optimistic about improvement/recovery for people with depression than nursing staff who reported less familiarity (Björkman, Angelman & Jönsson, 2008). Those participants who had worked longer in nursing held more positive attitudes about people with schizophrenia regarding perceived dangerousness and unpredictability than nurses who had less experience. A similar pattern is found among trainees. Pharmacy students who had previously worked in a pharmacy reported less desire for social distance than students who had no pharmacy work experience (Volmer, Mäesalu & Bell, 2008).

Prospective studies also demonstrate positive effects after contact. An experimental study showed that contact was more effective than education in producing positive attitudes about recovery and dangerousness, intended social distance and size of donation to a mental health advocacy organization (Corrigan et al., 2002). Contact also encourages people to assign less responsibility for the onset of mental disorder on the individual, which corresponds to more positive affect and behaviours (Corrigan et al., 2002; Weiner, Perry & Magnusson, 1988). In contrast to improvements resulting from education, the positive effects resulting from contact were maintained one week later (Corrigan et al., 2002).

The effect of contact on the attitudes of trainees has also been examined as most training in the health professionals involves fieldwork. This is provided on the basis that contact with patients will enable trainees to learn and practice new skills, increase knowledge and familiarity with particular issues and have contact with the patients they will later work with. Studies by

Beltran, Scanlan, Hancock and Luckett (2007) and Lyons and Ziviani (1995) demonstrated that occupational therapy students held more positive attitudes after completing practical placements. Before fieldwork, students generally thought people with mental disorders were frightening, violent and unpredictable. After fieldwork, students' views reflected a better understanding of what it might be like to live with a mental disorder and believed people with mental disorders are not very different to others, that they have many strengths and can achieve recovery. Thus, fieldwork that provides positive contact experiences and focuses on positive recovery principles, can be beneficial.

Community programs that aim to reduce the stigma of mental disorders often involve both education and contact. For example, Mental Illness Education ACT (in the Australian Capital Territory, Australia, [http://www.mieact.org.au]) offers education programs to schools that are delivered by people who have experience with mental disorders (either by having a mental disorder themselves or having a friend or relative who has), thereby providing information about mental disorders and contact with a person who can provide their personal account of living with mental disorder. An evaluation of this program demonstrated it was effective in increasing knowledge and improving attitudes and social distance intentions among students (Rickwood, Cavanagh, Curtis & Sakrouge, 2004). The evaluation also demonstrated that increased knowledge about mental disorders could not fully account for improved attitudes, indicating that having the education program delivered by people with personal experience of mental disorder (i.e., contact) added to the effectiveness of the program.

A second example of such a program is *In Our Own Voice* of the National Alliance on Mental Illness (Virginina, U.S.A., [http://www.nami.org]). Evaluations of this program demonstrated it too was effective in improving attitudes and knowledge about mental disorders and reducing social distance intentions (L. Rusch, Kanter, Angelone & Ridley, 2008; Wood & Wahl, 2006). Overall, research investigating the effect of positive contact with people with mental disorders, particularly in providing education about mental disorders, demonstrates that people with mental disorders themselves are a valuable resource in reaching the public on the issue of stigma.

Another interesting process for encouraging positive attitudes in adolescents combined education about mental disorders with an activity which shared similarities to contact (Hanson et al., 2008). As Hanson et al. explain, psychiatric training often involves inviting healthy adolescents to portray a person with a mental health difficulty (or other medical illness) in role play with the trainee (this is also common practice for training in other health-related fields). The adolescent participants in this study received education and training to assist them to portray either an adolescent with depression and suicidal thoughts or an adolescent with a cough. Results demonstrated that education, training for the role and rehearsal in portraying an adolescent with a mental disorder resulted in participants reporting they would be more comfortable portraying someone with a mental health disorder in the future compared with participants who portrayed a cough-related illness. The research did not show that the role play changes attitudes and behaviours towards people with mental disorders, however it does suggest another process to reduce unfamiliarity with mental disorders and produce improved understandings of what it may be like to live with a mental disorder.

Protesting Stigma Expressions

The third method for reducing stigma which has received empirical attention involves discouraging the expression of stereotypic judgments about people with mental disorders to prevent negative attitudes being perpetuated. This occurs at both the individual and collective levels. At the individual level, research has shown that instructing participants to "avoid thinking about [a person with a mental disorder] in a stereotypical manner" was effective in reducing stereotypical statements (Penn & Corrigan, 2002, p. 271). However, this study did not report whether these stereotypic judgments were negative and did not analyse the effectiveness of this approach on reducing stigma (e.g., on beliefs or social distance). A similar strategy involves protesting against the expression of negative attitudes. An intervention utilising protest to condemn negative attitudes (e.g., "we must stop thinking that way!") demonstrated this had no effect on attributions about perceived controllability (blame) for the disorder or attitudes about the potential recovery of people with mental disorders given the appropriate treatment (Corrigan, River et al., 2001, p. 189).

At the collective level, protests against stigma frequently target the media. An example is SANE Australia's StigmaWatch campaign, which monitors and promotes sensitive reporting of mental disorders in the media [this is an example of the work of a mental health advocacy group, which are discussed in general in Chapter 3]. Statistics reported by SANE Australia (2010a) show that in 2009, 276 reports of stigmatizing media portrayals and 61 examples of responsible and sensitive reports of mental disorders were received. StigmaWatch takes action to contact those in the media to provide information about responsible reporting to prevent future stigmatizing reports and provide positive feedback to reinforce the messages of "good news stories" (SANE Australia, 2010b). The direct impact of protest on improving media portrayals is difficult to measure as it usually involves action after the stories have been printed or aired (A. Orr, StigmaWatch, personal communication, April 21, 2010). Online media, however, is more fluid and of the 33 stigmatizing reports received and followed-up by StigmaWatch in 2009, all resulted in changes to the news item (A. Orr, personal communication, April 22, 2010). Additionally, although there are some publications that continue to be identified for producing stigmatizing reports, none of the individual media personnel contacted by StigmaWatch (e.g., journalists, producers) went on to be the source of a subsequent stigmatizing report (A. Orr, personal communication, April 21, 2010). Protest, then, is a strategy that appears to have more influence at the collective level than in improving the attitudes of individuals.

Treatment Practices and Therapeutic Programs to Assist in Coping with Stigma

Given the clinical and psychological implications of stigma, an important issue remains as to how clinicians may identify the effects of (self-)stigma in their clients and assist them (and their family, if appropriate) to overcome these effects. A number of suggestions have been offered and will be briefly reviewed here. First, however, I wish to provide a cautionary note.

I stated earlier in this paper that not all people with mental disorders will be negatively affected by stigma. Thus, the following clinical practices may not be appropriate for many clients. In other words, the suggestions in this section are not designed to find a problem where there is not one. They may be helpful, however, for clinicians who do come across potential self-stigma in their clients or who suspect such beliefs offer a partial explanation for coping behaviours. It is in this context, and in the context of collaboration with the client, that the following suggestions are offered.

Three suggestions for clinical practices that may assist clients in overcoming the effects of stigma can be drawn from the literature. First, given the widespread nature of attitudes and beliefs about mental disorders in the general public, adequate information about the disorder and treatment options should be provided to the consumer. This is especially important given that the negative attitudes of some people with mental disorders reflect those of the general public and psychoeducation is likely to improve outcomes and engagement in treatment (Gonzalez-Pinto et al., 2004). Clinicians should also ensure they provide adequate information in communications with other professionals of the treating team. The careful explanation of clinically relevant issues is required over the shorthand of a diagnosis to professionals who may not understand its intended meaning. This practice will help to reduce the careless use of diagnostic labels which has been identified as an example of stigma (Sartorius, 2002).

Second, referrals to self-help and community organizations may be appropriate. Self-help and community organizations can be effective in aiding recovery through building self-reliance and self-esteem and participating in a supportive environment (Corrigan, Slopen et al., 2005), which have been identified by researchers as some of the detrimental effects of stigma. Additionally, self-help groups may provide an avenue for clients to become engaged in activities relevant to improving mental health care and which may shift attitudes about the perceived legitimacy of stigma, which is an important factor in self-stigma (Watson et al., 2007). This is also an example of assisting clients to develop more active strategies for coping with stigma in comparison to the secrecy and social isolation often employed (Van Zelst, 2009). Clinicians, however, may require more knowledge about self-help groups and their benefits to become familiar with referral options and support the approaches they value, which are often contrary to those in traditional professional education (Castaneda & Sommer, 1989; Constantino & Nelson, 1995; Glick & Dixon, 2002).

Finally, incorporating family members in the treatment process, whether working with children and adolescents or with adults who believe working with their families will be beneficial, can assist relatives manage the effects of courtesy stigma and reduce their stigmatizing experiences with health professionals. Providing adequate information (Dixon, Adams & Lucksted, 2000; Scharer, 2002), valuing their competence and experience in supporting their family member (Angermeyer et al., 2003) and providing referrals for family self-help and advocacy organizations (Glick & Dixon, 2002) may assist them.

While the above three suggestions provide guidance to assist clients in managing the effects of stigma, for some clients the effects of stigma will need to be addressed directly. Examples of therapeutic programs that have been suggested include cognitive restructuring to challenge self-stigmatizing beliefs (Holmes & River, 1998) and narrative change to assist the individual in shifting their construction of the self from one defined by self-stigma to one compatible with recovery (Kondrat & Teater, 2009). Positive outcomes have been demonstrated for people with schizophrenia who participated in a group Cognitive Behavioural Therapy program focused on stigma and self-esteem (Knight, Wykes & Hayward, 2006).

CONCLUSION

Stigma is a significant social and clinical program. The negative attitudes and behaviours that characterise stigma have significant negative effects for some people with mental disorders, their families and friends. The most common methods for reducing stigma in the research literature are education, contact and protest, of which contact appears to be the most effective. This highlights the important status of consumers as vital resources to reduce stigma. Given the clinical implications of stigma, a number of suggestions for clinicians were also offered in working with clients to combat the negative psychological, social and therapeutic consequences.

This paper has therefore provided an overview of approaches to stigma in the psychological literature. As the reader may realise in reading this review and in being familiar with these works, an enormous number of research articles and papers have addressed this issue. By and large, these papers focus on changing stigma in individuals and overwhelmingly follow the same directions and identify the same themes for tackling the stigma of mental disorders. That is, this research continues to examine the three main strategies for reducing stigma (education, contact and protest) that focus on efforts to reduce prejudice and discriminatory practices perpetuated by individuals. While these approaches are valuable, they do not influence changes that will address the structural stigma identified as a significant problem by consumers, relatives, professionals and researchers. Likewise, the clinical interventions and practice guidelines presented in this paper provide strategies for assisting individuals with mental disorders to find more helpful strategies for coping with *the presence of* stigma.

There is an emerging focus in the literature (e.g., Schulze, 2007) which argues that health professionals need to take an active role in advocating for better resources for mental health and targeting stigma. This is particularly important given that stigma has been found amongst health professionals in addition to members of the public and people with mental disorders themselves. While this, along with the examples of the structural disadvantage faced by people with mental disorders, highlights the significance of the problem it also points to what is needed to overcome it. Gee and colleagues (e.g., Gee, Khalaf & McGarty, 2007) propose that an approach by which three sociological groups that each have a vital role in the conceptualisation of mental disorders – people with mental disorders, health providers and members of the public – may address stigma at the structural level. This, they argue, can be achieved through the development of a cooperative community characterised by participation, action and respectful communication in the context of a shared common cause that reflects a social identity around support for mental health advocacy. This perceived sharedness, and an orientation towards change that proposes cooperation in order to achieve positive change, offers one suggestion that may be useful in reducing the stigma of mental disorders by encouraging action to create positive social and systemic changes. It is suggested that to provide a comprehensive literature for reducing stigma, future directions of stigma research incorporate research using social psychological methods. This would enable researchers to more closely examine the role of intergroup relations in producing positive social change to reduce the stigma experienced by people with mental disorders and in particular to address the problematic structural stigma that perpetuates stigma among individuals.

CHAPTER CONCLUSION

The paper presented in this chapter concluded with the suggestion that the structural stigma of people with mental disorders needs to be addressed in addition to the strategies that address individual stigma. The approach introduced by Gee et al. (2007) for producing positive change at the broader social level primarily involves participation, action and cooperation. This arrangement of social relations relies on a framework by which to understand the world as comprising of groups. I explain what this means in the next chapter, where I review two contributions to such a framework that rely on social analyses of group membership: the mental health advocacy movement and social identity theory.

CHAPTER 3

MENTAL HEALTH ADVOCACY AS A SOCIAL IDENTITY

In the previous chapter, I reviewed research on the stigma of mental disorders. The extent of that review reflects the great breadth of the research literature on this significant social and clinical issue. The primary approaches for tackling that stigma have overwhelmingly followed the same direction and repeated the same themes for tackling that stigma. Although that research proposes that stigma occurs at individual and structural levels, it focuses primarily on reducing stigma among individuals from the public, health professions and stigmatized group. As an alternative, this thesis explores a framework to promote mobilisation towards social change and reduce stigma in individuals by addressing structural stigma.

In this chapter, I will present the background for the empirical and theoretical chapters that follow. In order to provide this context, I will first describe the action taken by people with mental disorders, referred to in the previous chapter, who may be seen to utilise advocacy as a coping strategy (Corrigan & Watson, 2002; Wahl, 1999) but in doing so participate in a broader social movement that includes many advocates who do not identify as having a mental disorder or who have never been mental health service users. My particular interest is in understanding the approach of the mental health advocacy movement in addressing structural stigma. The second section of this chapter provides a theoretical understanding of group memberships by which we may understand the roles of identity, action and change.

THE MENTAL HEALTH ADVOCACY MOVEMENT

Advocacy as a strategy to reduce stigma has received much less attention in the research literature than other interventions, although recently it has become more prominent. Reflecting the two levels of stigma identified by the literature, individual advocacy involves advocating for the rights of an individual (or family) to participate in decisions about their care and to access adequate services, while systemic (or *collective*; Stringfellow & Muscari, 2003) advocacy involves seeking changes in the disadvantageous policies and practices of legal, government and health systems that relate to people with mental disorders. This thesis proposes that overcoming the stigma of mental disorders relies on building collaboration between people who share commitment to positive social change. It follows that collective mental health advocacy will repay close attention.

Mental health advocacy gained momentum in the early 1900s as a response to the injustices suffered by people institutionalised for having a mental disorder (Foulks, 2000; Mental Health America, 2010). The modern advocacy movement is said to have arisen in the 1970s with the decline of institutionalisation (Kaufmann, 1999). The contemporary movement focuses on showing that people with mental disorders should have more control over services and treatments.

Although they may differ in their aims and activities, advocacy organizations seek to promote political and social change in relation to mental health, especially by the involvement of consumers in the planning, delivery and evaluation of policies, mental health services and research (Funk, Minoletti, Drew, Taylor & Saraceno, 2005; Levine, Toro & Perkins, 1993; Stringfellow & Muscari, 2003). These organizations have also had a significant positive influence on the terminology (representing conceptualisations) surrounding mental health and mental disorders (Reaume, 2002). The work of advocacy groups has recently received more attention in the government and non-government sectors who now recommend consumer participation in the development and evaluation of health services (e.g., see Happell & Roper, 2006a; Lefley & Vogel-Scibilia, 2004), however advocates argue much more work is required for this to occur in practice. Mental health advocacy is also receiving attention in communications to the public: a study on reports of mental disorders in mainstream American newspapers revealed approximately 20% of stories highlighted the need for action to address issues of concern to advocates (Corrigan, Watson, Gracia et al., 2005).

Systemic advocacy groups have generally been run by consumers of mental health services and/or family members, however there are also "omnibus" advocacy organizations which include members of the general public (Lefley & Vogel-Scibilia, 2004). Recently, there has been a stronger focus on the need for government officials and government departments, as members of the general public who represent collective interests, to work with advocacy organizations in order to produce change on issues related to mental health and human rights (e.g., Funk et al., 2005). Additionally, there is growing recognition that health professionals need to become more involved in working with advocacy groups to influence governmental policies and secure adequate resources for quality mental health services (Foulks, 2000; Schulze, 2007). People with mental disorders, members of the general public and health professionals are therefore considered to be "stakeholder" groups as they each have "a share, experience, or an interest in the topic" of mental health and mental disorders (Van Dorn, Swanson, Elbogen & Swartz, 2005, p. 154). However, each of these stakeholder groups may have different interests or agendas.

Encouraging them to work collaboratively, then, brings up an interesting question of how, or why, people may come to act on behalf of a collective movement. The behaviour displayed by those committed to systemic mental health advocacy fits Wright's (2001, p. 410) definition of collective action: "a group member engages in collective action any time that she or he is acting as a representative of the group and the action is directed at improving the conditions of the entire group". Thus, people do not engage in collective action to benefit themselves as individuals; they engage in collective action to improve the conditions that disadvantage people with mental disorders as a group (Wright, 2001). In order to behave this way, however, people must come to see themselves as having a shared identity with other people perceived as similar to the self. This identity, which is social in nature, is based on the assumptions that the world is organised according to group memberships and that people are motivated to belong to some of these social groups.

SOCIAL IDENTITY, IDEOLOGY AND SOCIAL CHANGE

According to social identity theory (Tajfel & Turner, 1979/1986) social behaviour lies between two extremes on a continuum from behaviour that is entirely interpersonal in nature (acting as an individual) to behaviour entirely defined by an intergroup context (acting as a group member). The individual strategies for reducing stigma discussed in Chapter 2 clearly lie towards the interpersonal side of the continuum, but the success of these strategies relies on recognising membership of two different social categories (i.e., those with mental disorder and those without). Strategies for reducing structural stigma, as expressed in collective mental health advocacy, clearly lie further towards the intergroup end of the continuum. This thesis explores commitment to group actions that aim to influence changes in the social (intergroup) context. The social identity perspective, comprising of social identity theory (SIT; Tajfel & Turner, 1979/1986) and self-categorization theory (SCT; Turner et al., 1987), provides one theoretical framework that seems useful for this purpose and I review this perspective below, beginning with the SIT definition of 'group'.

People belong to a social-psychological group when they perceive themselves to share a social category (Tajfel & Turner, 1979/1986; Turner, 1982). More specifically, SCT stipulates that people perceive the self as belonging to a group when they perceive their similarity to others as greater than the differences between group members on a particular characteristic (Turner et al., 1987). According to SIT the set of these group memberships together constitute a person's social identity but in SCT identity is inherently flexible so that a person has multiple social identities.

According to both SIT and SCT people seek to achieve positive social identities. This can be achieved through comparing the ingroup (i.e., the group to which the person belongs) positively with outgroups (i.e., alternative groups to which the person does not belong). When acting in terms of the intergroup behavioural end of the continuum, people tend to favour the ingroup over the outgroup and aim to achieve maximum differences between groups. In doing so, they often discriminate against the outgroup.

The features used to define social-psychological groups may include those that define social categories such as skin colour, nationality, religion, ethnicity, gender, class and organizational membership. However, Bliuc, McGarty, Reynolds and Muntele (2007) have suggested that people can form meaningful group memberships (and thus social identities) on the basis of a shared opinion. An opinion-based group forms when people come to define themselves and others in group terms by having the same opinion or common cause (Bliuc et al., 2007). Rather than a group membership based on an affiliation (e.g., a local church group) or social category (e.g., being Catholic) which nonetheless involve shared opinions, opinion-based groups are formed directly on the basis of a particular shared opinion (e.g., being pro- or anti-homosexual marriages). In other words, people who share the opinion develop a social identity on the basis of a feature or property that sets its members apart from the wider social context and, in particular, from those who do not agree with that opinion, thus satisfying the definition of a social-psychological group (see Tajfel & Turner, 1979/1986; Turner et al., 1987).

Bliuc et al. (2007) and McGarty, Bliuc, Thomas and Bongiorno (2009) argue that opinion-based groups are distinguishable from social categories but tend to be *about* relations between social categories or formed *on behalf of* a social category. Thus, an opinion-based group often consists of members primarily from a particular social category (e.g., pro-feminist members may be primarily women), but not entirely (e.g., men may also be pro-feminist) and will not involve all members of the social category (e.g., not all women are pro-feminist).

This recent contribution has important implications in particular for understanding the second dimension provided by the social identity perspective (Tajfel & Turner, 1979/1986) which, related to the interpersonal-social behavioural continuum, represents the way a person perceives relations between social groups. At one end of the continuum, social mobility refers to the ability of individuals to improve their individual circumstances when they are dissatisfied. At the other end, individuals desire social change when the wider social context makes it difficult for them to improve their situation. Collective or social action is one way (or, according to Wright & Lubensky, 2009, the only way) to overcome the structural disadvantage of a social category or group as a whole.

Research has generally shown that people are more likely to participate in collective action the more strongly they identify with a particular social group expected to benefit from the action (e.g., Klandermans, 2002; Simon, Stürmer & Steffans, 2000). However, Bliuc et al. (2007) have demonstrated that social identification with an opinion-based group representing support for a political party yielded a stronger correlation with political action intentions than often found in previous research. The problem that arises then, according to Bliuc et al. (2007) and McGarty et al. (2009), is that researchers find relatively weak correlations when the defined "group" is actually a social category, leading Bliuc and colleagues to question whether action researchers have been measuring identification with the correct (i.e., most relevant) social-psychological group.

Opinion-based groups are also distinguishable from action groups. Bliuc et al. (2007) and McGarty et al. (2009) have suggested that, while others have shown that identification with an advocacy organization can explain the actions of advocates, identification with an opinion-based group can explain collective actions (e.g., participation in mass protests) among people who are not active advocates. The authors go on to propose that opinion-based groups may be the "intermediate stage between broad social categories and the activist groups" such that "the formation of action groups can be considered as emerging from opinion-based groups" (Bliuc et al., 2007, p. 21). Thus, according to this view, although we find a number of advocacy organizations devoted to the same cause spread throughout the world, these emerged from, and thus represent different *instantiations* or *crystallisations* of, a broader opinion-based group (McGarty et al., 2009).

Returning to the issue of focus for this thesis, support for mental health advocacy can be understood as an opinion-based group and in this sense is consistent with the involvement not just of people with mental disorders but also carers, professionals and other members of the public that are found in omnibus advocacy groups. Support for mental health advocacy therefore captures a social identity around the opinion that people with mental disorders should not be discriminated against or excluded and specifies that social action is required to overcome this current disadvantage. However, this alone does not define the type of collective action or framework for how to go about achieving the aims of mental health advocacy.

For this we need to understand the ideology or orientation towards change that is held by these group members. The social identity perspective (Tajfel & Turner, 1979/1986) has been concerned with the ideology towards social change to explain the factors involved in decisions to take collective action. An SIT position contends that collective action may result when an individual perceives: (a) him or herself as a member of a relevant group identity; (b) the ingroup to be comparatively disadvantaged and the outgroup as the oppressor in that disadvantage; (c) the boundary between the disadvantaged and advantaged groups as impermeable (closed) so that individuals cannot improve their own position through upward mobility; (d) the ingroup's disadvantage to be illegitimate (unfair) and changeable (unstable); and (e) ingroup members as having a sense of agency or collective efficacy in being able to bring about change in the status of their group (Turner & Tajfel, 1979/1986; Wright, 2001; Wright & Lubensky, 2009). These factors, particularly in perceiving the outgroup as advantaged oppressors, reflect an ideology towards social change and an "ideological justification for action" (Wright & Lubensky, 2009, p. 298).

Other contributions have focused on ideology as reflecting moral convictions, which are strong drivers for collective action because these beliefs of morality "describe what one 'ought' to do" (Wright, 2009, p. 869). Thus, moral-based ideologies – which imply "absolute" and "sacred" judgments or beliefs about social conduct (Wright, 2009; van Zomeren & Spears, 2009) – imply norms for group actions in cases where the ingroup's moral convictions are seen to be violated by an outgroup (Wright, 2009). Along similar lines, van Zomeren and Spears (2009) argue that some people ("intuitive theologians") engage in collective action to defend fundamental group moral values, particularly for people who strongly identify with their ingroup. Moral ideologies therefore represent group-based motivations for action when these are a shared value of group members.

Group-based ideology was empirically examined by Cameron and Nickerson (2009) as reflecting a shared orientation held by members of a collective opinion-based group identity. Specifically, they proposed that an anti social dominance orientation (i.e., rejection of the social dominance and social hierarchical structure of social groups in favour of egalitarianism) reflects a core ideology for supporters of the anti-globalisation movement. Their results showed that demonstrators' endorsement of this ideological orientation significantly predicted inclinations towards normative (i.e., group endorsed) collective protest in support of the anti-globalisation movement while social identification as an opinion-based group member mediated this relationship. Thus, consistent with proposals that ideologies are strong drivers for action (Wright, 2009; van Zomeren & Spears, 2009) and previous research demonstrating that high social identification is associated with group action (Klandermans, 2002; Simon et al., 2000), Cameron and Nickerson's results indicate that endorsement of the group's shared ideology predicts engagement in group-oriented action for people who strongly identify with a group formed on the basis of a shared opinion relevant to their ideology.

Returning again to the central arguments of this thesis, I propose that the stigma of mental disorders can be overcome with cooperation between people with mental disorders (and carers of people with mental disorders), health providers and members of the public (including their government representatives). As these are three primary stakeholders for issues relating to mental health, I contend that their cooperation is necessary to address the structural stigma of mental disorders and change the systemic disadvantage that is symptomatic of, and enables, stigma. This cooperation will be more likely to be effective when it occurs in the context of shared support for the aims of mental health advocacy, which is an example of an opinion-based group membership. Therefore, I propose that aspiring to a cooperative community for positive change represents an ideological basis, or psychological orientation, for supporters of mental health advocacy. In this way, the development of a cooperative community provides an ideology for supporters of mental health advocacy in moving forward in a desirable direction.

This proposed relationship between ideology and opinion-based group membership builds on the arguments of Gee et al. (2007) who state the cooperative community arrangement can be realised "through expanding involvement in values consistent with the advocacy movement so that greater numbers of the community, professional and consumer groups become committed to the aims of mental health advocacy" (p. 103). By building on this commitment, those people would be "working together for the same cause and effectively crafting a cooperative community to see a more cooperative, integrated and interdependent community" (Gee et al., 2007, p. 103).

To summarise, ideology, group membership and social action provide different, though related, contributions in navigating the path towards reducing the stigma of mental disorders. The development of a cooperative community (i.e., a shared group ideology) can be considered to provide the vision representing the type of changes desired and a commitment to work with people who are affected by stigma, thus providing a positive direction (or bearing) towards reducing the disadvantage of people with mental disorders. Support for mental health advocacy, which articulates the goals for stigma reduction, may provide the vehicle to move in the desired direction by providing a collective identity that converts the ideological content into group practices and norms about the actions to be taken by people who support mental health advocacy. Finally, collective action is one of these actions and represents footsteps that group members can follow to overcome the structural disadvantage of people with mental disorders and work towards a more integrated and inclusive social structure.

This thesis investigates these ideas and explores social identity, aspirations and intended action by members of an opinion-based group in support of mental health advocacy.

STATEMENT OF RESEARCH AIMS

In order to explore the proposed approach, I will present five studies designed to address the following overall research aims:

1. Explore support for mental health advocacy among people who are not currently active advocates for mental health;
2. Define the psychological constructs involved in holding an orientation towards a cooperative community for positive social change;
3. Explore the perceived utility of this approach among members of the public, potential trainees and mental health advocates; and
4. Explore the practical applications of developing cooperative communities for positive change in mental health.

In Studies 1, 2 and 3 (Chapter 4), I explore the roles of identification with mental health advocacy and aspirations for a cooperative community in commitment to reducing stigma among potential trainees, health professionals and members of the general public (aims 1, 2 and 3). Chapter 5 builds on the findings of these studies and presents key theoretical arguments behind the development of a cooperative community as well as some of the practical considerations involved (aims 2 and 4). Finally, Studies 4 and 5 (Chapters 6 and 7) explore ideological and action orientations towards a cooperative community in two mental health advocacy groups (aims 2, 3 and 4).

CHAPTER 4

ASPIRATIONS FOR A COOPERATIVE COMMUNITY AND SUPPORT FOR MENTAL HEALTH ADVOCACY: A SHARED ORIENTATION OF AN OPINION-BASED GROUP (STUDIES 1, 2 AND 3)

CONTEXT STATEMENT

This chapter presents three studies that explore the social identity reflecting support for mental health advocacy and aspirations for a cooperative community, hypothesised to reflect a shared ideology of this group identity. The aspirations construct was developed following my previous research (described in part by Gee et al., 2007) where I created micro advocacy groups using nominal supporters of mental health advocacy. After reading information about mental health advocacy (incorporated into the method of Studies 1 and 2 in this chapter), undergraduate university students who identified as supporters of mental health advocacy engaged in group interaction to discuss and agree on strategies that would reduce the stigma of mental disorders (see also Thomas & McGarty, 2009). Ideas generated during group discussions promoted integration, compassion and integration in the university and wider community for people with mental disorders, through strategies such as educating the public by providing personal accounts of living with mental disorder, organizing a support group or online forum, encouraging universities to implement more flexible policies for students with mental health concerns and organizing mental health awareness activities on campus to provide knowledge, raise money and offer fun community activities (e.g., sausage sizzles, jumping castles, seminars and networking). Additionally, the group interactions were observed to reflect a number of characteristics that contributed to a positive and validating experience including participation, valuing the contributions of all group members and respectful communication.

These discussions may provide a process that mirrors – on a small group scale – the ways that people and groups in the broader community might define desired changes and propose strategies for moving in a positive direction towards that change. These issues that arose from observing the group interactions led to the proposal that a set of relations in the mental health sector that allowed these characteristics of participation, contribution, integration and respectful communication may be beneficial for producing and delivering strategies to combat stigma. This led to the aims of Studies 1–3 in this chapter which investigate a scale measuring aspirations for a type of community defined by these characteristics and explores the perceived desirability of that approach.

More specifically, Studies 1–3 explore the relationship between aspirations for a community defined by cooperation, social identification with the aims of mental health advocacy and attitudinal and behavioural outcomes that demonstrate commitment to the reduction of stigma (and are frequently used in stigma research as reviewed in Chapter 2). This chapter contains a manuscript submitted for publication in a peer-reviewed psychological journal. The reference for this manuscript is:

- Gee, A., & McGarty, C. (2010). *Aspirations for a cooperative community and support for mental health advocacy: A shared orientation of an opinion-based group.* Manuscript submitted for peer-review publication.

ABSTRACT

This paper examines the role of aspirations for cooperative relations between people with mental disorders and other community members in promoting positive social change for people with mental disorders. Two studies demonstrate that aspirations for a cooperative community are distinct from social and community identification measures and strongly predict social change action intentions and positive beliefs about, and intended social interaction with, people with mental disorders. In a third study, a pictorial measure showed most participants saw a cooperative community as the most

desirable approach for change. Overall, results indicate aspirations for a cooperative community add to knowledge about collective identities and their implications for fostering social change for the benefit of groups experiencing stigma.

INTRODUCTION

Community-based efforts to promote social change frequently involve cooperation between people who have been directly affected by an issue and other people such as volunteers and supporters who may have been indirectly affected or unaffected by the issue. For example, in a study of volunteers for an AIDS organization, Omoto and Snyder (1995) found that one-third of their sample had not previously known a person who suffered from AIDS. Similarly, mental health advocacy (efforts to improve relevant social, community and service systems to reduce stigma and discrimination) has been led by people with mental disorders and carers, but also involves the cooperation of health service providers and members of the general community (including government representatives).

What brings people who have not personally experienced stigma and discrimination to form common cause with people who have? One way that social psychologists often understand common cause is to think of it as involving the formation or transformation of social groups (S. Gaertner, Dovidio, Anastasio, Bachman & Rust, 1993; McGarty, 2006; Subasic, Reynolds & Turner, 2008). If this is the case then a key question is: what sorts of group will be best suited to fostering or promoting common cause?

Social psychology provides a number of answers to this question. One prominent suggestion in domains such as race and ethnic relations is to promote the formation of inclusive or overarching groups that include groups at the lower level. In social psychology this idea is most often associated with the common ingroup identity model (S. Gaertner et al., 1993). Following this approach, African Americans and European Americans might be encouraged to form an identity as Americans in order to reduce bias.

This idea has proven merit but it is not immediately obvious as to how this approach would apply to reducing bias towards people with mental disorders. Hence Gee et al. (2007) suggest a different approach for promoting mental health advocacy based on Bliuc et al.'s (2007) proposal that social identities based on shared opinion are useful for understanding some forms of social action. In particular, they suggest it is helpful to focus on shared opinions about reforming or changing the world in some way. Understanding group memberships as being based on a shared opinion (e.g., support for mental health advocacy) rather than other sorts of social categories (e.g., people who have a mental disorder) is consistent with the existence of social movements such as the environmental, animal welfare, anti-globalisation or peace movements whose members are not drawn exclusively from specific readily-identifiable social categories. Thus we can have an opinion-based group that includes some, but not necessarily all, people with mental disorders and some, but not necessarily all, people without mental disorders.

The next question is: which opinions are such groups based around? Gee et al. (2007) have explored support for mental health advocacy as reflecting opinion-based group membership. Supporters of mental health advocacy tend to endorse aims such as upholding the rights of people with mental disorders, improving available services, promoting knowledge and understanding about mental disorder and developing an integrative community. Gee et al. argue that holding aspirations for the development of a cooperative community is related to this group membership. In other words, supporters of mental health advocacy tend to hold a shared orientation (in overtly political contexts this may be termed an ideological stance) that cooperation between people with mental disorders, community members (and their government representatives) and health providers is a desirable and ultimately effective approach to further positive change.

The three studies presented in this paper explore a measure of aspirations for a cooperative community. Previous research has shown that identification with an opinion-based group is a reliable predictor of socio-political action to promote change (Bliuc et al., 2007; Cameron & Nickerson, 2009; Musgrove & McGarty, 2008; O'Brien & McGarty, 2009; Thomas & McGarty, 2009). Much of this research (with the exceptions of the work by Cameron & Nickerson and Thomas & McGarty) has measured social identification as a uni-dimensional construct reflecting identity certainty. In order to study social identification with more precision, and acknowledging its multidimensional nature, we also include multi-factor measures of social identification in the present studies (Cameron, 2004, in Study 1; Leach et al., 2008, in Study 2).

Study 1 explores aspirations for a cooperative community as an ideology compatible with supporting mental health advocacy, an opinion-based group. Specifically we ask whether, in line with the arguments of Gee et al. (2007), aspirations for a cooperative community are associated with social identification with supporters of mental health advocacy, positive stereotypes about people with mental disorders and favourable behavioural intentions (both to interact positively with people with mental disorders and to work to promote improved circumstances for people with mental disorders).

In Study 2 we examine aspirations for a cooperative community alongside existing community and social identification measures in predicting beliefs about people with mental disorders, intended participation in actions to promote mental health advocacy and willingness for social interaction with people with mental disorders.

Finally, Study 3 explores a pictorial measure of group relations and a cooperative community to assess relations perceived as desirable to achieve significant and positive change.

STUDY 1

The first study was conducted to explore our contention that aspirations for a cooperative community are associated with support for mental health advocacy as an opinion-based group. In Study 1, we explore a scale designed to reflect aspirations and examine (a) the scale's internal reliability, (b) whether it predicts positive beliefs about people with mental disorders, willingness for social interaction with people with mental disorders and intended social participation to promote mental health advocacy, and (c) its association with identification as a member of the pro-mental health advocacy group.

Method

Participants

Australian university students (N = 198, 71 male and 127 female, M_{age} = 20.8 years, age range 17-51 years, SD = 5.4) completed the questionnaire in a first-year psychology class on stigma and mental disorder. Of the sample, 126 participants reported having a close friend or family member diagnosed with a mental disorder, 80 reported contact with people with mental disorders through paid or voluntary work (most often reported to be "every week" or "occasionally") and seven had previously been a mental health advocacy network member.

Design

Study 1 was conducted as part of a larger study in a laboratory class. The questionnaire had one manipulated variable with two levels (self-categorization, no self-categorization). All participants who self-categorized ($n = 86$) identified themselves as a supporter (as opposed to not a supporter) of mental health advocacy.

Procedure and Materials

Participants who self-categorized read information correcting common misconceptions about people with mental disorder (e.g., a tendency towards violent behaviour) and describing mental health advocacy before identifying their position. Of those participants who did not self-categorize ($n = 112$), 35 still read the information. The questionnaire for all participants consisted of the following scales (items were rated 1 = strongly disagree to 11 = strongly agree).

Beliefs regarding people with mental disorders. Sixteen items measured perceived dangerousness (e.g., "people with mental disorders are likely to show physically violent behaviour"), worry about contact (e.g., "I would be worried about becoming a friend with a person with a mental disorder"), independent living capabilities (e.g., "people with mental disorders have the skills and ability to live alone", reverse-scored item) and treatment in society (which included items from Taylor and Dear's, 1981, Community Attitudes towards the Mentally Ill scale; e.g., "more tax dollars should be spent on the care and treatment of people with mental disorders", reverse-scored item).

Behavioural intentions. Sixteen items measured willingness for social interaction (e.g., "if a former psychiatric patient came to live next door, I would greet them occasionally in the street"), stigma challenging behaviours (e.g., "I intend to participate in an advocacy or community group to challenge negative stereotypes of individuals with a mental disorder and/or provide information about mental health resources to the public") and community involvement (e.g., "I intend to participate in a public display of support in the fight against stigma and for improved mental health care, such as a rally or fun-run").

Aspirations for a cooperative community. Ten items measured the degree to which participants aspired to a cooperative community (see Appendix B). This scale assessed support for changes that reflected cooperation, the type of change expected to result from cooperation, how achievable it was perceived to be and personal commitment to the vision.

Group identification. Sixteen items measured identification as a supporter of mental health advocacy: 12-items measured ingroup ties, centrality and ingroup affect (Cameron, 2004) and four items measured identity certainty (Bliuc et al., 2007). For reasons of brevity we focus on the three Cameron subscales in the analysis. For participants who self-categorized, the page was split into two columns; participants answered questions only on the side of the page associated with their identity category (for example, "overall, being a supporter (left side of page)/non-supporter (right side) of mental health advocacy has very little to do with how I feel about myself"). Participants who did not self-categorize read a short paragraph outlining mental health advocacy and completed the same identification items with modified wording (e.g., "I have a lot in common with other supporters/non-supporters of mental health advocacy" became "I have a lot in common with people who support mental health advocacy").

Results

Scale Properties

Principal components and reliability analyses were applied to each scale (McGarty & Smithson, 2005). Table 4.1 presents the mean score, percentage of variance explained and reliability coefficient for all scales. All items yielded loadings greater than .40 for its respective scale (and smaller than .40 for the competing scale in multi-factor solutions, see below) unless stated.

Table 4.1. *Descriptive statistics and properties of each scale (Study 1)*

Scale (No. items)	*M* (*SD*)	% explained	α
Aspirations (10)	8.4 (1.2)	45.4	.84
Ingroup ties (4)	7.0 (2.1)	66.6	.83
Ingroup affect (4)	9.0 (1.5)	55.9	.73
Centrality (4)	4.5 (2.3)	65.3	.82
Certainty (4)	8.2 (1.9)	76.7	.90
Beliefs (16)	3.5 (1.3)	42.9	.90
Socio-political action (8)	5.1 (2.4)	39.6	.94
Social interaction (7)	8.9 (1.4)	19.0	.74

Note. Beliefs scale is negatively scored such that low scores reflect positive views.

The beliefs and aspirations scales each performed adequately as unitary measures while behaviours were best suited to a two-factor solution. Socio-political action included participation in student or community groups, organizing activities to increase awareness and displays of support (e.g., signing a petition). Social interaction included, for example, advising caution to a family member intending to marry a person with a mental disorder (reverse-scored item), greeting a neighbour with a mental disorder and supporting a fellow student. One item[1] yielded loadings of .52 and .46 on both components, however remained in the scale yielding a greater loading (social interaction). Deleting one social interaction item, "if I found out that someone I had been spending time with was a former psychiatric patient, I would stop seeing them", although it yielded a strong loading, resulted in a considerably

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[1] "(If someone I sit close to at university told me they were having some mental health problems, such as anxiety or mood, I would) tell them I am someone they can talk to when needed".

higher reliability coefficient ($\alpha = .74$ without the item, $\alpha = .61$ with the item). This item alluded to a more intimate friendship or potential romantic involvement and ratings indicated that participants were very likely to end such a relationship (M = 10.0, SD = 1.8). All four social identification subscales demonstrated good levels of reliability.

Relationship Between Aspirations, Social Identification, Beliefs, Socio-Political Action and Social Interaction[2]

Bivariate correlations (Table 4.2) revealed that holding aspirations for a cooperative community was significantly correlated with all four components of identification. Aspirations for a cooperative community was the strongest predictor of beliefs about people with mental disorders and intended social interaction and the second best predictor of intended socio-political action to promote mental health advocacy, behind centrality of group identity.

Centrality predicted socio-political action intentions and to a lesser extent social interaction but not beliefs, which were most strongly predicted by ingroup affect. These findings indicate that centrality of group identity relates to a commitment to seeking to change other people while ingroup affect may relate to putting mental health advocacy ideals into everyday practice. Ingroup ties was moderately correlated with all three outcome measures and this was the pattern demonstrated by aspirations.

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[2] Independent sample t-tests revealed no significant differences between self-categorization and no self-categorization for beliefs, $t\ (196) = 1.18, p > .23, d = 0.17$, socio-political action, $t\ (196) = -.47, p > .63, d = 0.07$, social interaction, $t\ (196) = -1.58, p > .12, d = 0.23$, ingroup affect, $t\ (196) = -1.43, p > .15, d = 0.21$, identity certainty, $t\ (196) = -1.86, p > .06, d = 0.27$, or aspirations for a cooperative community, $t\ (196) = -.10, p > .92, d = 0.02$, which indicates people develop aspirations even in the absence of the relevant opinion-based group context. Differences between groups were found for ingroup ties, $t\ (196) = 3.74, p < .001, d = 0.54$, and centrality, $t\ (196) = 2.12, p < .05, d = 0.30$, with people who had not self-categorized reporting higher levels of both measures. Given that very few differences were found between samples, reported analyses were conducted on the entire sample.

Table 4.2. *Intercorrelations between measured variables (Study 1)*

	1	2	3	4	5	6	7	8
1. Aspirations	-	.54***	.62***	.30***	.68***	-.59***	.45***	.63***
2. Ingroup ties		-	.47***	.49***	.63***	-.37***	.43***	.36***
3. Ingroup affect			-	.15*	.73***	-.55***	.25***	.52***
4. Centrality				-	.34***	-.02	.63***	.15*
5. Certainty					-	-.53***	.41***	.53***
6. Beliefs						-	-.14	-.69***
7. Socio-political action							-	.23**
8. Social interaction								-

Note. Beliefs scale is negatively scored such that low scores reflect positive views.
*$p < .05$, **$p < .01$, ***$p < .001$.

Hierarchical Regression Models

To clarify these results we conducted three hierarchical regression analyses using the identification subscales and aspirations as predictors of beliefs, socio-political action intentions and social interaction. We entered familiarity with mental disorders in Block 1 and added the social identification subscales in Block 2 and aspirations for a cooperative community in Block 3.

Results show that the identification subscales in Block 2 added significantly to the prediction of each outcome, Block 1 (beliefs): F (2, 195) = 13.78, $p < .001$, $R^2 = .12$; Block 2 (beliefs): F_{change} (3, 192) = 25.24, $p < .001$, $\Delta R^2 = .25$, Block 1 (socio-political action): F (2, 195) = 1.93, $p > .14$, $R^2 = .02$; Block 2 (socio-political action): F_{change} (3, 192) = 46.73, $p < .001$, $\Delta R^2 = .41$, Block 1 (social interaction): F (2, 195) = 13.87, $p < .001$, $R^2 = .13$; Block 2 (social interaction): F_{change} (3, 192) = 22.19, $p < .001$, $\Delta R^2 = .23$. Ingroup affect was an especially good predictor in the second block for beliefs as were social interaction and centrality for socio-political action (see Table 4.3). Aspirations for a cooperative community added to prediction over and above the familiarity and identification variables for all three outcomes, demonstrating that it is an important independent predictor, Block 3 (beliefs): F_{change} (1, 191) = 28.74, $p < .001$, $\Delta R^2 = .08$, Block 3 (socio-political action): F_{change} (1, 191) = 14.05, $p < .001$, $\Delta R^2 = .04$, Block 3 (social interaction): F_{change} (1, 191) = 40.99, $p < .001$, $\Delta R^2 = .12$.

Table 4.3.*Summary of hierarchical regression analyses (Study 1)*

Predictor	Beliefs *β*	Socio-political action *β*	Social interaction *β*
Block 1			
Family/friend diagnosis	-.30***	.14	.33***
Work contact	-.13	-.01	.08
Block 2			
Family/friend diagnosis	-.16**	.02	.19**
Work contact	-.08	.03	.05
Ingroup ties	-.19*	.09	.12
Ingroup affect	-.43***	.12	.43***
Centrality	.15*	.57***	.01
Block 3			
Family/friend diagnosis	-.14*	.00	.16**
Work contact	-.06	.02	.03
Ingroup ties	-.09	.02	.00
Ingroup affect	-.24**	-.01	.21**
Centrality	.19**	.54***	-.05
Aspirations	-.40***	.27***	.47***

Note. Beliefs scale is negatively scored such that low scores reflect positive views.
**p* < .05, ***p* < .01, ****p* < .001.

Discussion

Results of Study 1 show the aspirations for a cooperative community scale is correlated with existing measures of social identification but remains empirically and conceptually distinct. The full set of predictors accounts for around 50% of the variance in each of three variables that capture extremely relevant responses and reactions to people with mental disorders. This suggests that measuring social identification and aspirations for a cooperative community could be an extremely useful activity.

Although findings are consistent with previous research showing a link between familiarity with mental disorders and more positive beliefs and social behaviours (e.g. Angermeyer et al., 2004; Couture & Penn, 2003), aspirations strongly predicted beliefs about people with mental disorders and intended social interaction and socio-political behaviours even after controlling for prior familiarity and social identification. These findings lead us to consider how these aspirations relate to, and compare with, additional measures of social identification. Study 2 further explores aspirations for a cooperative community in predicting beliefs and behavioural intentions in comparison to existing measures of community identification often utilised in action research. We also expand on measures of familiarity with mental disorders to control further for this effect.

STUDY 2

Researchers have examined identification with a community to understand what leads people to become involved in socio-political behaviour. Davidson and Cotter (1986, 1989) demonstrated a link between high identification with an individual's city (or sense of community) and willingness to give more time and monetary contributions to local agencies and participate in political behaviours reflecting community interests (e.g., frequency of voting, contacting officials about social issues and participating in or forming groups to work on public problems). Similarly, a measure of perceived identification with fellow residents of a town developed by Stürmer and Kampmeier (2003) was shown to predict participation in local community activities (e.g., organizing local events, volunteering for community agencies) and activities relating to community service (e.g., campaigning support for the fire brigade).

Although both these measures are good predictors of participation for a local community, they limit the definition of community by location. This becomes problematic when applied to predict participation in wider social movements that cut across geographical boundaries. This point has also been made by Omoto and Malsch (2005), who proposed a psychological sense of community scale based on their investigations of the motivations of HIV/AIDS volunteers. Their scale captures perceived obligation or concern for communities affected by HIV/AIDS and predicts socio-political action for the cause (e.g., donating, planning or attending fundraisers, writing letters to politicians).

Subsequent to collecting the data for Study 1 there have also been developments in the measure of identification with psychological groups. Leach et al.'s (2008) research on existing identification measures revealed five components of ingroup identification (nested within two higher level factors: self-definition and self-investment) rather than the three suggested by Cameron (2004). We use the five dimensional scale in Study 2, where we examine aspirations for a cooperative community's relationship with sense of community, community identification, psychological sense of community and opinion-based group identification. We also explore the ability of each measure to predict beliefs about, and intended social interaction with, people with mental disorders and socio-political behaviours to support change. It was predicted: (a) aspirations for a cooperative community and the four identification measures would be empirically distinct constructs; and (b) aspirations for a cooperative community would significantly add to the prediction of beliefs, actions and social interaction over and above the contribution of the other measures.

Method

Participants

One hundred and thirty-eight people[3] (98 female, 35 male and 5 who did not indicate their gender, M_{age} = 27.7, age range 18-68 years, SD = 10.8) completed an online survey, of which 57 first-year psychology students received course credit. The remaining participants were recruited by email using the snowball method. Completion of the survey was anonymous.

Aside from undergraduate students, 15 participants reported their main occupation was in research or postgraduate studies, 10 were in administration, management or project coordination and 7 were in health or community care (e.g., psychologist, doctor, nurse). The remaining participants were in law, teaching, child care, IT, customer service or other areas, however seven

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[3] An additional 23 people who completed the survey indicated they were members of a mental health advocacy organization. As this study investigates community attitudes about mental health advocacy, reported analyses exclude these advocacy members.

participants did not provide a response. An additional seven participants reported they were volunteers.

Procedure and Materials

Participants completed the questionnaire online through a secure website. The questionnaire for all participants consisted of the following scales (items were rated 1 = strongly disagree to 11 = strongly agree).

Beliefs. The same 16 items from Study 1 measured beliefs about people with mental disorders.

Behavioural intentions. Fourteen items from Study 1 measured willingness for social interaction and involvement in socio-political action (two items were excluded because they related specifically to participating in a student group).

Aspirations for a cooperative community. The same 10 items from Study 1 measured participants' aspirations to a cooperative community.

Psychological sense of community. Five items reflecting psychological sense of community (Omoto & Malsch, 2005) measured perceived obligation or concern for communities affected by mental disorder (e.g., "I want to help members of communities affected by mental disorder").

Sense of community. Five items reflecting sense of community (short version; Davidson & Cotter, 1993) measured participants' perceived connection to their city (e.g., "I feel like I belong here").

Community identification. Six items (Stürmer & Kampmeier, 2003) reflected perceived identification with others in participants' local community/town (e.g., "I feel strong ties with other citizens of my community/town").

Group identification. Participants read about the aims of the mental health advocacy movement (to promote well-being of people diagnosed with mental disorder through improving available services, promote knowledge and understanding in the community to reduce discrimination and stigma, uphold the rights of people diagnosed with mental disorder and promote an integrative community for mental health) and self-categorized as either a supporter or not a supporter of the aims of mental health advocacy. Only the 125 participants who self-categorized as supporters are included in this analysis (10 indicated they were not a supporter of mental health advocacy and 3 did not answer the question). They then completed 18 items of social identification as a supporter of mental health advocacy (14 items from Leach et al., 2008; 4 items from Bliuc et al., 2007).

Familiarity with mental disorder. Four items assessed prior familiarity with mental disorder. Participants responded (yes/no) whether they (personal diagnosis) or a family member or close friend (family/friend diagnosis) had received a diagnosis of a mental disorder and whether they had contact with people with mental disorders through paid or voluntary work (work contact) or in social situations (social contact).

Results

Scale Properties

As in Study 1, principal components and reliability analyses were applied to each of the scales (McGarty & Smithson, 2005). As in Study 1, beliefs and aspirations performed adequately as unitary measures, as did psychological sense of community, sense of community and community identification (Table 4.4). One belief item ("people with mental disorders should be in charge of their own medications") and one aspirations item ("the changes to Australian society described above represent a vision that will never be achieved") yielded loadings of only .20 and were thus deleted. All remaining items for those five scales yielded loadings greater than .40.

Behavioural intentions were again suited to a two-factor solution with varimax rotation reflecting social interaction and socio-political action. One item ("I would advise caution to a family member intending to marry a person with a mental disorder") was deleted due to a loading of only .36. Another item (signing a petition) yielded loadings of .53 on the action component and .42 on the interaction component, however was retained in the socio-political action scale.

Social identification items were suited to a four-factor solution with varimax rotation. Seven items reflect Leach et al.'s (2008) combined solidarity and satisfaction subscales (similar to Cameron's, 2004, affect component in Study 1), four reflect centrality, four reflect Leach et al.'s combined individual self-stereotyping and ingroup homogeneity subscales (measuring similarity of individual with group members and of ingroup members to each other) and three items reflect Bliuc et al.'s (2007) identity certainty. All 18 items yielded loadings greater than .40 onto one component, however three solidarity/satisfaction items with loadings of .67, .67 and .73 also yielded loadings of .58, .54 and .53, respectfully, onto centrality. These three items were retained in the solidarity/satisfaction subscale onto which they had the highest loadings.

Table 4.4. *Descriptive statistics and properties of each scale (Study 2)*

Scale (No. items)	*M* (*SD*)	% explained	*α*
Aspirations (9)	8.8 (1.5)	56.5	.91
Self-stereotyping/ingroup homogeneity (4)	5.8 (2.0)	6.4	.91
Solidarity/satisfaction (7)	7.2 (1.9)	56.3	.93
Centrality (4)	5.0 (2.5)	9.8	.93
Certainty (3)	6.8 (2.2)	5.9	.83
Sense of community (5)	8.1 (2.2)	68.1	.88
Community identification (6)	7.2 (2.3)	76.7	.94
Psychological sense of community (5)	6.7 (2.1)	71.6	.90
Beliefs (15)	3.1 (1.4)	46.1	.91
Socio-political action (6)	5.1 (2.3)	31.6	.88
Social interaction (7)	9.4 (1.2)	18.4	.75

Note. Beliefs scale is negatively scored such that low scores reflect positive views.

Intercorrelations Investigating Relationships Between Measures

Bivariate correlations between variables (Table 4.5) indicate the community and identification scales are distinct measures, with the possible exception of psychological sense of community and solidarity/satisfaction which yielded a very high correlation (r = .74) and demonstrated similar correlations with other measures, thus raising the prospect that the two variables are measures of the same construct.

The three most consistently strong predictors of the three outcome measures were aspirations for a cooperative community, solidarity/satisfaction and psychological sense of community. Community identification, sense of community and self-stereotyping/ingroup homogeneity did not significantly predict all of the outcome measures.

Hierarchical Regression Models

Three hierarchical regression analyses were conducted with the three strongest predictors. This allowed us to tease out the apparent overlap between psychological sense of community and solidarity/satisfaction and explore whether aspirations significantly adds to prediction above existing identification measures. Additionally, we controlled for the relatively large proportion of the sample who reported prior familiarity with mental disorder, through a personal diagnosis (P = .34), a family member or close friend with a diagnosis (P = .79), work contact (P = .55) or social contact (P = .78). For each of the three dependent measures, we included the four familiarity variables in Block 1 and added psychological sense of community and solidarity/satisfaction (Block 2) and aspirations for a cooperative community (Block 3). Beta values for all predictors are presented in Table 4.6.

Table 4.5. *Intercorrelations between measured variables (Study 2)*

	1	2	3	4	5	6	7	8	9	10	11
1. Aspirations	-	.37***	.60***	.40***	.48***	.31**	.24**	.50***	-.54***	.43***	.64***
2. Self-stereotyping/ingroup homogeneity		-	.57***	.67***	.53***	.30**	.37***	.53***	-.17	.43***	.28**
3. Solidarity/satisfaction			-	.71***	.66***	.28**	.28**	.74***	-.47***	.61***	.51***
4. Centrality				-	.65***	.20*	.16	.60***	-.27**	.56***	.31***
5. Certainty					-	.28**	.29**	.48***	-.37***	.32***	.45***
6. Sense of community						-	.67***	.11	-.26**	.13	.37***
7. Community identification							-	.19*	-.13	.22*	.21*
8. Psychological sense of community								-	-.41***	.72***	.46***
9. Beliefs									-	-.24**	-.72***
10. Socio-political action										-	.31**
11. Social interaction											-

Note. Beliefs scale is negatively scored such that low scores reflect positive views.
**p* < .05, ***p* < .01, ****p* < .001.

Table 4.6. *Summary of hierarchical regression analyses (Study 2)*

Predictor	Beliefs β	Socio-political action β	Social interaction β
Block 1			
Personal diagnosis	-.32***	.13	.21*
Family/friend diagnosis	-.15	.06	.23*
Work contact	-.20*	.11	.04
Social contact	-.01	.10	.08
Block 2			
Personal diagnosis	-.22*	-.05	.07
Family/friend diagnosis	-.12	-.04	.18*
Work contact	-.13	-.06	-.05
Social contact	.03	.00	.03
Psychological sense of community	-.08	.62***	.14
Solidarity/satisfaction	-.29*	.20*	.34**
Block 3			
Personal diagnosis	-.19*	-.05	.04
Family/friend diagnosis	-.09	-.05	.15
Work contact	-.16*	-.05	-.01
Social contact	.07	-.00	-.03
Psychological sense of community	-.05	.62***	.09
Solidarity/satisfaction	-.10	.17	.10
Aspirations	-.40***	.06	.50***

Note. Beliefs scale is negatively scored such that low scores reflect positive views.
$*p < .05$, $**p < .01$, $***p < .001$.

Predicting beliefs about people with mental disorders. After controlling for familiarity in Block 1, F (4, 116) = 7.39, $p < .001$, $R^2 = .20$, solidarity/satisfaction (but not psychological sense of community) significantly added to the prediction of beliefs in Block 2, F_{change} (2, 114) =

8.20, $p < .001$, $\Delta R^2 = .10$, however this effect was fully accounted for when aspirations was added in the final step, F_{change} (1, 113) = 17.83, $p < .001$, $\Delta R^2 = .10$.

Predicting social interaction. The prediction of willingness for social interaction showed the same pattern: again after controlling for familiarity in Block 1, F (4, 116) = 5.19, $p < .01$, $R^2 = .15$, only solidarity/satisfaction added significant prediction in Block 2, F_{change} (2, 114) = 13.42, $p < .001$, $\Delta R^2 = .16$, however aspirations was the sole predictor when added in Block 3, F_{change} (1, 113) = 32.62, $p < .001$, $\Delta R^2 = .15$.

Predicting socio-political action. None of the familiarity variables significantly predicted socio-political action intentions in Block 1, F (4, 116) = 2.06, $p > .09$, $R^2 = .07$. Both solidarity/satisfaction and psychological sense of community contributed significant variance in Block 2, F_{change} (2, 114) = 63.17, $p < .001$, $\Delta R^2 = .49$, but the latter was the sole significant predictor when the measure of aspirations was added in Block 3, F_{change} (1, 113) < 1, $\Delta R^2 = .002$.

Discussion

The results of Study 2 fully support the first hypothesis and show that aspirations for a cooperative community, solidarity/satisfaction and psychological sense of community are empirically distinct constructs in that they predict different outcomes. Aspirations was the sole significant predictor for beliefs and social interaction when added into the regression model (thus partially supporting the second hypothesis) while psychological sense of community added unique prediction of socio-political intentions. Clearly, both measures offer unique contribution in predicting change-oriented behaviours and from the current findings emerges an important distinction between individual practice and social action behaviours. People who are committed to making changes in individual practice appear to be more likely to take on the opinion-based group's message in everyday interactions with people with mental disorders and in challenging stigmatizing attitudes on an interpersonal level. People with a strong sense of community, on the other hand, appear more likely to support action to influence the views of others.

In these data both individual practice (i.e., beliefs and intended social interaction towards people with mental disorders) and a commitment to take action for positive social change (i.e., socio-political action) were predicted by aspirations for a cooperative community. This indicates the aspirations construct may express an overarching ideology reflecting two important elements for improving inter-category relations. Both are needed to establish real and positive change for people with mental disorders and both have received considerable attention in stigma reduction (targeting individual practice) and collective action research (e.g., Corrigan, River et al., 2001; Wright & Lubensky, 2009).

Of the identification measures examined in this study, the social action component of the aspirations scale is fully accounted for by psychological sense of community. These findings are in line with those of Omoto and colleagues (Omoto & Malsch, 2005) and add to their work to demonstrate the utility of psychological sense of community in predicting socio-political action in a different domain to its original construction and testing (communities affected by HIV/AIDS).

Community identification and sense of community were significantly correlated with two of three outcome measures. Although they have been shown to predict civic action in the relevant local community (Davidson & Cotter, 1986, 1989; Stürmer & Kampmeier, 2003), identification measures that performed better in the current study were relevant to a specific issue (i.e., identification as a supporter of mental health advocacy, aspiring to a cooperative community, obligation to communities affected by mental disorder) rather than a specific town. Thus, Study 2 clearly demonstrates that measures of identification with others based on opinions about an issue were much stronger predictors of relevant outcomes in the mental health domain than identification with fellow town residents.

Results of Studies 1 and 2 provide strong evidence that the aspirations for a cooperative community scale is a valuable addition to community and social identification measures that predict beliefs about people with mental disorders and behaviours. We now turn to Study 3 to explore a pictorial means of communicating the potentially complex idea of the cooperative community and perceived current and desired social relations for the mental health domain.

STUDY 3

Previous researchers have used diagrams to measure perceptions of social relations. The Inclusion of Other in the Self (IOS) Scale (Aron, Aron & Smollan, 1992) is a visual measure of perceived closeness in romantic relationships. Individuals choose one of seven diagrams, in which two circles (representing self and partner) range from just touching to three-quarters overlapping, that most strongly represents their relationship. This measure is strongly correlated with item-based questionnaires measuring closeness, intimacy, satisfaction and commitment in existing relationships and subjective closeness, liking, love and interpersonal judgement in relationships formed in a research setting (Aron et al., 1992). Additionally, written responses from participants confirmed they interpreted the diagrams of the IOS as representing connectedness and closeness. The authors suggest the IOS (and other pictorial measures) reveals important perceptions of social relationships more quickly than questionnaire-based measures and where the perceived interconnectedness between parties is of particular interest.

In measuring perceived connection between self and group, the IOS scale has shown high correlations with ratings of social identity, similarity of self to group and perceived belongingness (Coats, Smith, Claypool & Banner, 2000; De Cremer, 2004). A modified version of the IOS (L. Gaertner & Schopler, 1998) measures perceived closeness of self in relation to others (ingroup entitativity) and of outgroup members (outgroup entitativity). Perceptions of both increased after interacting with an ingroup, such that participants saw themselves as more connected to other ingroup members and saw outgroup members as more connected to each other. Like Aron et al. (1992), L. Gaertner and Schopler used this measure to focus on perceived interconnection in defining social relationships.

Perceived relations between groups was measured pictorially by Nadler and Liviatan (2006) to reflect Israeli-Jewish participants' views about future relations between Israelis and Palestinians. This was strongly related to three questionnaire items measuring expected conflict resolution between the groups ($\alpha = .74$), showing consistency in perceived relations obtained from pictorial measures and traditional questionnaire items.

Pictorial measures, then, enable researchers to focus on perceived interconnectedness for social relations in a way that can be quickly and easily grasped. We suspect a similar measure would be useful for representing complex relations between social categories in mental health. Thus, we conducted a pilot study to explore how participants would interpret visual representations of social relations.

Pilot Study

Thirty participants in the lunching area of an Australian university completed a short response booklet that included four diagrams. Each diagram contained three rings to represent three categories (people with mental disorders, health providers and community members) which varied in physical proximity (see Figure 1, images A, D, E, F). Participants wrote their interpretation of each diagram ("To me, Diagram _ represents…").

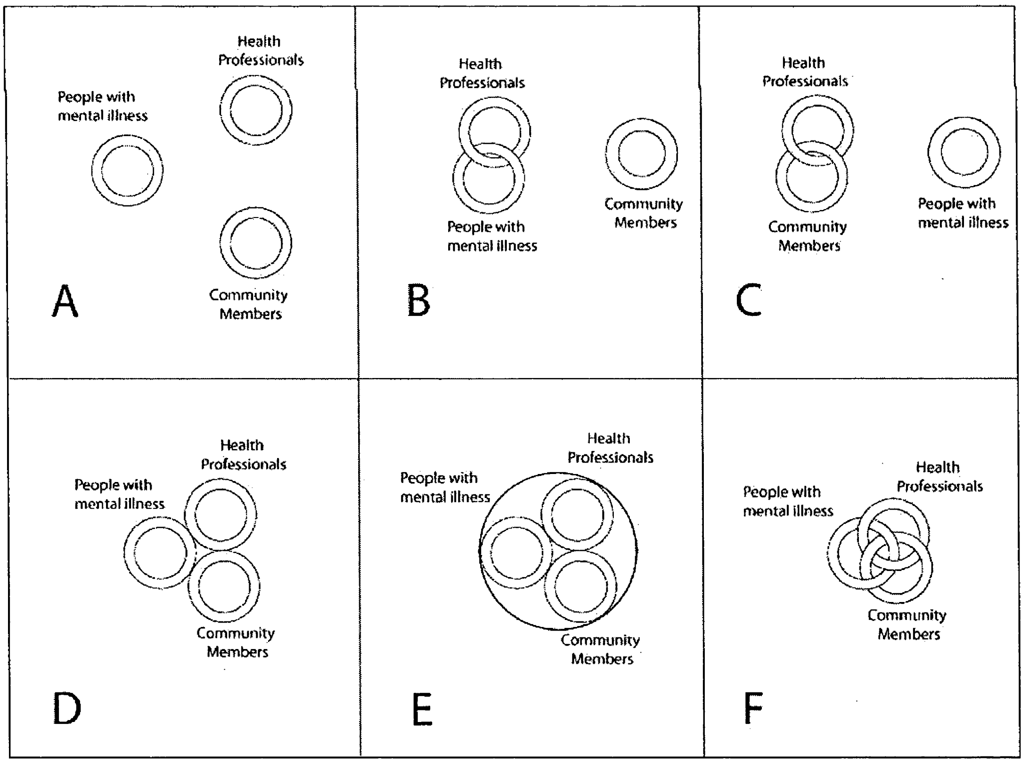

Figure 1. *Pictorial measure representing relations between categories relevant to mental health.*

A content analysis revealed consistency in participants' interpretations. All participants interpreted the diagram in which the three rings were positioned away from each other (Figure 1, image A) as representing disconnection or separation (e.g., no interaction/common roles, lack of interest, understanding or communication). Most participants ($P = 0.90$) interpreted the diagram in which the three rings were touching (Figure 1, image D) as representing functional distance (e.g., groups having some connection, interaction, communication or awareness but still independent or minimally linked). The third diagram maintained the positioning of the three rings but contained them within a larger circle (Figure 1, image E). This received less consensus among participants: two stated they did not know what it represented and one stated it was not different from the previous diagram. The remaining participants referred to the groups' connection within a larger framework ($P = 0.60$), representing a subpopulation or isolation from the rest of the community ($P = 0.20$) or forced closeness ($P = 0.07$). In the final diagram the rings were linked together (Figure 1, image F) and most participants described this as the groups working closely together ($P = 0.80$) or being too interlinked to function alone ($P = 0.13$). Of the 12 participants who drew their own diagram, seven drew one group as separate from the other two linked groups (Figure 1, images B and C). These were included into the measure and thus Figure 1 presents the final six-diagram pictorial measure for Study 3.

Having established through pilot testing that participants grasped the intended meanings behind the diagrams, we now turn to Study 3 to test the pictorial measure in portraying the cooperative community arrangement. In Study 3 we examine perceived current and desired relations for mental health and ability for participants to identify a visual representation of the cooperative community ideals.

Method

Participants

The same 125 people from Study 2[4] completed a short section of the online survey relating to the pictorial measures.

Procedure and Materials

After completing the community identification scales (Study 2), participants indicated which of six diagrams representing people with mental disorders, health professionals and other members of the general community (Figure 1): (1) “best represents the current relationship between these three groups in society”; and (2) “best represents what you, personally, think is the most desirable set of relations to combat stigma for the future”.

After reading a paragraph explaining the characteristics of a cooperative community (see Appendix B), participants indicated which diagram “best represents the desired set of relations as reflected by a cooperative community”.

Finally, participants rated the extent to which they aspired to a cooperative community on a single item (1 = not at all aspire, 11 = strongly aspire).

Results

Aspirations to a Cooperative Community

Most participants ($P = 0.92$) rated their aspiration to a cooperative community at ≥ 5 ($M = 8.2$, $SD = 2.2$), leaving seven who rated at ≤ 4 and three who did not answer the question.

Diagram Choices

Table 4.7 presents the number of participants who selected each diagram for the three questions. For question three, almost three-quarters of participants ($P = 0.73$) correctly identified Diagram F (Figure 1) to reflect a

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[4] For consistency with Studies 2 and 3 we have excluded people who did not support mental health advocacy

cooperative community. Results below refer only to the 91 participants who correctly identified that image.

A large proportion of participants selected Diagram F (reflecting a cooperative community) as the most desirable set of relations ($P = 0.87$). This is substantially larger than the proportion that selected Diagram F to reflect current relations, $P = 0.03$, with the 99% confidence interval for the proportion, $CI_{0.99} = [0.73, 0.94]$, demonstrating a significant discrepancy between perceived actual and desired relations.

Table 4.7. *Number of participants who chose each diagram for the three questions (Study 3)*

Diagram	Perceived current relations		Desired future relations		Cooperative community relations
	($n = 91$)[b]	($n = 34$)[c,d]	($n = 91$)[b]	($n = 34$)[c,d]	($n = 125$)[a]
A	7	3	0	0	1
B	40	12	1	2	2
C	8	6	0	2	0
D	22	6	0	4	5
E	11	1	11	10	20
F	3	1	79	11	91

Note. [a]Six participants did not provide a response. [b]Participants who correctly identified the cooperative community diagram. [c]Participants who did not correctly identify the cooperative community diagram. [d]Five participants did not provide a response.

Relationship Between Aspiration Level and Diagram Choice

Selecting Diagram F as desired relations was not significantly predicted by level of aspiration to a cooperative community ($r = .19$, $p > .06$). Thus it was not necessary for participants to aspire to a cooperative community in order to select it as the most desirable option. Equally, aspiration level did not significantly predict not choosing Diagram F to reflect current relations ($r = .11$, $p > .28$). Thus it was not necessary for participants to aspire to a cooperative community to recognise that the current situation did not reflect these cooperative relations.

Discussion

Results of Study 3 show that almost three-quarters of the participants correctly identified the cooperative community diagram. About the same number chose that diagram as the most desirable set of relations to bring about positive change in the future. What's more, choosing a cooperative community as the most desirable relations did not depend on whether people aspired to it. Finally, there was a discrepancy between perceived separation characterizing current relations and cooperation characterizing desired relations for the future, which shows participants recognise the need for positive change in relation to mental health.

Findings indicate a visual representation of cooperation between people with mental disorders, health professionals and general community members can be readily understood and the pictorial measure examined in Study 3 is a useful way to measure perceived current and desired relations to achieve important change for people with mental disorders.

GENERAL DISCUSSION

In this paper we have examined aspirations for a cooperative community in three studies. Overall, findings show this construct adds significantly to prediction offered by social identification measures that are themselves moderate to strong predictors of beliefs and behavioural intentions. We demonstrated in Studies 2 and 3 that aspirations for a cooperative community are related to measures of social and community identification (Bliuc et al., 2007; Cameron, 2004; Davidson & Cotter, 1993; Leach et al., 2008; Omoto & Malsch, 2005; Stürmer & Kampmeier, 2003) but are distinct from these constructs in that the aspirations scale adds significantly to prediction of positive beliefs and intended social interaction with people with mental disorders and predicts socio-political action intentions.

Interestingly, analysis of the items constituting Leach et al.'s (2008) five-factor identification scale (Study 2) revealed a three-factor extraction to be best fit. Despite this apparent discrepancy between current and prior findings, current results are consistent with the two overarching dimensions identified by Leach et al. For the dimension reflecting a person's investment in the group, current findings combined Leach et al.'s solidarity and satisfaction subscales while maintaining centrality. For the dimension reflecting a person's self-definition as part of the group, current analyses combined individual self-stereotyping and ingroup homogeneity.

These scales (and those of Cameron, 2004, in Study 1) measured social identification with an opinion-based group to support mental health advocacy. Our findings add evidence from a new domain to previous research demonstrating that opinion-based group membership predicts socio-political action (e.g., Bliuc et al., 2007; Cameron & Nickerson, 2009; Musgrove & McGarty, 2008; O'Brien & McGarty, 2009; Thomas & McGarty, 2009). Aspirations for a cooperative community were strongly associated with social identification with mental health advocacy, with correlations across the three studies all highly significant ($p < .001$). Additionally, mean levels of aspiration across the studies, which consisted only of mental health advocacy supporters, were high (> 8 on an 11-point scale). These findings suggest that aspirations for a cooperative community are an orientation towards change that is a significant part of the relevant opinion-based group identity.

Being a supporter of mental health advocacy and holding aspirations for a cooperative community thus appear to denote membership of a psychological group which crosses the boundaries imposed by existing social categories. Although defining groups along social categorical lines is important for a cooperative community (indeed, we have been referring to these social categories throughout this paper), it does not explain why people who have not personally experienced stigma and discrimination may come to see themselves as having common cause with those who have. This highlights the necessity of distinguishing between group memberships based on social categories and those based on psychologically meaningful attributes, such as an opinion (see McGarty et al., 2009).

The opinion-based group approach has also been considered by Cameron and Nickerson (2009) who note there are a number of different social categories drawn together by the anti-globalisation movement, which represents a group identity based on a shared opinion and whose members share a negative social dominance orientation. Cameron and Nickerson examined collective action amongst apparent outgroup members when defined in terms of social categories (which suggests these actions represent outgroup helping; Wright, 2009), however identifying anti-globalisation opinion as the basis of group membership defines these actions as behaviour of an ingroup. As Wright (2009, p. 862) points out for groups defined by opinion rather than social categories, "the advantaged group member is no longer acting on behalf of an outgroup but rather is acting as a representative of a newly defined ingroup". This is an important point in understanding the criteria on which group identities form and thus what brings people with mental disorders, health providers and community members together to advocate for change and work in a cooperative community with common cause.

We also demonstrated in the current three studies that working towards a cooperative community is perceived as an effective and desirable approach to reduce the stigma of mental disorders. Participants who rate highly on aspiring to a cooperative community (Studies 2 and 3; see aspirations scale in Appendix B) believe this approach would be effective in breaking down barriers and achieving positive changes. These views were made more explicit with a pictorial measure in Study 3, in which the majority of participants selected the cooperative community image as the most desirable and effective relations for reducing stigma. A cooperative community therefore shows promise as both a prejudice reduction and social change strategy.

Holding aspirations towards change is extremely important in facilitating action. As well as providing a clear direction, aspirations reflect a conceptualisation of the world that allows consistency between perceptions of current arrangements and desired change. That is, people recognise that the current situation is characterised by separation (or inter-category conflict) but this does not preclude aspirations for future relations to be characterised by cooperation between categories. This is a vital point. We expect on the basis of self categorization theory that the salience of group memberships or categories varies according to context (Turner et al., 1987). Under some circumstances, the context which makes membership salient also makes clear the distinction between groups or categories. In mental health advocacy, for example, these distinctions are often salient such that an individual either has experience with a mental disorder or not, or is either a consumer or health provider. These distinctions have important implications for communication between those people. Facilitating perceptions about group relations that encourage perceived commonality with members of a categorical outgroup (as proposed by the common ingroup identity model, S. Gaertner et al., 1993; S. Gaertner & Dovidio, 2000) will only produce real and lasting change if these new perceptions are not at odds with an individual's experience of inter-category relations in situations outside of this perceived commonality.

Aspirations for a cooperative community do not seem to fall victim to these discrepancies. Rather, this construct offers perceived commonality via an ideology that is consistent with how things are between groups now (i.e., separation or conflict) in the various contexts in which they interact (e.g., mental health policy development) and between how things can be in the future (i.e., cooperative) through building on shared aspirations. A cooperative community, then, is both entirely consistent with these variations and made stronger by the distinction between category members because, according to this approach, contributions from all members characterises, in part, successful positive change.

It is both current conceptualisations of conflict and future orientation towards change that allows supporters of mental health advocacy, no matter what their social category, to share an identity robust enough to maintain common cause and together develop solutions to achieve positive change for the future.

CHAPTER 5

DEVELOPING COOPERATIVE COMMUNITIES TO REDUCE STIGMA: LEARNING HOW TO BE PART OF THE CHANGE

CONTEXT STATEMENT

This thesis proposes that cooperation between people with mental disorders and carers, health providers and other members of the general public can reduce the stigma of mental disorders. Studies 1–3 in the previous chapter of this thesis explored support for mental health advocacy and aspirations for cooperation in commitment to stigma reducing attitudes and behaviours. Those studies demonstrated that holding aspirations represents an ideology of supporters of mental health advocacy that is associated with endorsement of positive individual practices (i.e., beliefs about people with mental disorders and social interaction intentions) and commitment to seeking social change to improve the systemic disadvantage of people with mental disorders.

The current chapter presents a manuscript that further develops the theoretical basis for this ideology, considers how the cooperative community approach differs from other prejudice reduction strategies and explores some of the practical applications of developing cooperative communities for positive change. The reference for this manuscript is:

- Gee, A., & McGarty, C. (2010). *Developing Cooperative Communities to Reduce Stigma: Learning How to Be Part of the Change.* Manuscript in preparation for submission.

ABSTRACT

This paper explores the theoretical and practical considerations of developing cooperative communities to reduce the stigma of mental disorders and achieve meaningful structural and systemic change. A cooperative community is conceptualised as a framework that facilitates change at various levels and systems in the mental health community and integrates a number of

processes and techniques to achieve positive social change. We propose that in order to bring about change it is helpful for people to aspire to the desired change. In this case aspirations for a cooperative community comprising (a) people with mental disorders, (b) members of the broader public and (c) mental health service providers can constitute a coherent world view that entails ways to bring about a desired change. We argue that techniques that challenge problematic individual attitudes and behaviours, promote harmonious group relations and challenge systemic and structural discrimination are also required to effectively address stigma.

INTRODUCTION

There are many ways to approach the problem of negative attitudes towards and discrimination against members of stigmatized social categories. When it comes to reducing the stigma of mental disorders there are many positive suggestions from the mental health advocacy movement and from research in psychology and other disciplines. These include education about mental disorders, providing consumer perspectives, contact with people with mental disorders to overcome concerns due to unfamiliarity, changing perceived intergroup relations and influencing mental health policies.

Stigma reduction strategies have largely addressed stigma as a problem that requires eliminating the negative attitudes of one segment of the community about another segment of the community. While this is one way to think about the problem there are alternatives. Rather than portraying stigma as an attribute that needs to be removed from some people who hold negative attitudes we can instead look for ways to strengthen positive attitudes that contest or work against stigma. That is, we can build those attitudes that will promote community-oriented behaviours.

This paper develops the proposition that two components are needed to reduce stigma towards people with mental disorders[5]. The first requires an

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[5] Stigma has been defined as the process of labelling, stereotyping and discrimination (Link & Phelan, 2001). This term therefore refers to both prejudice – negative attitudes and beliefs about people based on their membership in a sociological group – and its behavioural expression (Allport, 1954).

understanding among people who wish to achieve positive change of the type of changes desired by those who are directly affected by stigma. It also requires a commitment to work with people affected by stigma to achieve that desired change. To this end, Gee et al. (2007; see also Gee & McGarty, 2010) proposed that meaningful changes could be achieved in a cooperative community: an alliance of people with mental disorders, health professionals and members of the general public who share the desire for change and work together to reduce stigma and influence social change. In this paper, we expand the notion of cooperative communities and explore the psychological construct reflecting aspirations for cooperation. We present this construct as a coherent ideology that supports and partially defines the desired change.

The second component required to reduce stigma is an understanding of the techniques available to facilitate desired change. To this aim, we review research on strategies designed to challenge problematic attitudes and behaviours, promote collaborative processes and challenge the systemic disadvantage that perpetuates stigma. We also outline how the cooperative community approach relates to those existing techniques. In the final sections of this paper, we draw from this research to consider some of the practical implications of developing a cooperative community and briefly describe our research with two mental health advocacy organizations as instantiations of cooperative communities in the mental health sector.

PSYCHOLOGICAL PROCESSES INVOLVED IN THE DEVELOPMENT OF A COOPERATIVE COMMUNITY

There are three nominal groups that need to be involved in mental health advocacy: people with mental disorders (and carers of people with mental disorders), the broader general public (including government representatives) and health providers (considered here to include people who develop, support and administer services). The relationship between these groups has a powerful impact on current practices and future directions in the mental health sector. In contemporary Western societies there are ample opportunities for these groups to be perceived as separate and distant (see Chapter 4, Study 3) and this separation contributes to the stigma of people with mental disorders by reinforcing their marginalised position (Gee et al., 2007). This state of affairs can be challenged by a shift towards cooperation between these groups and increased opportunities for positive changes in the social systems that affect the position of people with mental disorders in society. This shift involves the combined effort of people from different backgrounds, knowledge and experience who nonetheless share commitment to positive change. In this way, recognition of the current disadvantage of people with mental disorders (i.e., the relationship between groups) can become a strength, or at least a precondition, for efforts to overcome that disadvantage. While in everyday language we might locate such changes as occurring in what might be called "the community" the efforts are really located in that subset of the community that acts like a community. It is this subset that we term the cooperative community.

In understanding the group processes at the heart of a cooperative community, Gee and McGarty (2010) argued that at particular times supporters of mental health advocacy can come to see themselves as members of a psychological group based on their shared opinion (Bliuc et al., 2007). This group identity based on support for mental health advocacy also involves a shared ideology or aspiration that the best way to go about reducing stigma is to craft a community based on cooperation between people with mental disorders, health providers and community members. Empirically, the relationship between opinion-based group identification and its ideology was investigated by Cameron and Nickerson (2009) who examined the role of these constructs in predicting the socio-political behaviours of anti-globalisation supporters. Their findings revealed that identification with the anti-globalisation movement (i.e., the opinion-based group) mediated the significant relationship between negative social dominance (i.e., the ideology) and participation in collective protest. We found similar results for Gee and McGarty's (2010, Study 2/Chapter 4, Study 2) data to show that aspirations for a cooperative community significantly predicts socio-political action intentions (e.g., participating in student/community groups, signing a petition, attending a rally) and this is fully mediated by social identification as a supporter of mental health advocacy (measured with the full scale from Leach et al., 2008).

In addition to predicting intended socio-political action, holding aspirations for a cooperative community is associated with other positive outcomes frequently tested in stigma research, namely more positive beliefs about people with mental disorders (e.g., that they are not likely to be violent, are able to live alone) and more willingness to interact socially with them (i.e., less intended social distance; Gee & McGarty, 2010). Aspirations for a cooperative community reflect a broader ideology which endorses positive individual practices *and* seeking social change, behaviours which are instrumental in reducing the prevalence of stigma experiences, engaging in a cooperative community and achieving systemic changes (Gee & McGarty, 2010).

The psychological construct reflecting aspirations for a cooperative community offers a unique empirical and conceptual contribution to social and community identification measures. However, it does share some overlap with psychological sense of community (Omoto & Malsch, 2005), a measure of perceived obligation or desire to help a particular community (e.g., communities affected by HIV/AIDS). Empirically, while both constructs strongly predict positive beliefs, social interaction and socio-political action, holding aspirations provides unique prediction of positive beliefs and intended social interaction and psychological sense of community provides unique prediction of intended socio-political behaviour (Gee & McGarty, 2010). Conceptually, similarities between the two constructs have emerged since developments which resulted in the original 5-item psychological sense of community scale being expanded to 18 items said to capture six components (Omoto & Snyder, 2010). Two components are aligned with defining characteristics of a cooperative community. These refer to looking forward to create a “legacy” or better future and the perception that working together will achieve the greatest chance of “success”. The importance of orientations like these are made explicit by the cooperative ideology, which defines: (a) *what* the desired change is (i.e., positive change, reduction of stigma and improved relations in the mental health sector); (b) *who* should be involved (i.e., people with mental disorders, health providers and other community members); and (c) *how* to achieve that change (i.e., by cooperation between key parties). Endorsing these changes specified by the ideology may be strengthened with the use of methods that influence the behaviours of individuals in group contexts. The next few sections review some of the social psychological techniques for challenging attitudes and behaviours of individuals, changing intergroup relations and challenging systemic disadvantage which may be useful in developing a cooperative community.

TECHNIQUES FOR CHALLENGING PROBLEMATIC ATTITUDES AND BEHAVIOURS OF INDIVIDUALS

Methods designed to reduce the stigma of mental disorders primarily target problematic attitudes and behaviours of individuals. In particular, they target the commonly held prejudices that people with mental disorders are dangerous, unpredictable and weak of character (e.g., Griffiths et al., 2006; Phelan et al., 2000; Taylor & Dear, 1981). Existing prejudices inform opinions about how the community and health system should respond to people with mental disorders. For example, those who believe people mental disorders are irresponsible also believe they should have decisions made for them; those who perceive people with mental disorders as childlike believe they need to be cared for; and those who believe people with mental disorders are to be feared believe they should be excluded where they may come into contact with others (Holmes et al., 1999). These prejudices can result in discrimination against people with mental disorders in areas such as finding or maintaining employment or housing, wage earnings, maintaining social contacts and social participation (Baldwin & Marcus, 2006; Corrigan, 1998; Hocking, 2003; Link, 2001; Schulze & Angermeyer, 2003; Wahl, 1999). Stigma reduction programs aim to reduce those prejudices and problematic behaviours so that people with mental disorders will be less likely to experience stigma.

These programs typically draw on one or more of three techniques: education about mental disorders; suppression of (or protest against) the expression of negative attitudes and behaviours; and contact with people with mental disorders (see Watson & Corrigan, 2005, for a review). There are many examples of community programs in the mental health sector which utilise all these methods. The research literature reveals that contact produces the largest and more sustained positive effects for individuals (e.g., see

Corrigan et al., 2002; Gee et al., 2007; Penn & Corrigan, 2002; Watson & Corrigan, 2005).

Although contact is a method that aims to shape the attitudes and behaviours of an individual, Allport (1954) proposed that it is effective primarily through building common interests between the individual and the stigmatized other: "prejudice… may be reduced by equal status contact between majority and minority groups in the pursuit of common goals … provided it is of a sort that leads to the perception of common interests and common humanity between members of the two groups" (p. 281). Allport's point thus draws attention to the group-based nature of an interaction between apparent individuals in effective contact situations. While the aim of the interaction is to elicit more positive attitudes and behaviours of an individual towards a stigmatized person, an effective positive interaction requires the individual to see the other person not as an individual but as a representative group member of a conflicting (i.e., stigmatized) group. When this occurs, any improvement gained is more likely to generalise to positive opinions about other members of the outgroup (Hewstone & Brown, 1986). Thus, for stigma reduction programs to be effective, even those which target the attitudes and behaviours of individuals, it must be recognised that the stigma they are designed to overcome is a group phenomenon in that it exists only in a comparative group context.

Recognising the role of group processes in perpetuating and reducing stigma presents the opportunity to draw on techniques developed to change the way conflicting or separated groups interact. These techniques encourage collaboration in place of existing conflict and attempt to create more harmonious intergroup relations.

TECHNIQUES FOR CHANGING FUNCTIONAL AND PERCEIVED INTERGROUP RELATIONS

The work of Sherif and colleagues (Sherif, 1970; Sherif, Harvey, White, Hood & Sherif, 1961) demonstrated that conflict between groups could be replaced by cooperative relations when the group context emphasised shared goals. Like Allport (1954), they saw the development of perceived commonality between group members as playing a central function. This commonality, according to Sherif and colleagues, was captured by the presence of superordinate goals, which are "goals of high appeal value for both groups which cannot be ignored by the groups in question, but whose attainment is beyond the resources and efforts of any one group alone" (Sherif, 1961, p. 202). Thus, superordinate goals create interdependence and the cooperation required to achieve them replaces existing intergroup conflict.

Empirical support for this approach was provided by one of Sherif et al.'s (1961) summer camp field experiments which investigated the interactions between twenty-four 12 year old boys. In the initial phase, the boys formed two ingroups. This process was facilitated by activities that required shared ingroup goals and ingroup cooperation, intergroup competition and attributions of blame toward the outgroup. Relations between the groups soon became hostile, characterised by verbal threats, derogatory name-calling, preferred segregation (e.g., during meals and activities) and, at times, violence. The experimenters then staged a series of problems that required cooperation between the groups to achieve mutually desired outcomes. For example, the boys worked together to solve a problem with the drinking water tank, pooled resources to hire a popular movie, pull-started a truck that had broken down but was required to fetch food supplies and prepared joint meals. Each of these activities fostered willingness for cooperation and relations between group members gradually became more harmonious and collaborative. This, however, was not the only outcome of intergroup cooperation.

With intergroup cooperation, campers were able to solve problems and achieve practical and desirable outcomes that were beyond the efforts of only one group. Thus intergroup cooperation is a technique that can result in harmonious intergroup relations as well as significant achievement. Developing a community based on cooperation between people with mental disorders, health providers and community members provides an illustration of this where desirable social relations can reduce prejudice towards people with mental disorders and bring meaningful positive change in complex social and health systems.

The potential of intergroup cooperation in the health domain was explored by Bartunek, Foster-Fishman and Keys (1996). They examined collaboration between people with developmental disabilities, family members and professionals on an advisory board developed to address issues related to developmental disabilities. As well as an emphasis on superordinate goals for the purpose of encouraging collaboration, Bartunek et al. emphasised the need for empowerment of participants in creating positive, effective, ongoing collaboration. This empowerment related to participants being able to represent the needs of their group in a respectful environment and having input into decisions of the board. We acknowledge that empowerment and perceived efficacy are crucial in collaborative and participation processes, including the development of a cooperative community and we view this as arising in the context of strong identification as a supporter of mental health advocacy. However, future research that examines the role of empowerment in a cooperative community, and whether this can be enhanced, would be beneficial to better understand this factor.

Despite apparent parallels between the cooperation observed in the campsite experiment, on the advisory boards and in a cooperative community, there is one vital difference. According to Sherif (1970; Sherif et al., 1961), intergroup cooperation occurs in the presence of *superordinate goals that require* cooperation. Thus, superordinate goals provide the functional basis to build common interest and enable cooperation. The cooperative community approach, however, specifies that cooperation occurs in the presence of a *shared ideology that endorses* cooperation. While superordinate goals may emerge in a cooperative community, they arise on the basis of a shared vision for social change in order to overcome the disadvantage of people with mental disorders and thus are a function of the existing group identity supporting mental health advocacy.

Gaertner and colleagues (S. Gaertner et al., 1993; S. Gaertner & Dovidio, 2000) argue that the common interest which arises from a superordinate goal reduces prejudice because it encourages people to perceive themselves as belonging to one larger ingroup (or superordinate identity) instead of belonging to a group that conflicts or competes with an outgroup. For example, European Americans and African Americans will recognise common interests when encouraged to perceive both groups as Americans. Research has demonstrated this approach can increase helping behaviours and willingness for cooperation directed towards people previously perceived as outgroup members (see Dovidio, S. Gaertner, Shnabel, Saguy & Johnson, 2010, for a review). Thus, it has been argued that increasing the salience of this larger group identity reduces prejudice (see Dovidio et al., 2010).

One drawback to this common ingroup approach is that while group members may perceive a superordinate identity in particular contexts, this new perception may not be sustainable in the face of ongoing intergroup relations. As self-categorization theory states (Turner et al., 1987), the salience of a particular group membership varies according to the intergroup context. Taking our earlier example, European Americans and African Americans may be perceived as Americans when America competes in the Olympic Games but these racial differences are highlighted in the context of Government health policies that are seen to contribute to the disadvantage of African Americans who, for example, have more than nine times the estimated rate of AIDS than European Americans (Centers for Disease Control and Prevention, 2007). Encouraging a perceived superordinate identity, therefore, is unlikely to be enough to improve intergroup relations over the long term, especially in contexts that again reinforce the original (negative) intergroup differences and which highlight inconsistencies between the encouraged superordinate identity and the more strongly perceived subgroup differences.

These inconsistencies which are problematic when encouraging a superordinate identity do not arise for people who aspire to a cooperative community. The development of a cooperative community is highly consistent with both how the world *is now* (i.e., a society where perceived negative differences reinforce separation between people with mental disorders, health providers and community members*) and how the world can be in the future* (i.e., these groups can move towards a more cooperative arrangement to achieve positive social change). An arrangement that allows consistency between these two states recognises problems with the current arrangement and desired future changes and relations. Thus, rather than revealing the problems in changing group contexts, it serves to highlight the need for positive change and reinforces the shared ideology to achieve that change.

As an alternative to the common ingroup model, it has been argued that in situations where it is not feasible to replace original outgroup distinctions with one superordinate identity, encouraging people to perceive their dual identity (reflecting membership of both the superordinate and smaller ingroup) would provide the greatest opportunity for generalising new positive perceptions (S. Gaertner et al., 1993; S. Gaertner & Dovidio, 2000; Dovidio, S. Gaertner & Saguy, 2007). In this model, members of conflicting groups are encouraged to think of themselves as a European American or an African American, as opposed to being a white or black person or an American (the superordinate identity). However, definitions of the superordinate identity, and perceptions of whether belonging to it allows you to maintain your subgroup identity, appear to depend on which subgroup you belong to, particularly when these are marked by a power discrepancy.

This arises, in part, because people define the superordinate identity along the same characteristics that define their ingroup (Mummendey & Wenzel, 1999). As a result, even though the superordinate identity involves more than one subgroup, ingroup qualities (and the members who hold them) are perceived as more representative of the inclusive identity than a comparative outgroup. Thus members of both subgroups will see their ingroup as a superior example of the inclusive category and this may contribute to intergroup conflict as members compete to have the qualities of their ingroup recognised in the wider group context.

This conflict will especially occur in circumstances where one of the subgroups is high in status (usually the majority) and the other is low (usually the minority). Groups of high status are in a stronger position to demand that the inclusive identity reflect characteristics of their own group (Mummendey & Wenzel, 1999). This reinforces the status quo in power, distribution of resources and the high value placed on the characteristics of the socially dominant group (cf. Wright & Lubensky, 2009). Thus, for a European American (a member of the high-status majority), the sub- and superordinate identities are very similar, whereas these two identities continue to be perceived as very different for an African American (a member of the low-status minority).

It is much harder for groups of low status to achieve the position of having the superordinate identity defined by the characteristics of their ingroup. They are therefore more likely to call for debate on the defining characteristics of the inclusive identity (Mummendey & Wenzel, 1999), a process which requires dialogue, argument and change (Wright & Lubensky, 2009). It is not surprising, then, that members of a majority group tend to prefer a common ingroup (i.e., superordinate) identity and minority group members tend to prefer a dual identity (Dovidio et al., 2010; Dovidio, S. Gaertner & Saguy, 2009). Improving group relations by encouraging a dual identity nonetheless involves both subgroups being perceived as representative of the inclusive identity (Mummendey & Wenzel, 1999) and to do so, the identities of both groups should inform the definition of the superordinate identity.

A framework for achieving this outlines how organizations may encourage groups (or sections) of employees to Actualise their Social and Personal Resources (ASPIRe) and contribute to the formation and definition of the organization (Haslam, Eggins & Reynolds, 2003). According to the ASPIRe model there are four phases of identity formation: (a) ascertaining the group identities that may contribute to the overarching approach; (b) defining the goals and identities of the subgroups; (c) defining the goals and identity of the whole based on input of the goals and identities of the subgroups; and in using these outcomes, (d) define organizational planning and direction for the overarching identity. Although ASPIRe was developed in an organizational setting, we concur with Haslam et al.'s suggestion that it may apply to a broader approach for conflict management or improving social relations where several group identities are involved.

The broader applicability of the ASPIRe model stems from its organic pluralism underpinnings (Haslam et al., 2003; Haslam & Parkinson, 2005), which specify that in this framework people with a stake in the arrangements are given the chance to engage and inform the process of development in order to represent and "advance *collectively* their various causes, aspirations and social identities" (Haslam, 2004, p. 230, original emphasis). A cooperative community is compatible with this philosophy and particularly through the ideology endorsing aspirations for cooperation.

Unlike the reviewed common and dual identity techniques, a cooperative community does not represent a hierarchical structure of social categories (cf. Turner et al., 1987) where a broader or superordinate identity (e.g., Americans, an organization) contains subgroups (e.g., European or African Americans, IT or sales employees). The social structure of a cooperative community is placed on a horizontal plane, where a sampling of people from different social categories are brought together by shared aspirations and support for mental health advocacy. Thus, instead of people with mental disorders, health providers and community members being sampled up and merging as an ingroup as they would for a superordinate or dual identity, those people are instead drawn together by a shared view for cooperation.

Cooperation, common identity and dual identity models provide techniques to facilitate harmonious relations between groups. They do not, however, seek to address the social and structural systems that maintain the disadvantage of the low-status minority group. These changes come about only by collective action (Wright & Lubensky, 2009) and we now consider the role of this technique in overcoming the stigma of people with mental disorders.

CHALLENGING STRUCTURAL AND SYSTEMIC DISADVANTAGE

While techniques for targeting individual attitudes and improving conflict between groups can bring required changes in reducing the prevalence of stigma in the community and building harmony, the success of those techniques will not bring change in the structures and systems that create and perpetuate the negative views in the first place. Thus, improvements resulting from these techniques alone may be subject to recidivism (cf. Lewin, 1947).

One reason for this is that while perceptions of intergroup boundaries and group memberships are malleable, the existing power disadvantage is more fixed. For people with mental disorders, this results in structural discrimination including difficulty accessing services, inadequate funding from government and health/community systems, inadequate crisis intervention services, public communications which promote stigma and legislation that offers little protection from discrimination (Corrigan, 1998; Corrigan, Watson, Gracia et al., 2005; Corrigan, Watson, Heyrman et al., 2005; Link & Phelan, 2001; Schulze & Angermeyer, 2003).

As we explained earlier, members of disadvantaged groups (e.g., people with mental disorders) will resist accepting a more inclusive identity (e.g., community member) when this will result in promoting the status quo and thus the interests of the advantaged group (Dovidio et al., 2010; Mummendey & Wenzel, 1999; Wright & Lubensky, 2009). According to Wright and Lubensky (2009), collective action is the only way to challenge this status quo and thus the structural and systemic discrimination that maintains the disadvantage of a low-status minority group. Wright, (2001, p. 410) defines collective action as behaviour by a member of a group which is "directed at improving the conditions of the entire group". This has been the focus of those acting on behalf of the mental health advocacy movement for the last century.

Although the mental health advocacy movement rose to prominence in approximately 1970 (Kaufmann, 1999), the issues which concerned the movement were publicly discussed as early as Beers (1908/1952), who was instrumental in establishing the National Committee for Mental Hygiene in the U.S. and Canada shortly after (e.g., see Russel, 1918). Mental health advocates aim to influence mental health policy and legislation in order to reduce structural discrimination, improve conditions and uphold the rights of people with mental disorders (World Health Organization, 2003). Although largely driven by people with mental disorders and carers, action to support change is not limited to them, as other community members (such as government representatives) are also required to become involved so that changes can be made (Gee & McGarty, 2010). What, then, drives people to become involved in a collective movement such as mental health advocacy?

Research shows that people take collective action in the context of increased identification with an ingroup relevant to the cause (Cameron & Nickerson, 2009; Klandermans, 2002; Thomas & McGarty, 2009; Gee & McGarty, 2010; Wright, 2001). Such an ingroup need not be defined along the lines of nominal social categories. For example, Simon et al. (2000) showed that although homosexual males who more strongly identified with the homosexual community were more likely to volunteer for an AIDS organization than homosexual males who did not identify with that community, homosexual and heterosexual males were *both* more likely to volunteer if they identified with the AIDS volunteer service (i.e., the cause). This is consistent with research that shows homosexual males and people who have previously known someone with HIV/AIDS are not the only ones who volunteer (e.g., see Omoto & Snyder, 1995). Thus identification with those who share an opinion and commitment to a *cause* is a significant factor in decisions to take collective action to support and advance that cause (see Bliuc et al., 2007). Group identities based on an opinion are powerful psychological identities. The boundaries that define membership to this group are clear: ingroup members share the opinion and outgroup members do not. In relevant contexts, ingroup members quickly ascertain who is an ingroup and who is an outgroup member. This provides a basis for ingroup identification and solidarity such that group members feel connected to other ingroup members. These processes can then lead ingroup members to take action in line with the aims of the group. The mental health advocacy movement represents one of these powerful group identities. In the next section, we consider the processes through which the norms and ideological content of these group identities come to be defined.

DEFINING POWERFUL GROUP IDENTITIES

Postmes, Haslam and Swaab (2005; see also Postmes, Spears, Lee & Novak, 2005) suggest that two processes are involved in forming social identities. The first is a top-down or deductive process, through which group members take on the existing social identity of a perceived ingroup. An example is belonging to a religious group that defines the rules of behaviour, social customs and dress. The second process outlined by Postmes and colleagues is a bottom-up or inductive process and this involves group members influencing definitions of the group identity. Through this process, the admired behaviours and qualities of ingroup members are perceived to be representative, typical or desirable for the entire group. Alternatively (or additionally), this type of identity formation may involve a targeted process of discussion, debate and consensus among group members who together define the group identity. The formation of the ACT Mental Health Consumer Network (ACTMHCN, n.d.) provides an example of inductive identity formation. A small number of consumers decided to form a consumer-run group in 1997 after attending a workshop on consumer representation. They formed a committee and secured a small amount of funding from the state government. Two years later, the group became incorporated after the group's volunteers established a constitution and the Network expanded in providing a drop-in centre for mental health consumers to share information and resources. Members of the Network continued to engage in inductive identity formation and, in 2005, group members agreed that the Network would provide systemic advocacy and consumer representation to influence mental health reform.

These identity formation routes provide an indication of the processes by which a cooperative community for positive change may be developed. The social identity involved is the group reflecting support for mental health advocacy and this, we have shown, involves the ideological content of holding aspirations for cooperation. Thus, it is the norms and content of both these constructs that are to be developed. We will consider how inductive identity formation may play a role in defining this identity and providing movement towards a cooperative community before exploring the role of deductive identity formation in this arrangement.

A central function of inductive identity formation is for group members to define, or add to an already defined, group identity. We have identified a number of components that define the group identity reflecting support for mental health advocacy. For example, it involves a shared opinion that supports important positive changes for people with mental disorders. It identifies upholding the rights of people with mental disorders and improving available health care as some of those changes. This group identity also involves a shared ideology that specifies how these aims may be achieved, that is by cooperation between people with mental disorders, health providers and other members of the general community. Thus, this social identity is defined clearly enough to determine ingroup members and to demonstrate it is a psychologically meaningful identity for members. Yet there are still many aspects of this identity that are not defined. For example, what behaviours and strategies will ingroup members use to achieve cooperation? How will they promote cooperation in the mental health sector? What exactly are the roles that each person (and organization) will have in a cooperative community? And how will these be negotiated? These are questions that can only be answered by group members themselves and are likely to yield different answers depending on the various sections and organizational structures in which they are to be applied.

Although a number of suggestions may be offered, the approaches that will be used and the purposes for which they will be used can only be decided by those creating a cooperative community. Thus discussion, debate and consensus among group members are required activities of the inductive process to determine these approaches (Postmes, Haslam et al., 2005). This interaction process was explored in our previous work (Gee et al., 2007), in which supporters of mental health advocacy actively engaged in group discussions with other ingroup members to discuss and develop ways to successfully combat stigma (see also Thomas & McGarty, 2009, for similar discussions relating to support for international aid). By discussing and agreeing on what they believe to be the best strategies, "participants … seek to reach consensus about norms for this (rather diffuse) group [and] in a sense participants are asked to play a leadership role for their group in articulating the norms for the movement in a positive, validating and rewarding way" (Gee et al., 2007, p. 103). A similar process of ongoing interaction would be required among those working to implement a cooperative community in the various health, political and community systems so they may develop a framework, or terms of reference, defining the conditions of those relationships and joint projects.

Inductive identity formation occurs in conjunction with deductive identity formation. While group members are engaging in the process of inducing the group identity, they must also consider how they will assimilate the norms defined by the group identity (which they helped to create) into his or her personal identity and everyday actions. Supporters of mental health advocacy who also aspire to a cooperative community have more positive beliefs about people with mental disorders and are more willing to engage in social interaction with them (Gee & McGarty, 2010). Thus group members must determine how these will be incorporated into their individual practices. As the group identity becomes more clearly defined, additional behaviours of group members may be indicated and this should also lead to changes in the individual action practices of group members.

MAKING THE MOST OF WHAT WE KNOW: INTEGRATING EXISTING TECHNIQUES AND THE COOPERATIVE COMMUNITY APPROACH TO CONSIDER PRACTICAL IMPLICATIONS

At the outset of this paper, we proposed that reducing the stigma of mental disorders requires an understanding of both desired future change and techniques that may be helpful to achieve that vision. We presented aspirations for a cooperative community as representing an ideology which captures the desired change. We then reviewed techniques that: (a) target problematic individual attitudes and behaviours, such as contact with a person with experience of mental disorder; (b) facilitate intergroup cooperation in the context of superordinate goals or highlight common or dual identities; and (c) utilise collective action behaviours to overcome structural and systemic discrimination. The differences between these techniques and of the cooperative community approach were also discussed.

It should be noted that the cooperative community approach does not preclude the use of other techniques which target individual attitudes. As Sherif (1970) argued, the development of perceived common interest, which is facilitated by intergroup cooperation, can provide the "motivational base essential if specific measures [to reduce prejudice] are to be effective" (p. 130). Thus, positive movement in the direction of a cooperative community may be assisted by techniques that enhance perceived commonality such as contact, education, opinion-based group interaction and a focus on shared goals (Allport, 1954; Gee et al., 2007; Sherif et al., 1961; Watson & Corrigan, 2005). Although holding aspirations for a cooperative community, and seeing this arrangement as the most desirable, exist in the absence of any intervention (Gee & McGarty, 2010), these techniques may be particularly useful to challenge the attitudes of individuals who do not support the reduction of stigma and bring them to a state of readiness where they may accept and/or support the cause.

The development of a cooperative community is strongly placed as a group-based approach. Holding aspirations for a cooperative community reflects a commonality, or shared ideology, which is widely understood to be an important factor for promoting harmonious social relations (Allport, 1954; Dovidio et al., 2010; S. Gaertner et al., 1993; Sherif, 1970; Sherif et al., 1961).

Further, holding aspirations reflects an ideology endorsed by supporters of mental health advocacy, a group identity for which social identification encourages collective group actions (Bliuc et al., 2007; Gee et al., 2007; Gee & McGarty, 2010). Because the defining property of this social identity is support for a particular opinion, supporters of mental health advocacy can come from virtually any existing social category. A cooperative community brings together people from a number of different nominal social groups which have different, even competing, interests in the mental health sector. The differences between people with mental disorders, health providers and community members are maintained and in this way it is an arrangement which has some similarities to dual identity approaches although it does not share the same hierarchical structure (e.g., S. Gaertner & Dovidio, 2000; Haslam, 2004; Mummendey & Wenzel, 1999). Importantly, the differences between people of those nominal groups must be positively valued so that all members have the opportunity to contribute to the definition of the arrangement. Without this, valuable experiences and perspectives may be lost and we risk ignoring important group identities and differences (as in the colour-blind approach; see Schofield, 1986).

This sentiment is reflected by the principles of organic pluralism (Haslam et al, 2003; Haslam & Parkinson, 2005; Haslam, 2004) which emphasise the value of an active process in which the ideas of contributing members inform the direction of the larger entity. This process involves discussion and debate among interested parties so that group members can build on their diversity in knowledge and experience to induce (i.e., define) the group's identity (Postmes, Haslam et al., 2005; Postmes, Spears et al., 2005).

The collective behaviours of members of a disadvantaged group also spark discussion and debate. This process can effectively challenge structural and systemic disadvantage and in many situations, may be the only way to do so (Wright & Lubensky, 2009). Cooperation between people with mental disorders, health providers and other members of the community (including government representatives) provide a forum where the collective actions of mental health advocates can develop into joint projects which will result in significant positive changes. The cooperative framework involves bringing together people from different levels of community and health systems so they may reach agreement on important issues and accomplish meaningful changes. Changes are required at local, state and national levels of community and government as well as director, management and officer levels of the health system to be effective in reducing the stigma of mental disorders. The development of a cooperative community offers an approach that can promote change in these different levels by utilising techniques that will challenge individual attitudes and behaviours, utilise group processes to promote social identification and cooperation and challenge the existing structural and systemic disadvantage of people with mental disorders. On top of this, a cooperative community offers a framework of consultation where those who are directly affected by stigma are involved in solutions to overcome it. Unfortunately, little published psychological research is directed towards this issue. To further understand some of the practical considerations in facilitating cooperation between people with mental disorders, health providers and community members, we will briefly discuss some findings from our research with two mental health advocacy groups. This research investigated the views of consumer and carer representatives about the cooperative community approach and current organizational practices relating to whether, and how, these groups might be working towards such an arrangement.

APPLICATIONS OF COOPERATIVE COMMUNITIES

Interviews with members of two systemic mental health advocacy organizations in Australia provided insight into how the development of a cooperative community was perceived in active members of the mental health community. Additionally, current organizational practices and values that may relate to a cooperative approach were explored.

Cooperative Aspirations of a Consumer-Run Mental Health Advocacy Group

The first project involved one-on-one interviews with five committee members and staff of a consumer-run advocacy group operating in an Australian state. Each interviewee commented on the type of community they and the organization were working towards. This was described as a community that recognised and valued the positive contribution made by people with mental disorders and an inclusive and integrative community where people with mental disorders are listened to and have their social, occupational and health needs adequately met.

Interviewees were then shown a diagram in which three rings – labelled people with mental illness, health professionals and community members – were interlinked (Figure 2). No explanation of the diagram was offered by the interviewer who simply asked them to "consider a set of relationships that looked like [the diagram] in advancing the cause to realise" the type of community they had described. Previous research shows this diagram is perceived to represent a cooperative community (Gee & McGarty, 2010). All interviewees indicated this image reflected commonality or connectedness between the groups which was explained by interaction, common interests, common experience or a similar approach. These descriptions from advocates are consistent with explanations obtained during a pilot study with participants on a university campus (Gee & McGarty, 2010).

Figure 2. *Image presented to interviewees, without explanation, for their comment. This figure represents the development of a cooperative community (Gee & McGarty, 2010).*

All interviewees indicated the image was positive or that it would bring improvements to the current situation and outlined 12 positive outcomes for the mental health sector and wider community. These related to more harmonious relations, better awareness/knowledge/understanding, balanced input, all opinions being taken into account and better interaction and communication between the groups leading to more productive advocacy outcomes. The aspirations described by interviewees were highly consistent with material in organizational documents. Of particular note was a statement of the organization's support for a community in which people with mental disorders, carers and health professionals shared open and respectful communication.

Interviewees went on to suggest 26 key aspects for the success of the approach. Overall, these related to an approach characterised by respect, understanding, flexibility and open communication between parties, that maintained and valued diversity in opinions, that was sufficiently resourced and that reflected a shared desire for improvement among contributing members. It was also highlighted that such an arrangement would require considerable effort from all involved and that movement in and out of the formation at times would allow members (particularly consumers) to continue work in their own sections and prevent burnout.

The interview and written material gathered from this research provides evidence that members of this consumer-run organization aspire to the characteristics of a cooperative community and believe that such an arrangement would advance mental health advocacy and benefit people with mental disorders. In addition, current networking and advocacy practices indicate the organization is working towards a cooperative approach and commentary from members during discussions after the completion of the research project support this, with several members arguing strongly that this approach was something the organization had been working towards for many years.

Cooperative Aspirations and Activities of Consumer and Carer Advocates

The second project we will describe involved separate telephone interviews with four consumer and carer members of an advocacy organization and examination of core organizational documents. These analyses revealed the structure of the organization was based on cooperation between consumers, carers and government representatives and current activities were also focused on strengthening relations with health professional bodies. The structure of the organization involved at its core the ability to build and balance effective relationships among different perspectives, levels and systems. This involved local, state and national levels of government departments, consumer and carer groups and health professional bodies. This organization therefore appears to be forming and maintaining relationships among the nominal groups in a cooperative community (Figure 2), however provides an example from the mental health sector that allows us to further extrapolate the different levels and groups which may contribute to each of the three rings in a comprehensive structure (see Figure 3).

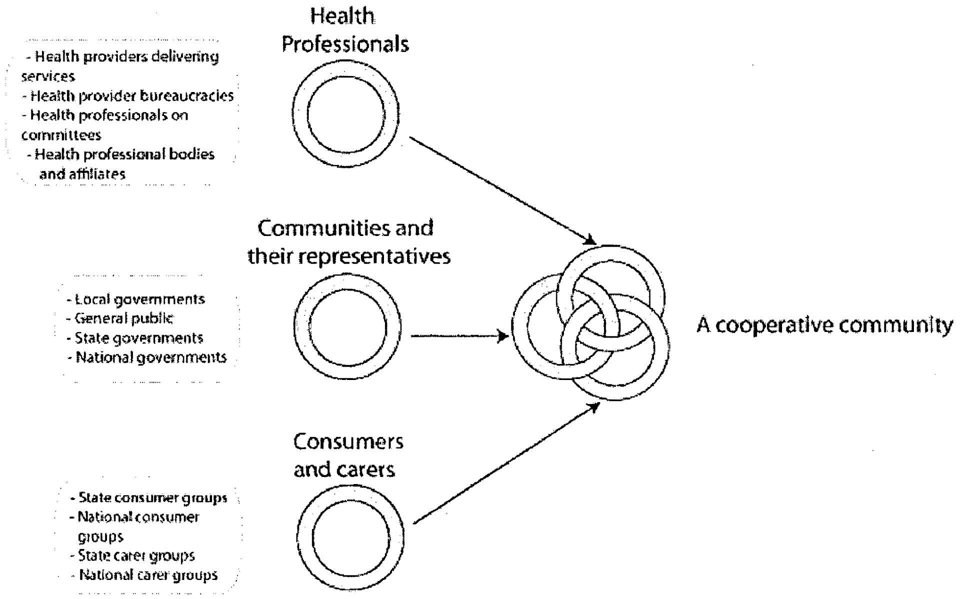

Figure 3. *Levels of government, community and systems in the mental health sector that may contribute to the development of a cooperative community.*

Comments from interviewees supported the organization taking a cooperative approach. All interviewees agreed strongly that having consumers, carers, health professionals, government bodies and other members of the general community working together would make a positive difference. The 12 potential benefits of this were a better understanding about different perspectives, developing true partnerships, allowing new solutions, sustaining positive change and building flexible and responsive services for consumers and carers to access. In order to achieve this, interviewees believed this approach required leadership around valuing different perspectives, a preparedness to listen to the messages and a perceived efficacy in being able to help create change.

The two studies described above provide evidence that two active advocacy organizations in the mental health sector aspire to a community in which people with mental disorders (and carers), the community (and government) and health providers work together for positive change. This approach is perceived to have a number of benefits for people with mental disorders and mental health reform. Further, these studies provide evidence that both groups are, to varying degrees, working towards this arrangement. These two studies, therefore, provide illustrations of the practical application of the development of cooperative communities for positive change.

CONCLUSION

We have based this paper on the proposition that reducing the stigma of mental disorders requires both an ideology that will specify and support the desired change and an understanding of techniques that will mobilise people to produce that change. In relation to the first point, we have argued that holding aspirations for cooperation between people with mental disorders, health providers and other members of the community offers an ideology that specifies the current problem, the desired change and a path towards achieving that change (see also Gee et al., 2007; Gee & McGarty, 2010). Supporters of mental health advocacy who share this ideology endorse behaviours and norms that reflect both individual practices (e.g., positive beliefs about people with mental disorders, social interaction with people with mental disorders) and actions that encourage social change. Practical issues in developing cooperative communities were also considered and to this aim we drew on our work with two mental health advocacy groups as instantiations of cooperative community aspirations and practices among active groups in the mental health sector.

In relation to the second point, we reviewed a number of techniques from the research literature which aim to challenge problematic individual practices (e.g., through contact, education or suppression of negative attitudes and behaviours; Allport, 1954; Watson & Corrigan, 2005), improve perceived and functional intergroup relations (e.g., through intergroup cooperation, emphasising common ingroup and shared goals, maintaining a dual identity or engaging in opinion-based group interaction; S. Gaertner & Dovidio, 2000; Gee et al., 2007; Haslam, 2004; Mummendey & Wenzel, 1999; Sherif et al., 1961) and challenge systemic discrimination (e.g., through collective action; Wright, 2001; Wright & Lubensky, 2009). We maintain that techniques which elicit changes in all three of these areas are required and that the development of a cooperative community, which involves a group identity to be both induced and deduced by group members (Postmes, Haslam et al., 2005), offers a framework in which these techniques may be utilised to realise the desired changes in the multiple levels and systems of the mental health sector.

We do, however, need to reconcile the integration of these techniques with the arguments developed by Wright and Lubensky (2009), who describe the points at which strategies for improving intergroup relations (i.e., prejudice reduction) and those for overcoming systemic disadvantage (i.e., collective action) emphasise very separate agendas. This is well summarised by their proposition that prejudice reduction strategies such as contact, education, common ingroup and dual identity models, aim to stamp out intergroup conflict in order to promote intergroup harmony, whereas collective action aims to bring about equality and social justice, which often requires some conflict and debate between groups. Thus, the distinction between these two approaches, as described by Wright and Lubensky, is marked and presents a fork in the road where the option, apparently, is to go one way or the other. As we argued earlier in this paper, intergroup cooperation offers more than the opportunity to evolve harmonious relations between groups. It is also conducive to achieving positive change beyond the ability of one group alone. A cooperative community therefore offers more than a prejudice reduction strategy to improve intergroup relations: it also presents the opportunity to achieve something great. Perhaps then aspirations for a cooperative community represent the best of both paths, where the desire to achieve meaningful structural change is met with improved cooperative relations in that process.

CHAPTER 6

ASPIRATIONS FOR COOPERATION AND CHANGE AMONG ADVOCATES, I (STUDY 4)

This thesis explores the proposal that the stigma of mental disorders can be reduced by having people with mental disorders, health providers and members of the public working cooperatively together with common cause. Holding aspirations for this type of cooperative community has been conceptualised as reflecting an ideology held by people who support mental health advocacy. In exploring these proposals, Chapter 4 presented three studies that explored aspirations for cooperation among nominal supporters of mental health advocacy and Chapter 5 further developed the theoretical contribution of this approach to prejudice reduction, collective action and stigma research literatures.

In exploring the relationship between support for mental health advocacy and aspirations for cooperation, findings of Studies 1 and 2 revealed that aspirations were significantly correlated with social identification as a supporter of mental health advocacy. Additionally, in Study 3 most participants saw a cooperative community as the most desirable approach for change. These results indicate that aspirations for cooperation represent an ideology towards change held by people who support mental health advocacy. This ideology, conceptualised further in Chapter 5, represents an orientation among supporters of mental health advocacy that supports and partially defines the desired change.

The ideology reflecting aspirations for a cooperative community also has direct implications for outcomes that represent a commitment to reducing stigma. A scale reflecting aspirations for a cooperative community was shown in Studies 1 and 2 to be an excellent predictor of positive beliefs, social interaction intentions and intended socio-political behaviours in support of mental health advocacy. This provides support for the argument developed in

Chapter 5 that aspiring to cooperation as the desired change is helpful in encouraging people to act in ways that will bring about significant changes.

Results from the three studies presented in Chapter 4 therefore indicate that an ideology towards cooperation is highly relevant to nominal supporters of mental health advocacy, as evidenced by high mean ratings for cooperative aspirations well above the scale midpoint. In aspiring to a cooperative community, supporters of mental health advocacy demonstrate a commitment to work with people who are directly affected by stigma to reduce that stigma. This is an important and exciting finding for considering ways to reduce stigma and suggests it is important to explore ideas for change among groups who are directly affected by stigma. In other words, I have demonstrated an ideology of cooperation held by nominal supporters of mental health advocacy, but does this also capture a driving ideology for people who are active advocates in support of mental health advocacy? In seeking answers to this question, it would be helpful to consider the actions and values of action groups that, as McGarty et al. (2009) suggest, represent instantiations or crystallisations of a group identity based on support for mental health advocacy.

As the reviews in Chapters 2 and 3 indicate, the debate about the social and systemic treatment of people with mental disorders and the methods that would be effective in reducing stigma is one that has been happening in the community and psychological research for some time. This dialogue has been fuelled and maintained by mental health advocates to highlight the disadvantage of people with mental disorders and encourage change. The view promoted by mental health advocates for achieving this change is that people with mental disorders have something important and relevant to add to this issue – that they should be consulted, recognised for their knowledge and expertise and supported in making a contribution to decision making and the delivery of services in the mental health systems. Thus, advocates appear to desire the integration of people with mental disorders into community and service structures. A key research question for the next two studies is whether mental health advocates believe that the best way to go about achieving these positive changes is through cooperation between people with mental disorders, health providers and members of the general public.

As a preliminary exploration of this question, reported aspirations for cooperation from 21 mental health advocacy members excluded from analyses in Study 2 were explored (the additional two participants excluded from Study 2 were not examined as their data sets had substantial missing values). Experience with mental disorder was high for these participants with only three indicating neither they nor a family/friend had received a diagnosis of a mental disorder (18 reported having a family or friend diagnosed with a mental disorder and seven reported a personal diagnosis). Nineteen participants were female and all ranged in age from 18 – 65 years ($M = 30$, $SD = 13.4$). These participants' ratings on the 10 items of the cooperative community scale (see Study 2, Chapter 4; Appendix B) yielded a mean of 9.9 on an 11-point scale, indicating very high aspirations for cooperation among these advocates. This is comparable to means of 8.4 (Study 1) and 8.8 (Study 2) in the samples of nominal supporters of mental health advocacy, indicating that advocates may aspire very strongly to a cooperative community as a solution that will achieve the aims of mental health advocacy. The next two studies explore the aspirations of members of two action groups in their efforts to advance the aims of mental health advocacy. Additionally, the next two studies explore the views of, and seek feedback from, these advocates on the potential of the cooperative community approach for reducing stigma.

Studies 4 (this chapter) and 5 (Chapter 7) were conducted with two different types of mental health advocacy organizations. The first organization was approached for this research as the peak consumer-run systemic advocacy organization in Canberra, Australia (Study 4). The second organization was approached as a peak systemic organization in Australia consisting of both consumers and carers. Both organizations were actively involved in activities that aimed to influence mental health policy and improve awareness of mental health issues among Australian communities. Each of the two studies that will be presented in Chapters 6 and 7 represent a process of collaboration, negotiation and consultation over a period of 12 months between members and staff of the organizations and myself. Approval for the research projects was obtained from several levels of each organization, including endorsement from staff, members and governing committees. As the primary researcher, I also had the opportunity to attend and observe planning meetings of the second organization in order to become oriented to the group's approach and influence in mental health reform.

These studies utilise mixed quantitative and qualitative methods in order to tap into the richness of advocates' views, ideas and feedback relating to their work and the proposed cooperative community approach for advancing mental health advocacy. These studies therefore employ two methodologies to address the research objectives. First, content analyses were conducted on key organizational and communication documents for each of the organizations to identify references to each organization's goals, activities and values. These analyses were supplemented by interviews with 4–5 key members and staff to gain additional insight into each organization's aspirations for the community and for mental health reform. Additionally, interviews with members provided the opportunity to gain feedback about the potential of cooperation between people with mental disorders, health providers and members of the general public in advancing the aims of mental health advocacy as well as barriers and limitations to this approach.

Note that the current and following chapters (Chapters 6 and 7) contain one paper for each of the two studies. These papers were prepared for the purpose of reporting back to the organizations themselves. As such, the papers are in the style of reports suitable for the non-government mental health sector and reflect a general rather than academic readership. A context statement is presented prior to each report to outline information specific to the report and/or study conducted with that particular organization.

CONTEXT STATEMENT

This chapter presents a study that was conducted with a systemic consumer-run mental health advocacy organization in Canberra, Australia. The report in this chapter was prepared for the organization, whose members also had the opportunity to provide input and feedback relating to the report. The report was received well by the organization and I was invited to launch the report at their Annual General Meeting in 2009 and author two articles in their newsletter to introduce the report and research project as well as make further comment on some of the recommendations in the report.

This report begins with statements from the author and organization about experiences from the project and hopes for the report. Note from this that members of the organization believed the cooperative community approach was something their organization had been working towards for some time. This, however, is not reflected in the research data as it arose during consultation and feedback sessions between the members of the organization and myself subsequent to data collection rather than during research interviews. I suspect their comments in the consultation process are indicative of the cooperative community approach presented in this thesis holding strong relevance to how members of this advocacy group have been conducting their work. I also suspect that the cooperative community approach provides an articulation of the group's vision or ideology that was perhaps implicit for group members. I maintain the contention that this articulation is required to develop a genuine cooperative community in which all relevant sociological groups, or stakeholders, can be involved.

Note that although the report presented in this chapter is available in the public domain, the name of the organization has been removed from the content of the report as presented in this thesis. The reference for this report is:

- Gee, A., McGarty, C., & O'Kearney, R. (2009). *What Does the ACT Mental Health Consumer Network Do and Why? A Big Picture Explanation for Making Advances in Mental Health Reform and Building an Inclusive Community.* The Australian National University, Canberra, Australia. http://www.actmhcn.org.au/cms/media/documents/actmhcn_making_advances_and_building_an_inclusive_community_gee_mcgarty_okearney2009.pdf

At the organization's request, the report begins with two position statements outlining experiences from the research project and hopes for the report. These were written subsequent to completion of data collection and analysis during the feedback and consultation process that occurred with organization members. The first is an *author's statement written by me as the primary researcher and author of the report* outlining my position on the topic of interest and my experiences from the research project. This author's statement is contained in the document as follows:

My awareness of the significant impact that stigma can have for people with mental illness was sharpened during my Honours study in 2003. Since then, I have been researching ways to overcome the stigma of mental illness. My approach to this problem has developed into a community-based perspective, in particular taking into account the groups that people belong to and the meanings of those groups to individuals. Some of these groups can be strong motivators for people to behave in ways expected by the group. For example, in our previous research (see Gee et al., 2007), we facilitated group discussions among first year psychology students who identify themselves as supporters of mental health advocacy (this group is interesting because they are members of the community who are also prospective mental health workers). We found that these discussions can help to increase the willingness of people to take action to support the aims of mental health advocacy.

This is an encouraging finding, so it makes sense to look at groups within the mental health advocacy movement more closely, not least because research on the stigma of mental illness must involve those who are affected by that stigma. In addition, our previous research suggests that providing information to people about the mental health advocacy movement and the existence of consumer-run mental health advocacy groups such as the organization in this study can help to improve attitudes about people with mental illness by presenting them as an organized and proactive group of people rather than the negative stereotypes of being lazy, disorganized and passive (Khalaf, 2002; see also Gee et al., 2007).

All of the above has led me to the current research project to better understand [the current mental health advocacy organization's] approach to stigma and advocacy. A second aim of the project was to seek members' views about a framework for defining relations between the key players in the mental health sector.

My engagement with this project has demonstrated to me that the richness of [this organization] is found in the people and welcoming atmosphere of this group. I have tried to convey this richness in this report and see it reflected most strongly through the interviewees' own

> comments. This report was written to present the results of an objective research analysis on consumers' views about mental health reform and as such has stayed true to reporting members' own comments. I hope the analysis shows where consumer advocates are coming from, what the consumer perspective is about and what the organization is working to achieve in relation to mental health advocacy. I hope it also conveys the positive spirit with which [the organization] functions. It is clear the relationships of consumers (particularly advocates) with health providers and policy makers have a difficult history. It is also clear there is a strong desire at [the organization] to move forward to work more effectively with health providers (and policy makers) on equal footing rather than wanting to take over, stamp down or push health providers (or policy makers) out. Hopefully, this message is strong in the report and if it is, I hope this report will be of interest to consumers, health providers, governments and members of the general community in coming to develop solutions for the future. (A. Gee, pp. 6–7)

The second introductory position statement is an *organization statement written by a member of the organization in consultation with other members*. As such, it contains both personal experiences of being a mental health advocate and member of a systemic advocacy group and experiences and hopes for the research project and reporting document. This organization statement appears in the report as follows:

> I have been a mental health advocate, consultant and representative for many years now. I have to admit that at times I am like a dog that keeps nipping at the ankles of the legislatures and policy makers. It feels they were always reinventing the wheel, at great expense, just changing colours. As time went on, I just became more cynical. About five years ago, things started to change and I became a little hopeful. I found the [organization]. I was a member when it first started, but moved to other avenues for change. But there it was, [the organization]. Struggling a little, but so full of hope and willingness, they let me run with my ideas and gave me a home, an anchor to secure myself when times were hard. I also had to learn to be a little diplomatic rather than bull-headed.

> This project has picked up on what we have been trying to achieve. The report can be read through many different lenses, depending on who you are and your background. I am confident that it could be read by people from so many different fields who are at the coalface or have just a small interest in what people with a mental health issue can, and in fact do, achieve. Sometimes we representatives are so busy jostling to get our voices heard, that we need to remind ourselves there are other members and staff who just try to get people to feel empowered enough to be able to take those steps to speak up themselves.
>
> A good overview of where [the organization] is doing well is provided in this paper. It also shows where we have known we need to pick up loose ends. This paper is also about stigma. Somehow, we still have to knock down the old stereotypes of 'mad people' and that we are all violent and truculent. The worst is that statement dragged out almost by the minute, 'we are doing this for your good', as though we are brain dead. In fact, our lived experience allows us to contribute our valuable knowledge.
>
> This paper outlines what a person is capable of, despite the lack of faith from others. Then when two or more people get together that are of the same desire, it shows what an organization such as ours is capable of achieving.
>
> There have been a few doubting Thomases where the [organization] has been concerned. But with hard work and determination we have changed that and achieved more than many people, and other organizations, thought we could.
>
> There are a lot of organizations that are working on decreasing stigma, but still the message doesn't really get through. On the bright side though, we have come a long way in the last few years especially, in chipping away at the edges. As [an organization], the fact that we are now looked at to provide representatives and consultation from a lived perspective to new areas shows that we are still being noticed, and that people want to know what we are so passionate about.
>
> The very content of this paper shows that we are not perfect; but by goodness, we are trying. We are thankful for that. It also allows us

> to revisit the old aims and goals. I feel that this project came at a good time for the [organization]. I am glad that we could be so open to those who were interested in what we have achieved, and also what we need to look at more closely.
>
> I would also like to see [the organization] have this type of project revisited in a couple of years to measure our core values and changes. As a consumer representative with [the state government health service], we expect and demand outcome measurements from the Health System. A project like this shows that, as an [organization], we need to develop the capacity to form outcome measurements for and from our own sector.
>
> Although the relationships discussed in this paper are presented as a new model, this is something that the [organization] has been working towards, and doing, for many years. Our work in the mental health sector forces us to look at how to get along with the health system so that our voices are listened to and we are effective. As much as we are working within this model, its success relies on all sectors in mental health embracing it in equal partnerships. As I learned when I found the [organization], being diplomatic can lead to better outcomes. Perhaps, though, this report can add to the dialogue about ways forward in the mental health sector.
>
> This report will be available on [the organization's] website for anyone who wants to know more about what we as [an organization] do and what we are about. We also think this report could be used to send to people or other organizations in the mental health sector that would be interested in, or could spark an interest in, [the organization] and mental health advocacy. (J. Williams in consultation with other members, pp. 8–9)

EXECUTIVE SUMMARY

Project Overview

This report presents the findings of a research project conducted during January – June 2009. The project's primary objective was to provide analysis of this mental health advocacy organization's current communications of strategies to achieve its key goals. A subsidiary objective of the project was to seek feedback from members on a way of describing the goals and aspirations of mental health advocacy organizations that is new in the academic literature on reducing stigma.

Approach and Methods

Two methodologies were drawn on to explore the objectives. First, an analysis of the content of six strategic communication documents was conducted to identify the way in which the organization's goals, actions and values were presented to the membership and external parties. This analysis was followed with a series of five interviews with selected members and staff. The interviews were designed to provide additional insight into views about what the organization was working to achieve and what change in the community they aspired to. The interviewees were also asked to consider a specific way of describing the goals and aspirations of mental health advocacy (shown in Figure 2, Chapter 5).

Key Findings

The analysis of document content showed that the following goals, actions and values were consistently and frequently mentioned in the documents: doing and supporting representational work; improving mental health services; advocating social justice principles; being informed about developments in mental health; communicating the consumer's view; and collaborating with other agencies. The goals, actions and values that received the least coverage in documents related to: consumers' reintegration in the community; unity among consumers; upholding the rights and reducing discrimination of people with mental illness; empowering consumers; and promoting respect. Although these issues did not receive as much coverage in the documents, interviewees consistently raised them as important issues.

A second key finding from the research project was the importance of *ordinary* consumers being recognised for their everyday achievements. Interviewees described this as people with mental illness needing to be "artful" in the world and "the ability to contribute things otherwise fairly ordinary… that can be seen as quite an achievement in itself". The interviewees clearly saw this as an important message about the contributions that people with mental illness can make.

A third key finding, relating to the subsidiary objective of the research project, was that interviewees saw potential in reducing stigma and influencing mental health reform by being part of a revised set of relations which might help re-define mental health consumers, health providers and members of the community as working together with a shared vision.

Recommendations

Recommendation One

The [organization] considers the current balance and mix of themes in strategic communication documents and considers whether a stronger emphasis on the empowerment of mental health consumers, promoting unity among consumers and promoting respect in the community is desirable for key communication documents.

It is not surprising that representation, improving mental health services and social justice principles receive significant attention in the documents of a systemic mental health advocacy organization such as the one in this report. It is surprising, however, that empowering mental health consumers, reducing discrimination against people with mental illness and promoting community respect and unity among consumers received considerably less coverage, particularly given that these issues were raised as being important in the interviews. It is recommended that the organization considers whether these concerns should be more strongly communicated in strategic communication documents to portray a more complete picture of the organization's approach.

Recommendation Two

The [organization] considers using the theme of *ordinary heroes* in key communication documents to consumers and the public.

In line with suggestions from interviewees, there is the potential to boost membership of the organization by boosting the number of people in the community that identify with the organization. One way to achieve this is to directly describe the organization's representatives and members as everyday consumers who contribute to positive change within a supportive environment because they are committed to seeing better conditions. In other words, members are ordinary heroes, like those in the wider community, who are achieving gains and making important contributions. Public materials, such as the existing website and brochure, are ideal avenues to present this view.

Recommendation Three

The [organization] further considers the descriptive model for reducing stigma and influencing reform.

Interviews with members indicated that the descriptive model in which people with mental illness, health providers and community members work together to reduce stigma and influence reform may have considerable potential. It is recommended the organization further considers the applicability of this model for their own work and, if it is deemed fruitful, identify possible steps to facilitate commitment to this approach within the mental health sector. These steps should be guided by the key aspects of the approach identified by interviewees as necessary for it to work (see findings outlined in Required Key Aspects for the Model as Identified by Members in this report).

CONTEXT AND OVERVIEW OF RESEARCH PROJECT

Many people who experience mental health issues face the significant problem of stigma, a process of being labelled, viewed negatively, excluded and having services and rights withdrawn or made unavailable (Link & Phelan, 2001). Many people with severe mental illness have described the stigma they experience to be as distressing as the symptoms themselves (Hocking, 2003). To the extent that this stigma exists in the mental health system itself, it presents significant barriers to consumer participation in the evaluation and development of mental health policy, services and practices (see Happell & Roper, 2006b).

Mental health advocates work to address some of these barriers, which are seen to maintain inadequate services and policies. The World Health Organization (2003, p. 9) states, "mental health advocacy includes a variety of different actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations". Mental health advocacy groups, such as the organization in this report, work to change the necessary structures relating to the way people with mental illness are cared for and treated by the community and services as well as the *processes* by which society conceptualises mental illness, provides health services and develops mental health policy. The current organization, then, is a systemic advocacy group and this reflects its members' view of these systems, and the processes that underpin them, as fluid and changeable rather than only dependent on the framework which maintains them.

Reducing the stigma of mental illness and the barriers it presents would result in more opportunities for people experiencing mental health issues, services that are more responsive to consumers' needs (thus producing better outcomes) and a more inclusive community. Clearly, then, this stigma must be targeted. A research project was conducted to investigate how the approach and work of the current systemic advocacy organization, influences positive change and addresses the stigma of mental illness. This report presents the key findings of the research project, and a discussion of possible steps forward, according to:

- the primary research objective to provide an analysis of communications about the organization's goals and strategies; and
- the subsidiary objective to seek feedback from members on a way of describing how organizations like the current one aim to influence mental health reform and reduce stigma that is new in the academic literature.

It is important to emphasise that the expertise of the project team is in research at the interface of social and clinical psychology and in particular in relation to issues of preventing and reducing stigma about mental illness. Although the project involves an analysis of the content of strategic communication documents using appropriate psychological research techniques, and we provide that analysis here on a pro bono basis, the project team is not comprised of marketing and communication professionals. Specific advice on communications strategies should be sourced from professionals in that area.

METHODOLOGIES OF RESEARCH PROJECT

To identify the organization's goals, activities and values, and determine the relative coverage of each, the following core documents and communications from 2007-2008 were examined (see Appendix C for an outline of the coding process):

- Constitution
- Annual Report
- Workplan
- The Newsletter
- The Brochure
- About Us document

In addition, interviews were conducted with five members of the governing committee and staff, each of whom had been with the organization for at least two years. Interviews were guided around the following topics for discussion:

- interviewee's perspective of what the organization was working to achieve
- the type of community the organization and interviewees were aspiring to
- feedback on a proposed set of relationships for positive change (Gee et al., 2007), represented in visual form. This discussion included possible improvements as a result of the approach, key aspects for the approach to work, barriers to the approach, current barriers faced by mental health consumers, and the potential applicability of the approach for the organization.

GOALS, STRATEGIES AND VALUES: FINDINGS FROM A CONTENT ANALYSIS OF THE DOCUMENTS AND INTERVIEWS WITH MEMBERS

Overall, a number of themes came out very strongly across the organization's goals, actions and values. Material from documents and interviews indicated the organization was primarily about: representation and providing training and support for representatives; improving mental health services; social justice principles; being informed about developments in mental health; communicating the consumer's view; and collaborating with other agencies.

The goals, actions and values that received the least coverage in the documents were about: consumers' reintegration and inclusion into supportive communities; unity among consumers; upholding the rights and reducing discrimination of people with mental illness; empowering consumers; and promoting respect. However, these were consistently raised by interviewees as important issues.

The goals, actions and values identified from the documents and interviews will now be presented in more detail.

Identifying the Organization's Goals

Analysis of the documents revealed 15 goals (Table 6.1). The goal to provide representation for consumers was referred to most often (Table 6.2), followed by the goals to improve mental health services and communicate and work collaboratively with others. Also fairly strong in the documents was the goal to build a strong organization to ensure sustainability.

On the other end of the count, the goal to facilitate reintegration and inclusive communities for people with mental illness was referred to least often, followed by the goals to uphold the rights and overcome discrimination of people with mental illness, represent unity among consumers, and empower people with mental illness.

Table 6.1. *Definitions and examples of goals identified in documents (Study 5)*

Definition of goal	Examples from documents
Be **proactive** and take action in the organization's approach	"To provide proactive systemic advocacy"; "Acting in the interests of mental health consumers".
Collaborate and **communicate** effectively with others (e.g., non-government, government and community agencies) and facilitate effective communication between consumers, professionals and carers	"… make our interests known to the broader community"; "Communicate effectively with government and non government organizations and the community"; "Work collaboratively with other organizations and mental health consumers".
Draw on and develop the use of **consumer knowledge**	"Build and utilise consumer knowledge"; "… valuing [consumers'] experiences of the mental

	health system in the A.C.T.".
Develop consumer **research and** consumer **policy**	"Develop consumer research and policy capacity"; "Participating in and assisting with research programs".
Empower consumers	"Empower consumers to utilise all means to achieve and maintain better mental health"; "… To empower consumers" (*About Us*).
To **educate** and inform members, representatives and others and to facilitate learning	"Grow and support [the organization] as a learning organization"; "Increase mental health literacy amongst consumers and service providers".
Improve mental health services, policies and practices	"… to create a system that works better than this one" (Quote from representative); "Improving health and community services".
Influence change in mental health policy and services	"… influence decision making"; "Changing mental health services".
Build an established and sustainable **organization**	"Build and sustain [the organization's] organizational capacity"; "To govern the [organization] in a responsible and sustainable way".
Build consumer **participation** in policy and services review and decision making	"Participating in … health and community services"; "… I let them know that they need to include us in decisions".
Facilitate **reintegration** and inclusive communities for people with mental illness	"To create and build a supportive environment within the organization and outside"; "Working towards reintegration into quality life in our society".
Uphold **rights** of consumers **and** overcome **discrimination**	"Disseminate information and utilize other strategies aimed at enhancing recognition of rights and overcoming discrimination"; "For many of us, there is a silent determination not to let the lack of understanding of others stop us" (quote from representative).
Consumers representing **unity**	"I want to make links between our lives and to find ways in which we can take action together" (quote from representative).
Provide **representation** for consumer issues	"… the [organization] continues to represent a broad range of views and personal experience about the mental health system".
Provide a **voice** for consumer issues	"…remind people that, despite having a mental

	disorder, we actually do need a voice, and can often speak not just for ourselves, but also for the members of our community that don't have a voice".

Table 6.2. *Number of times each goal is referred to in documents (Study 5)*

	Document						
Goal	Constitution	Annual Report	Workplan	Brochure	Newsletter	About	Total
Proactive	0	1	1	2	2	0	6 (3)
Collaborate	3	2	5	1	0	1	12
Consumer knowledge	0	0	2	0	1	1	4
Research and policy	0	0	4	0	1	1	6
Empower	1	1	0	0	0	1	3
Educate	0	0	4	1	1	4	10
Improve	3	1	1	2	3	2	12
Influence	0	2	1	3	2	0	8
Organization	0	1	5	0	2	0	8
Participation	1	3	1	2	1	1	9
Reintegration	0	1	0	0	0	1	2
Rights and discrimination	1	0	0	1	0	1	3
Unity	0	0	0	3	0	0	3
Representation	1	3	3	5	0	4	16
Voice	0	1	1	1	2	2	7
Total	10	16	28	21	15	19	109 (106)

Note. Numbers in brackets are corrected totals after taking into account repeated entries.

Note that the number of times each goal is referred to in the documents should not be interpreted as a measure of their comparative importance. We cannot conclude, for example, that the goal of providing representation was four times more important to the organization than upholding the rights of consumers. A more accurate conclusion is that the two goals are very closely linked and, further, upholding the rights of mental health consumers probably drives the objective to provide representation. Nevertheless, the amount of written content devoted to each goal provides a good indication of the messages conveyed to the public and relevant constituents and stakeholders.

Goals for the organization as identified by interviewees were to:

- act in the interests of mental health consumers
- bring consumers into all levels of service design, development, delivery and evaluation for mental health care in the A.C.T.
- express the consumer voice
- influence committees to include consumers
- provide quality information about developments in the mental health sector (including research) and to inform members and the community of events
- put a consumer perspective to the mental health system
- raise concerns that are important for mental health consumers.

Broader goals identified by interviewees for the organization were consistent with the goals receiving the least attention in the documents. Interviewees described the organization as working towards achieving:

- a focus on the promotion of mental health
- a place where mental health consumers can attend without negative judgment they may otherwise find in the community
- a voice for what does and does not work for consumers
- change in the current power relationship between consumers and professionals in the mental health service to one where consumers are included in a collaborative effort
- change in the systemic issues that prevent consumer-driven best outcomes
- health and mental health services that meet everybody's needs and result in the best possible outcome for the consumer of that service (particularly for people with mental health issues)
- health services where the ‘best outcome’ is defined by what consumers of those services deem as the best outcomes
- less stigma and discrimination and more compassion and understanding for people who have experienced mental health issues among committees and the community, which arises through hearing a consumer perspective

- members who are kept informed of developments in mental health to assist in individuals making informed decisions that are right for them (for example, decisions about treatment and consumer participation)
- representation for a broad range of consumers in the community, including the variety of ethnic communities and the variety of those with mental health problems, from "psychiatric survivors" to "normal urban neurotics".

Identifying the Organization's Actions

Analysis of the documents revealed eight types of activities (Table 6.3). Activities relating to representation, advocacy and lobbying received the largest number of references in the documents (Table 6.4), with more than double that of providing training, knowledge and support for representatives and members (such as media training, consumer advocacy training, attending conferences and the opportunity for debriefing). This is entirely consistent with the goal to provide representation for consumers, which also received the highest number of references (discussed above).

Also among those activities receiving the largest number of references were collaborating and networking with other agencies (by, for example, sending invites to become members, jointly hosting activities) and providing information and resources to the public and as support for members (for example, by holding Forums, updating the website and distributing newsletters).

Strategies to boost membership received fewest references and information was not available as to whether these planned activities, such as holding fun runs, short story competitions and distributing flyers widely were completed.

The organization's constitution was the only document that contained no references to any type of activity aside from committee meetings held as standard governance practice. This document was primarily about outlining the specific processes and expectations for members and committee members. Surprisingly, this document did not specify the roles, expectations and other processes for representatives of the organization. It is understood the organization is currently working on such a document.

Note also that, unlike the other documents, the document about the organization contained reference to only one type of activity (representation and advocacy), indicating the focus of this document is to communicate the goals and values of the organization to the public.

Table 6.3. *Definitions and examples of activities in documents (Study 5)*

Definition of activity	Examples from documents
Providing opportunities for members' feedback and reporting to members **(accountability and consultation)**	"Regular consumer forums were held to share information, experience and to identify common policy themes"; "Hold twice yearly member forums to gain feedback about [group's] work".
Specific tasks relating to **representation, advocacy, and lobbying** for policy change	"[the organization prepared a] submission to the review of [mental health legislation]"; "[the organization's] representation on committees".
Good business practices to ensure a sustainable and professional organization	"[The organization] achieved a substantial increase in its core grant"; "Improve staff and volunteer conditions".
Activities to build and utilise networks, connections and **collaboration** with others	"Projects ... have included cooperative efforts with other organizations"; "[Send a] letter to organizations with pamphlet and invitation to become associate member of the [organization]".
Activities to **educate** and inform others on mental health consumer perspectives and convey consumer perspective to community, non-government and government organizations	"[Staff member] and I gave a lecture to second-year medical students at [university]... It went well, and I feel it gave the students an insight into the world of mental health consumers"; "Deliver consumer research papers at conferences"; "Conduct media interviews on issues of concern to mental health consumers".
Information sharing in providing resources to the public and as support for members	Information items in the newsletter, drop-in and support group meetings, adding key resource documents to the website, "regular fortnightly forums on areas of interest including mental health programs and policy areas directly impacting on consumers".
Strategies to **boost membership** and boost the organization's visibility	Holding fun runs, short story competitions and distributing flyers and newsletters widely.
Opportunities that increase knowledge and skills for members, including **training** and workshops, participation in	Examples include consumer advocacy training, media training, attending conferences, providing material support (e.g., a workstation) and other

educational activities **and support for representatives**	support (e.g., debriefing) for representatives.

Table 6.4. *Number of times activities are referred to in documents (Study 5)*

	Document						
Activity	Consti -tution	Annual Report	Work-plan	Broch-ure	News-letter	About	Total
Accountability and consultation	0	5	5	6	5	0	21 (13)
Representation, advocacy and lobbying	0	38	5	4	11	7	65 (51)
Good business practices	0	7	4	0	0	0	11 (8)
Collaboration	0	11	14	3	3	0	31 (29)
Educate	0	6	9	0	1	0	16
Information sharing	0	12	2	2	14	0	30
Boost membership	0	0	5	3	0	0	8
Training and support for representatives	0	12	16	2	1	0	31
Total	0	91	60	20	35	7	213 (186)

Note. Numbers in brackets are corrected totals after taking into account repeated entries for the same activity.

Interviewees also described activities by members of the organization:

- attending conferences (including conferences with people from multiple disciplines)
- distributing the newsletter and using email lists to share information about developments in mental health
- including consumers in the training for mental health clinicians and community workers
- the organization's representation work on numerous committees
- making statements to the media
- networking with others.

Identifying the Organization's Values

While the goals and activities provided a clear picture of what the organization was aiming for and doing, identifying the values of the organization gave a good indication of the principles that guided that direction and activity.

Analysis of the documents revealed 11 values (Table 6.5). Content reflecting social justice principles occurred most frequently (Table 6.6), which housed a number of sub-components such as equitable access to services and the importance of services and legislation based on participation and human rights. These principles strongly reflect the goals to represent the consumer view, promote participation and influence policies and services (described above).

The principles of social justice were referred to twice as often as the next highest value (being informed). Valuing consumer knowledge and experience also had significant presence in the texts, with many references to presenting the unique consumer perspective and expressing the consumer voice.

Receiving the lowest number of references in the documents were valuing (and developing) members' skills and strengths and characterising communities and relations based on respect. The value of respect was uniquely contained in the document about the organization, which was indicated as the desired basis for relations between consumers and others in the community. This was the only value contained in that document, thus showing that in one of the key communication documents to the public, the organization is presenting a clear message that respectful relations is a strong basis for what they do and what they are about.

Table 6.5. *Definitions and examples of values in documents (Study 5)*

Definition of value	Examples from documents
Having input **and accountability** to members (e.g., through **consultation**, feedback and reporting)	"The [organization] provides mechanisms for the … accountability for those in this role [of representative]"; "[The organization] aims to build a professional organization that …is directed by and is accountable to its membership and wider mental health constituency".
Consumer knowledge and experience	"Express the consumer voice"; "Unique consumer

as an important resource and point for providing input	perspectives".
Determination and commitment by members and the organization	"I am now determined to be an advocate" (quote from representative); "We all work hard to make changes and remind people that, despite having a mental disorder, we actually do need a voice".
Personal emotions of **dignity, pride, hope and empowerment** shared among members and mental health consumers	"We have, thanks to the Human Rights Act, no excuse for allowing ourselves to pick up crumbs from the plate and then to tip our hats and say thank you. We will one day (soon, I hope), be able to say 'This is what I want, when can you deliver?' That would be Great!!".
An **inclusive**, diverse and accepting culture and membership	Associate membership offered to people who do not identify as mental health consumers; "If you are interested in becoming involved in any of the [organization's] projects and activities, please do let us know. You will be very welcome".
Information and **informed opinion**	"Provide accountable broad representation that is informed"; Another example is attending conferences.
Being a **proactive and energised** organization	"Working proactively together to ensure provision of appropriate and timely support, assistance and treatment to mental health consumers"; "Build a dynamic...culture".
Respect in the organization and community	"Working to advance [consumers']... respect".
Responsibility and professionalism in the sustainability of the organization	"To govern the [organization] in a responsible and sustainable way"; "The [organization] has established itself as a respected and credible player in the health sector".
Principles of **social justice** including consumer participation, human rights and equality in the provision and accessibility of services and supports	Representation activities, targeted areas of policy reform (e.g., advanced directives and involuntary treatment), and the promotion of participation in decisions and policy; "Social justice is the backbone of consumer advocacy".
The development of members' **skills** and strengths	"Deliver strengths-based individual and organizational skills development for consumer advocacy and representation".

Table 6.6. *Number of times each value is referred to in documents (Study 5)*

	Document						
Value	Consti-tution	Annual Report	Work-plan	Broch-ure	News-letter	About	Total
Accountability and Consultation	6	3	1	2	5	0	17
Consumer knowledge	2	8	4	1	8	2	25 (23)
Determination and commitment	0	6	0	3	1	0	10
Dignity, pride, hope and empowerment	1	5	0	2	2	2	12
Inclusiveness	3	0	2	3	3	2	13
Informed opinion	1	14	2	2	8	0	27
Being proactive and energised	0	3	3	1	1	1	9 (8)
Respect	0	0	0	0	0	5	5
Being responsible and professional	5	10	4	0	0	0	19 (17)
Social justice	4	28	3	15	12	0	62 (58)
Skills development	0	2	2	1	0	0	5
Total	22	79	21	30	40	12	204 (195)

Note. Numbers in brackets are corrected totals after taking into account repeated entries.

It is also important to note that, although distinguishable, some values identified in this analysis are nevertheless very strongly related. Consider, for example, representation, which reflects the principles of social justice (by, for example, recognising individuals' rights, providing a voice for consumers and promoting consumer participation). Additionally, though, representation is about valuing consumers' experiences and knowledge, facilitating empowerment, showing pride and promoting a respectful environment (all of which were also among the identified values). This example shows that, although content was coded onto the one value it explicitly reflected, one activity can reflect many values. Thus, there is evidence in the documents that the organization's values run very strongly through its activities, goals and overall approach.

Values that arose in interviews with members and staff were:

- autonomy for consumers in being able to make informed decisions (for example, about treatments or participation)
- being representative of the community of mental health consumers in the A.C.T.
- consumer perspectives
- diversity of knowledge and ideas
- members' contributions to the newsletter, such as poetry, art or written pieces
- mental health consumers and members remaining informed, educated and up-to-date about developments and events in mental health
- new conceptions of knowledge
- the intelligence of consumers.

Barriers Faced by Consumers and Advocates

The documents contained two types of barriers faced by mental health consumers and the organization. There were nine references (all from the Annual Report) to difficulties faced by members from those outside the organization. Two of these referred to stigma (for example, from medical professionals), while others referred to funding restrictions in the system or less defined causes (for example, "[serving the organization] has felt like running a race, and yet in some areas of the mental health field, it feels as though nothing has changed", p. 3).

There were a further eight references in the Annual Report to difficulties faced within the organization itself, such as staffing changes, fatigue among representatives and stressful workloads of committee members.

Interviewees raised the following barriers faced by mental health consumers and members of the organization:

- a narrow preference of communication style, which can make it difficult for some consumers to be representatives (and be heard)

- committees that do not provide relevant material to representatives in advance of meetings
- finding enough people to do advocacy and representative work can be challenging and this is made more difficult given the demands, skills required and current barriers to being a representative
- negative judgements in the health care system itself as well as the general community
- services and service providers that expect consumers to be grateful for the service offered, even though it does not meet consumers' needs
- the current distinction between people as being either "ordered" or "disordered", with a clear emphasis on the ideas of "ordered" people being more highly valued
- the harm model of understanding, where consumers are seen as dangerous, effects how people in representative committees respond (for example, by not engaging fully in discussing ideas due to fear of "upsetting" consumers)
- the biomedical model of understanding who consumers are that
- does not allow for understanding from a consumer perspective,
- focuses on disease or deficits rather than seeing someone with mental illness as a whole person (with desires, ambitions and goals in the world),
- is particularly strong among psychiatrists and clinicians,
- is taken up by members of the general community,
- promotes patriarchal attitudes towards people with mental illness and
- results in a "one-size-fits-all" approach to services.

The Organization's Aspirations for the Community

One aspiration for the community was uniquely contained in the *About Us* website document. This aspiration described a "respectful and accepting system that involves Consumers, Carers and Professionals listening and respecting one another in an active healthy relationship".

Interviewees described the following aspirations for the type of community they would like to see develop:

- a community based on the values of "creativity, innovation and excitement" rather than the exclusion of difference or perceived "deformity"
- a community that provides options and flexibility in meeting the needs of people with mental illness
- a community where consumers are always listened to, particularly by health professionals, and where consumers have a say in their own treatment options (such as the type of medication they have)
- a community where consumers are "treated like people with full rights"
- a united and more compassionate community where the myths about people with mental illness are dispelled and having a mental illness is no longer seen as such a negative and debilitating thing
- an approach to system and community reform that allows for a number of different approaches to address problems with the current situation (including valuing "ordered" and "disordered" thinking equally)
- an inclusive community that values consumers' needs equally to the needs of other people in the community
- consumers are recognised for the positive contribution they can make as much as other community members
- consumers involved in representative work being recognised for their intelligence, experience and knowledge.

Recognising the Achievements of Ordinary Consumers (or *Ordinary Heroes*)

Interviewees reported the desire for consumers to be recognised for the positive contribution they can make to the community. This was described by one interviewee as an aspiration that would see the recognition of the creativity and "artfulness" required by many consumers to live in the world. Another interviewee stated, "the ability to contribute things otherwise fairly ordinary… that can be seen as quite an achievement in itself" for people managing mental illness.

MEMBERS' VIEWS ON A MODEL THAT DEFINES RELATIONS BETWEEN THE KEY PLAYERS IN MENTAL HEALTH TO INFLUENCE REFORM AND REDUCE STIGMA

Interviews provided the opportunity for members and staff to put forward their views and provide feedback of a proposed model for influencing mental health reform and reducing stigma. The proposed model is a new offering to the psychological research literature on reducing stigma. For this project, input was sought from those working in the mental health advocacy sector on their views about the relevance, applicability and potential of the set of relations defined by the model.

In presenting these findings, interpretation and explanation of the proposed model will be described through the words of the members and staff interviewed. A more detailed account and theoretical basis of the model will be provided in the General Discussion of this report.

Members' Interpretations of the Proposed Descriptive Model

Interviewees were asked to consider a set of relationships that looked like that presented in Figure 2 (Chapter 5), in advancing the cause to realise the aspirations for the community they described (see above).

Upon viewing the image, interviewees first noticed the interlocking area of the image and referred to this in suggesting that the image represents:

- a similar approach between groups
- common aims or shared ambition, reflecting a common interest for particular outcomes to be achieved
- common experience
- common ground
- connectedness
- interaction between groups or the groups working together
- interlinking that represents that "we're all in this together"
- less distinction between groups
- overlapping groups
- tightly interlocking groups.

Members' Views About the Potential of the Descriptive Model

All interviewees indicated the image was positive or that it would bring improvements to the current situation, such as:

- a more harmonious community generally
- a sense of belonging, resulting in less self harm and suicide
- all opinions and input being balanced and taken into account by each individual and the community as a whole
- better communication and more dialogue between groups
- better interaction between groups leading to more productive advocacy outcomes (particularly with advocates and health professionals working together)
- bringing cultural change quicker
- bringing the groups closer together and providing the opportunity for interaction at social events in the mental health sector
- more awareness in the community about the true nature of mental illness (for example, that it's not necessarily extremely disabling), leading to changes in contact with community members (including bus drivers, the police, and in supermarkets)
- more knowledge and understanding among health professionals about the approach and work of consumers, particularly the current organization, due to increased interaction
- recognition that mental illness is something that can be talked about as a community
- sharing experiences, common ground and reducing the gaps in experiences between the groups
- the opportunity for each group to learn about the others' perspectives, resulting in greater understanding and empathy.

Required Key Aspects for the Model as Identified by Members

Interviewees identified the following key aspects for the approach presented in the image to work:

- all members in the groups share and recognise a common desire for improvement with the view of moving forward

- consumers listening to and understanding the pressures and approaches of health professionals
- each group being willing to admit when mistakes were made and when things could have been done better
- each group is seen as having a contribution to make
- education of the roles and expectations of each of the groups
- education, recognition and deep listening to the consumer perspective, particularly
- about the effects of mental illness so that individuals experiencing mental health issues are seen "as human beings",
- in coming to understand the consumer as a whole person and not just as a condition,
- to move away from the medical model as the sole way of understanding people with mental illness and
- to overcome the negative attitudes of professionals that develop based on particular work experiences (for example, those working in crisis come to see people with mental illness as dangerous and their approach reinforces the harm model of legislation and service delivery)
- effort on the part of those involved to get over the divide and build up the intersections
- ensure that consumers, and those in representative work, are resourced sufficiently to be able to continue their work and stand strong
- having some degree of movement in and out of the formation so that each group continues to be strong and effective in completing its own work and is not worn down by the process of interacting
- increase the qualifications of health providers offering services
- leadership from higher levels to clearly define and communicate the intended direction where we are going and to guide what needs to be done at ground level
- realisation that the distinction between the groups is not necessarily as clear as currently believed, for example by

- consumers having a more active (self-directed) role in their own health care and in doing so, participating in more activities traditionally reserved for health professionals,
- having more people with mental illness employed as health professionals,
- realising that people with mental health issues are not necessarily that different from others and
- seeing the general community as including those who live with mental illness by pointing out, for example, that anyone in the general community can be affected by mental illness and that people with mental illness can "transition" into the wider community group with the right support
- relations between groups should be based around compassion and understanding
- stop the politics between different health professionals
- that diversity remains within each group
- that the groups are open about their own agendas
- the more people that become part of the approach the more effective it will be
- willingness for people to let go of their own ideas at times.

Two interviewees put forward alternative models to the one proposed. The principles of these are reflected in the points above, particularly that there should be more recognition of the overlap (i.e., less distinction) between the groups. One interviewee emphasised that having some movement away from the interaction is vital at times to buffer against consumers being worn down by the interaction process. It was suggested that constantly being in the interaction is debilitating for consumers due to the presence of stigma and the interaction being underpinned by the "conventions of everyday conversations … [so that] the only way to disrupt that is to separate out of it for a while". This interviewee also suggested that having consumers and health providers "opening up to each other more" (i.e., developing a stronger relationship) would then pull the community closer through that movement.

The second interviewee proposed a model that further emphasised the similarity between health providers, community members and consumers.

This interviewee described the relationship between group members reflecting an idealisation that did not distinguish between the three groups, stating "people would see themselves as occupying those roles equally ... there wouldn't be the need to especially insist on expressing the consumer voice because everyone else would be to some extent expressing the consumer voice". In this arrangement, it was said the consumer contribution would be recognised and presented automatically.

Members' Suggestions for the Roles of Community Members

As much of the discussion of the proposed model was around the relationship between consumers and health providers, interviewees were also asked specifically about the role of community members in reform. Overall, interviewees agreed there could be an important role for community members, suggesting that:

- community members could be involved in committees, where they would learn the consumer perspective for systemic advocacy and understand the work that is involved
- having the broader community involved in some level shows that community members "have a stake in [change]" because of the relevance of community issues raised by consumers (such as homelessness and employment issues)
- influencing a considerable portion of the community is important for other community members to come on board
- it would be important to have community members understand the perspective of consumers and have more education about mental illness.

Barriers to the Proposed Approach

Two interviewees stated there were no limitations to the proposed approach if it was put into practice and had the key aspects (listed above). Interviewees raised two barriers to achieving the proposed approach:

- getting health providers to commit to this approach could be difficult because the attitudes of some would need to change significantly

- the possibility that health professionals would prefer to keep the current arrangement to keep their "prestige" and promote themselves as being an "elite group with exclusive knowledge of the situation".

Members' Views About Possible Applications of The Model for the Organization

Potential applicability of the proposed approach to the organization was discussed with three interviewees (note that this was not discussed with the other two interviewees due to timing restrictions). Of those who discussed this topic, two interviewees stated that this approach is something that the organization should be striving for. Interviewees suggested two possible applications of the model for the organization:

- attempting to understand better the perspective of health professionals could result in less defensiveness on their part, which could then allow representatives to potentially identify better where the problem associated with a bad outcome may have stemmed from. As one interviewee described, working this way with health professionals "wouldn't stop us getting the outcomes that we ultimately seek, might even be a better way of achieving those, but once you get the health professionals defensive and a bit anxious about outcomes, then they can sort of close down and withdraw a bit whereas the only chance to get things done is by having some kind of dialogue and interaction"
- the organization's current work was involved in all three areas outlined by the model.

DISCUSSION AND LOOKING FORWARD

The findings of this research project show that the current mental health advocacy organization has clearly defined its goals in key organizational and public documents. The findings show that the actions and values of the organization are also readily identifiable from the documents.

Overall, responses from interviewees were highly consistent with the themes that emerged from the document analysis. Interviewees, however, conveyed a stronger feel for the type of community that the organization was trying to achieve than described in the documents (see Recommendation One in the Executive Summary of this report). Interviewees' responses were also consistent with each other.

One additional issue that was raised by interviewees was the desired recognition of mental health consumers achieving "ordinary" things and needing to be "artful" and resourceful in their everyday lives. Indeed, anti-stigma campaigns often present in the media the *exceptional* people with mental illness: the actors, the academics, the comedians and the film makers, who also happen to have a mental illness. There is much less heard about other people in the community living with mental illness that are also making important contributions to their community. Members of the organization are themselves some of these *ordinary heroes*, as they are ordinary members of the community who are achieving significant gains in mental health advocacy whilst themselves being consumers of mental health services. It is true that advocates are passionate, driven, committed, professional and skilled, however these are values that are also developed by being part of a mental health advocacy group. Previous research (e.g., Gee et al., 2007) has shown that people are much more likely to get involved in something if they see the people already doing it as similar to themselves. The important aspect of this is that similarity is not based on being in the same category (like having a mental illness), it is based on other dimensions such as sharing a passion (or opinion) about seeing a better world for people with mental illness (see also McGarty et al., 2009). Portraying this similarity of members with people from the wider community may help to boost membership (see Recommendation Two in the Executive Summary of this report).

Through the combined written and interview materials, the organization could easily identify numerous barriers faced by people with mental illness and consumer representatives engaging in mental health reform. Despite these significant difficulties, interviewees expressed a great deal of positivity and hope for significant positive change for the future. In doing so, interviewees recognised the hard work of consumer advocates and members in advances in mental health reform achieved thus far.

Although much discussion (and some written content), particularly about those barriers, focussed on unhelpful attitudes and actions of some health providers, members also readily identified and described how health providers can be instrumental in bringing about positive change. Indeed, although members felt a sense of *us* (consumers) *versus them* (service providers, policy makers) in their representative work, time and again the discussion reflected a desire to work better with health providers by helping them come to understand consumers and consumer advocates, rather than wanting to instil (or continue) a divide. As one interviewee eloquently described, "I think [with] a large part of what the [organization] does, we're trying to help health professionals do *what they want to do* better, by filling in the gaps of knowledge and empathy and understanding" (emphasis added).

The model presented to interviewees in this project, then, as members so readily interpreted, perhaps offers a fitting framework for defining relations in the mental health sector and direction for the organization (see Recommendation Three in the Executive Summary of this report). This model, termed a cooperative community for positive change (Gee et al., 2007) is new to the psychological literature on reducing stigma and will now be described in more detail.

According to the research literature, one way to reduce discrimination and prejudice is to create, instead of different groups, one big group to which everyone belongs (e.g., S. Gaertner et al., 1993). For example, rather than people identifying as being a mental health consumer, a service provider or a community member, these distinctions are ignored in favour of a larger basis of the grouping, such as everyone involved in the mental health sector.

The descriptive model represented by the three-ringed image in Figure 4 (see also Figure 2, Chapter 5) is somewhat similar to this principle, in that it attempts to create common ground where those involved can come together on equal footing. However, it differs to the one-group approach in two very important ways.

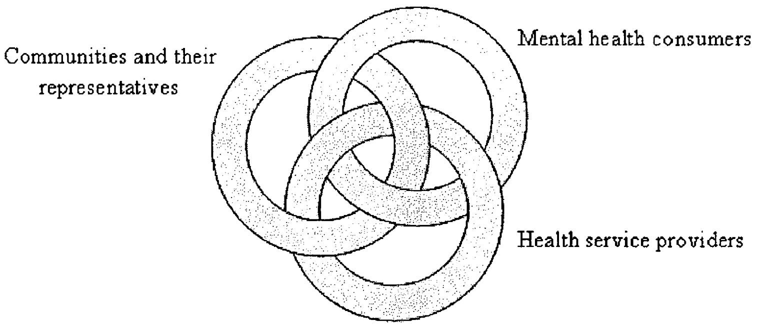

Figure 4. *A cooperative community for positive change*

The first point of difference is that the proposed model, as well as providing common ground, recognises that the different groups of people involved have different expertise. That is, it is *important* for consumer representatives of the current organization to identify as mental health consumers (or as psychiatric survivors) because doing so denotes their *unique, lived expertise.* It is through this identity that we can truly have the input from the perspective of people who have received (and in more consumer-driven services, shaped) those services. In other words, for members of the organization, being a consumer of mental health services *means* something, as reflected in their statement that the organization "is run by consumers for consumers".

Equally, it is important to recognise who the health providers are, and the particular expertise that comes from them, as having providers on board will be important in helping to produce change from within the service. Just as it is important to define who are community members, as having these on board will be important to make changes at the community level and to influence decision making and policy development (after all, those working in government are representatives of the community).

Thus, having the input of those who identify as mental health consumers is vital to move towards a service system that is better able to meet the needs of people with a mental illness (needs which have been voiced by consumer representatives) and to see a service system that makes a greater positive difference for those experiencing a mental health issue. As dedicated and hardworking as consumer representatives are, though, the current set of power relations means that consumers can not do it all themselves; they also need to be able to influence the people who can make (and enforce) the changes that consumers advocate.

The second important point about the proposed model, then, is the way that it defines the relationships between the groups involved. Note that the positioning of the rings is not meant to portray any degree of power imbalance between the groups. The more important aspects of their position is the way they interlink and their proximity to each other. Historically though, and even currently as mental health consumers and members well know, the relationship between the groups represented by the model has indeed been characterised by a power imbalance such that the involvement of consumers in the mental health sector has been largely in an attempt to define them purely in a passive capacity. As such, mental health consumers are involved in services that need to be done *to* them (and for which they should be grateful). The organization works hard to shift that balance and have consumers take on a much more active role in service decisions, delivery and evaluation, thus reflecting a more equal balance of power. From discussions with interviewees for this project, it seems that relationships in this area are shifting to be more positive. As one interviewee said, similar to the story of Christmas 1914 in World War I, "we [consumers and health providers] are putting our arms down and having a game of soccer in between the trenches". Perhaps, then, this provides a good opportunity to pause and reflect on the type of relations we *do* want. One strategy for continuing to move forward, which we have been suggesting in this report, is to work to create a set of relations where the groups involved are not fighting *against* each other to be heard and understood (or to shut the other down), but one where the groups are fighting *for* positive change together.

From the comments of interviewees presented in this report, such a direction does not seem to be a foreign or unwanted movement. Interestingly, the organization's own document about the organization refers to a similar aspiration, where "we promote a respectful and accepting system that involves Consumers, Carers and Professionals listening and respecting one another in an active healthy relationship". Perhaps such an approach could overcome many of the barriers identified by interviewees that people with mental illness and consumer advocates face.

On a final note, in talking with the organization's members and advocates, it has become clear that influencing change is a long and bumpy road where the light at the end of the tunnel can get intermittently closer and further away. Hopefully, this report is a small contribution that could make that light a little larger and within arm's length for mental health consumers, service providers, government members and community members alike.

CHAPTER 7

ASPIRATIONS FOR COOPERATION AND CHANGE AMONG ADVOCATES, II (STUDY 6)

CONTEXT STATEMENT

This chapter presents the second study that was conducted with a systemic mental health advocacy organization. The current study was conducted with a small national advocacy group, run by consumers and carers, that exists under the auspices of an Australian non-government organization for advancing mental health related interests. This chapter also presents a paper that was prepared to report the findings of the research to the group. The report was provided to the group for consultation, however due, perhaps, to operational demands and time restraints for members, no feedback was provided. As such, the advocacy group in this study will not be named in this thesis and will instead be referred to as the "group" to differentiate from its umbrella organization.

The report presented in this chapter is instrumental in further defining the contributors in the mental health sector to the development of a cooperative community. The reference for this paper is:

- Gee, A., McGarty, C., & O'Kearney, R. (2009). *The [Advocacy Group's] Approach to Mental Health Reform: Highlighting the Importance of Genuine Participation and Working Relationships for Creating Positive Change.* Unpublished report. The Australian National University, Canberra, Australia.

EXECUTIVE SUMMARY

Project Overview

This report presents the findings of a research project conducted with advocacy group during February – July 2009. The two main objectives for this project were to: (a) identify the goals, strategies, values and barriers that currently face the group; and (b) seek members' views on possible future directions for the group and mental health reform in continuing to influence positive change.

Research Methods

This research project employed two methodologies to address the objectives. Eleven of the group's key communication documents were analysed for their content in presenting the group's goals, activities and values. This content analysis was supplemented by interviews with four members and executive members to provide additional insight into the group's aspirations for the community and possible directions forward that would assist the organization in continuing to achieve meaningful change in mental health reform.

Key Findings

The findings of this research project clearly demonstrate that the group is very strongly focused on boosting genuine consumer and carer input into mental health reform. This is reflected in the goals, actions (e.g., representation) and values identified in the content analysis of documents as well as interviewees' comments. This advocacy group is dedicated to overcoming barriers to the involvement of consumers and carers in policies and services relating to mental health. This group has sought to build the strength of the group and therefore build the strength and visibility of the consumer and carer voice.

A second strong focus in the group's approach to mental health reform is on establishing and developing a number of partnerships at many different levels. This is also reflected in the structure of the group, which requires relationships between members and the Australian states they represent, relationships between consumer, and carer representatives, relationships at the national government level and relationships with other peak consumer, carer and professional organizations. It is clear from this project with the group that building relationships is very important in mental health reform.

This advocacy group's membership includes many different perspectives and backgrounds and this diversity was identified by interviewees as a significant strength of the group. However, difference of opinion can also present difficulties. Interviews with members demonstrate that the group has dealt with these particularly well and has turned these differences into strengths.

It was also clear from the findings of this project that participants believe that effective mental health reform requires cultural change in the mental health sector towards one that seeks out consumer and carer views and works to lead change in a positive direction forward.

Recommendations

Recommendation One

Key communication documents should more explicitly express that a strong consumer and carer voice and genuine participation by consumers and carers are of benefit to the community, the government and services.

Interviewees and key documents revealed a strong focus on the need for the consumer and carer voice to be heard and sought for their expertise. Surprisingly, however, the content of core documents from this analysis revealed a low number of references to valuing the consumer and carer experience. In addition, although interviewees emphasised the desire for those in the mental health sector to recognise what the consumer and carer input can offer, documents did not explicitly outline what these benefits would be. A separation publication by the advocacy group (not included in this analysis) outlines some of these issues, however it is recommended these benefits also be explicitly presented in key communication documents (for example, brochures and website material) for these target audiences.

Recommendation Two

The group should continue to build its strength by continuing to focus on relationships within the group and the values that characterise the relations of its members.

Interviews revealed that the diversity brought by members was considered to be a significant strength of the group in understanding the relevant issues and in representing consumers and carers. If diversity is not strongly valued this can create a basis for conflict and some interviewees referred to a difficult period in the group's history. Although this has now been overcome, it is recommended that the group continue to highlight the values that have turned these differences into a significant strength. This may begin with a discussion among members as to what these values are and could appear alongside members' responsibilities and code of conduct present in the relevant document (see 'Identifying Values' and 'Members' Views on the Strengths of the Group' in this report). In addition to keeping relationships within the group strong, such an approach would demonstrate to other partners in the mental health sector that which is desirable and successful.

Recommendation Three

The group consider emphasising a shared view that reflects support for positive change in mental health for all documentation and correspondence to those the group works with.

Interviews with members revealed that establishing strong partnerships between the group and other key players in the mental health sector was seen as vital for mental health reform. In addition, interviewees believed a change in the approach of those in the mental health sector was also required, towards one that demonstrated true leadership and forward thinking for positive change. It is recommended that the group attempt to influence this change by highlighting that the group and other consumer and carer groups hold a shared view with other players in the mental health sector (see the Discussion in this report). One way to do this is to emphasise that shared view in documentation and correspondence to those the group works with, for example in position papers, submissions, policy statements, reports and commentary.

CONTEXT AND OVERVIEW OF RESEARCH PROJECT

The stigma associated with mental illness can be a significant issue for people with mental illness and their families and is the process of being labelled, negatively perceived and having services and rights withdrawn or made unavailable (Link & Phelan, 2001). Many people with mental illness have described the stigma they experience to be as distressing as the symptoms themselves (Hocking, 2003) and there is evidence that people can come up against stigma in the community as well as in the services they seek for support (Schulze & Angermeyer, 2003).

For some consumers and carers, becoming involved in mental health advocacy is one way to cope with stigma (Wahl, 1999), however the presence of stigma in the mental health systems relevant to reform also presents barriers to consumer and carer participation in the evaluation and development of mental health policy, services and practices (see Happell & Roper, 2006a, b).

It is clear, then, that stigma itself needs to be addressed in order to make the changes requested by mental health advocates and to make some of those consumer and carer experiences in the community and mental health systems less detrimental. Much of the research addressing stigma has focussed on targeting attitudes of individuals (such as community members and health providers) and many are successful. This research project was conducted with a mental health advocacy group to explore and document the group's approach in advocating structural change in the mental health sector and addressing the issue of mental illness stigma. This report presents the key findings of that research project and a discussion of possible steps forward for this group and the broader context of mental health reform. Two sets of findings are presented according to the two research objectives to:

- define the goals, values and strategies that drive the group as well as the barriers faced by its members
- seek members' views on current conceptualisations and possible future directions for the group and the broader context of mental health reform.

It is important to emphasise that the expertise of the project team is in research at the interface of social and clinical psychology and in particular in relation to issues of preventing and reducing stigma about mental illness. Although the project involves an analysis of the content of strategic communication documents using appropriate psychological research techniques, and we provide that analysis here on a pro bono basis, the project team is not comprised of marketing and communication professionals. Specific advice on communications strategies should be sourced from professionals in that area.

Research Methods

The goals, activities and values of the group were identified, along with the relative coverage of each, by a content analysis of the following key organization and public documents for the period 2007-2008 (see Appendix D for an outline of the coding process):

- Strategic Plan
- Draft Forward Plan
- Operating Guidelines
- Brochure
- About Us information.

The group works under the auspices of an Australian non-government peak organization and thus additional content was drawn from sections of the umbrella organization's documents specifically devoted to the group. These documents were (see Appendix D for a rationale for these chosen documents):

- Annual Report
- Newsletters (Apr-May; February; June-July; Sep-Oct; December).

In addition, interviews were conducted with four members and executive members. All interviewees had been members for at least 2 years, with an average of 4 years. The interviewer guided discussion around the following topics:

- interviewees' perspectives of what the group was working to achieve
- the type of community the group and interviewees were aspiring to
- interviewees' views on what was required to achieve that type of community
- interviewees' views on the sets of relationships that would be helpful in progressing mental health reform.

GOALS, VALUES AND STRATEGIES THAT DRIVE THE GROUP'S DIRECTION AND BARRIERS FACED BY ITS MEMBERS

Overall, the goals, actions and values that emerged from documents and interviews with members reflected the following common themes: a focus on reform and influencing positive systemic change; providing voice and recognition for consumers and carers; collaboration and building fruitful relationships in the mental health sector; and genuine consumer and carer participation.

Interviewees painted a picture of the group consistent with the above, however also revealed additional insight into the strengths of the group and motivations for members as well as barriers faced by members and consumers and carers involved in mental health reform more generally. Findings for each of these topics will now be presented in more detail.

Identifying the Group's Goals

Analysis of document content revealed six goals (Table 7.1). The two goals that received the highest number of references in the documents (Tables 7.2 and 7.3) were to influence reform and provide a voice and recognition for the concerns of consumers and carers. Also related is the goal to increase consumer and carer participation in processes of the mental health sector and this received the next highest number of references. These findings demonstrate the three goals receiving the greatest attention in documents strongly convey the group as having a structural advocacy approach.

The goal with the least number of references was to raise the profile of the group. Note, however, that the number of times each goal is referred to in the documents should not be interpreted as a measure of their comparative importance. We cannot conclude, for example, that raising the profile of the group is less than one eighth as important than the goal of influencing reform. Indeed, the former is likely to significantly contribute to the success of the latter. Nevertheless, the amount of written content devoted to each goal provides a good indication of the messages conveyed to the public, relevant constituents and stakeholders.

Table 7.1. *Definitions and examples of goals identified in documents (Study 6)*

Definition of goal	Examples from documents
Increase consumer and carer **participation** in mental health promotion, raising awareness of consumer and carer issues, policy development, implementation, evaluation, reform and service delivery.	"Ensure the input of consumers and carers into the activities of the mental health sector"; "Increase meaningful opportunities for and capacity of mental health consumers and carers to advocate for and participate in legislation and policy development, implementation and evaluation at all levels".
Develop and promote working **partnerships** for the group and generally in the mental health sector	"Enhance, promote and progress genuine national partnerships"; "[the group] provides a mechanism for mental health consumers and carers to come together to foster partnerships".
Raise awareness of consumer and carer issues and initiatives	"To identify and raise awareness of mental health consumer and carer issues concerning privacy and confidentiality [priority issue] nationally"; "[Contributing to the reduction of the use of Seclusion and Restraint] by increasing awareness of best practice in clinical care".
Build up **the profile of the group** and build capacity in providing the consumer and carer voice	"Raising the profile of the [group]"; "Building [the group's] own capacity".
Contribute to mental health **reform** and influence change in mental health policy and practices based on consumer and carer concerns, including identifying and highlighting important issues.	"To utilise our lived experience and unique expertise in mental health to identify what does and does not work in the mental health sector"; "To identify best practice, protect human rights, highlight deficiencies and influence positive systemic change"; "Comprehensive identification of consumer and carer issues around privacy and confidentiality nationally with the aim of informing national initiatives".
Provide a **voice** for consumers and carers and contribute to the recognition of their concerns	"To strengthen and raise the profile of the national consumer and carer voice"; "[The group] will work first and foremost to give a voice to ... mental health consumers and carers across Australia"; "[Enhance] the recognition of mental health consumers and carers at all levels of government and community".

Table 7.2. *Number of times each goal is referred to in key documents (Study 6)*

	Document						
Goal	Strategic Plan	Operating Guidelines	Forward Plan	Brochure	About	Annual Report	Doc. Total
Increase participation	4	2	1	3	2	2	14
Partnerships	1	3	-	4	2	2	12
Raise awareness	10	-	-	-	-	1	11
Raise the profile of the group	1	-	-	-	-	1	2
Influence Reform	9	4	7	5	11	3	39
Voice and recognition	-	6	4	8	9	2	29
Total	25	15	12	20	24	11	107

Table 7.3. *Number of times each goal is referred to in newsletters (Study 6)*

	Newsletter						
Goal	*Apr-May*	*Feb*	*June-July*	*Sep-Oct*	*Dec*	News Total	Goal Total[a]
Increase participation	1	-	-	-	-	1	15 (14)
Partnerships	1	-	1	-	-	2	14 (9)
Raise awareness	2	-	1	-	-	3	14 (10)
Raise the profile of the group	1	-	1	-	-	2	4 (2)
Influence Reform	3	1	1	-	1	6	45 (28)
Voice and recognition	2	1	1	1	-	5	34 (22)
Total	10	2	5	1	1	19	126 (85)

Note. Document content is material from the umbrella organization's newsletters which relate specifically to the group. [a] Total number of goal references in all documents and newsletters (Table 7.2 + Table 7.3). Numbers in brackets are corrected totals after taking into account repeated entries.

Goals identified by interviewees were highly consistent with those identified in the documents. Interviewees additionally raised the importance of improving attitudes, understanding and behaviours towards people with mental illness and carers in services, bureaucracy, government, and the general community. Interviewees also reported the following for what the group was working to achieve:

- be a resource and provide reference material on particular issues relevant to mental health consumers and carers
- be directly involved in systemic advocacy to influence legislation and influence the health and mental health services that people with mental illness and their carers need
- be the peak voice for Australia to jointly represent consumer and carer perspectives on issues relating to mental health
- better things for the lives of people with mental illness and carers
- effect change across the board in terms of Australians' attitudes and values about respect and dignity for people with mental illness and their carers or families
- ensure best practice for human rights in regard to the mental health of all Australians
- ensure that the issues and concerns presented by the peak voice for consumer and carer issues are acknowledged and addressed and make a significant difference to national and local policies and procedures
- ensuring that people with mental illness are treated with respect and dignity and can get timely access to services that are respectful and responsive
- increase knowledge and familiarity with issues of concern to mental health consumers and carers among professional bodies and the community
- offer critique for mental health care in Australia and keep an oversight on the reform happening for the mental health sector at the state and national levels
- progress partnerships in mental health to improve access to information and the sharing of relevant information between networks and organizations
- promote and progress the recognition and inclusion of mental health consumers and carers at all levels of government and services,

including consumer and carer participation in decision making, implementation and evaluation of services

- provide a united consumer and carer group view to legislators, bureaucrats and professional bodies on issues relevant to consumers and carers in order to help drive reform
- to build credibility as an organization and influential voice.

Identifying the Group's Actions

Analysis of the documents revealed 11 types of activities (Table 7.4). Activities relating to collaborating with other agencies received the highest number of references in the documents (Tables 7.5 and 7.6), followed by consultation with members of the group and the wider consumer and carer community. Providing or undertaking training and support for members and others in the mental health sector received the least number of references in the documents, however these actions were identified by two interviewees to be extremely important. Interviewees also referred to the group's publication material, which document the group's views on a particular issue and thus were captured by activities identified by the content analysis.

Table 7.4. *Definitions and examples of activities identified in documents (Study 6)*

Definition of activity	Examples from documents
Activities that involve **collaboration and networking** between the group and other agencies	Distributing information through networks, seeking the support of other bodies, attending meetings, seeking the position of others (including political parties, policy makers and other organizations).
Consultation with members and wider consumer and carer community to define consumer and carer position, seek the input of members on projects and identify and highlight issues of importance to consumers and carers.	Survey to consumers and carers to identify issues, having members and others comment on draft papers.
Activities that involve **defining** ongoing **partnerships** between the group and other agencies	Developing an MOU with the umbrella organization

Undertaking or providing **training and support** relating to the mental health sector.	"The [group] also honed its own skills during the year with training in working with the media, communication skills and conflict resolution".
Representing and consumer and carer views in **documentation**.	Submissions, national mental health consumer and carer statements for particular issues.
The provision of **information** to members and to those outside the group.	Distributing documents, attending or providing information sessions or presentations at meetings of the group.
Actions around **lobbying** key decision makers, from government and health and service sectors to bring about change.	"Members in each state/territory to develop a plan to meet with members of parliament in that state/territory and ... seek their response".
Increasing awareness and **promoting the group's** activities.	"[Strategy:] Produce and strategically distribute a brochure, poster and information materials about the group".
Providing or seeking **reimbursement** for representatives in recognition of their time, expertise and expenses.	"The [group] demonstrates its commitment to consumer and carer participation by meeting the expenses incurred by ... representatives and remunerating them for their time".
Reporting to the group's stakeholders and those it represents.	Developing reporting strategies to the umbrella organization, government committees, and state/territory mental health branches; keeping them informed of group priorities;
Representation of the consumer and carer view, interests and concerns into processes with the aim of influencing change (e.g., in policies).	Representation on committees, providing input into reviews, and consultative work.

Table 7.5. *Number of times each activity is referred to in documents (Study 6)*

Activity	Strategic Plan	Operating Guidelines	Forward Plan	Broch-ure	About	Annual Report	Doc. Total
	Document						
Collaboration and networking	47	1	9	1	3	1	62
Consultation	28	3	1	2	3	1	38
Define partnerships	12	-	-	-	1	1	14
Training and support	-	-	1	-	1	1	3
Documentation	30	-	1	1	1	3	36
Information	30	-	-	2	2	-	34
Lobbying	9	-	1	-	1	-	11
Promoting the group	3	-	-	-	-	-	3
Remuneration	-	3	-	-	-	-	3
Reporting	4	6	-	-	1	-	11
Representation	14	-	2	1	1	1	19
Total	177	13	15	7	14	8	234

Table 7.6. *Number of times each activity is referred to in newsletters (Study 6)*

	Newsletters						
Node	*Apr-May*	*Feb*	*June-July*	*Sep-Oct*	*Dec*	News Total	Activity Total[a]
Collaboration and networking	1	1	1	-	1	4	66 (52)
Consultation	-	1	-	-	-	1	39 (33)
Define partnerships	-	1	-	-	-	1	15 (10)
Training and support	-	-	-	-	-	0	3
Documentation	-	-	-	2	-	2	38 (22)
Information	1	-	-	-	-	1	35 (17)
Lobbying	-	-	-	-	-	0	11 (8)
Promoting the group	-	-	-	-	-	0	3
Remuneration	-	-	1	-	-	1	4
Reporting	-	-	-	1	-	1	12 (10)
Representation	-	-	2	1	-	3	22 (18)
Total	2	3	4	4	1	14	248 (160)

Note. Document content is material from the umbrella organization's newsletters which relate specifically to the group. [a]Total number of activity references in all documents and newsletters (Tables 7.5 + 7.6). Numbers in brackets are corrected totals after taking into account repeated entries.

Identifying the Group's Values

While the goals and activities provided a clear picture of what the organization was aiming for and doing, the values of the group gave an indication of the principles that guided that direction and activity.

Analysis of the documents revealed 15 values (Table 7.7). Content relating to genuine consumer and carer participation received substantially more references in the documents than any other value (Tables 7.8 and 7.9). Tokenism was often referred to in this context, which was viewed as a significant barrier for meaningful change (barriers identified by this analysis are presented below). One interviewee suggested that stakeholders, government and others (i.e., "the systems") could demonstrate genuine interest in consumer and carer participation by seeking the consumer and carer voice, for example by approaching the group or the umbrella organization, and requesting representatives for that voice, whether it be for a "10-minute one-off training or ongoing consultation" process.

The value of working partnerships and cooperation received the next highest number of references and this content was largely (though not exclusively) reflected in the group's goals and activities seeking to establish or develop partnerships as well as content defining the structure of the group. The importance of successful partnerships and cooperation also received a great deal of attention in interviews and was highlighted by interviewees.

Values receiving the least number of references in the documents were energy and enthusiasm within the group, diversity of views and, perhaps surprisingly, valuing the consumer and carer experience. The latter received considerably more attention from interviewees, who often referred to the significant contribution that those with experience can make, particularly when describing their aspirations for the community (see "Members' Views on the group's Aspirations for the Community" below). Although valuing consumer and carer experience is closely linked to valuing genuine consumer and carer participation, it remains surprising that the former is not explicitly expressed in more document material.

Interviewees identified the following values they believe help the group to manage disagreements between members when they occur:

- all members are provided the opportunity to give a voice to their opinion
- being effective and respectful communicators
- being honest about the issues
- discussion among members focuses on the bigger picture or issue to address rather than individual differences or opinions
- include training in meetings to boost members' skills (for example training on systemic advocacy or communication)
- members attempt to demonstrate they are all there together and everyone there has experience and knowledge to offer
- members ensure they bring the voice of those they are representing and not their own personal opinion

- members express their opinion in a way that is respectful to other members
- members' commitment to wanting the group to work
- members treat each other with respect and dignity.

The values presented above are consistent with the values of members listening and respecting one another, being informed and skilled and acting ethically, all of which were identified in document material. However, not all values identified by interviewees were captured in the values identified by the analysis of documents.

Table 7.7. *Definitions and examples of values identified in documents (Study 6)*

Definition of value	Examples from documents
Being **accountable** to, and driven by, members and constituents. Includes reporting processes, consultation with members and consumer and carers and making documents publicly available.	"It is also each member's responsibility to report back to their nominating organization or ... their state or territory liaison contact, to keep them informed of [group] activities"; "[The group to] conduct and report on a survey seeking the advice of consumers and carers about their issues in relation to privacy and confidentiality".
Valuing the **experience** and knowledge of **consumers and carers**	"The [group] values utilising its members' personal, lived experience and shared, first-hand knowledge of the mental health service system in Australia"; "[Strategy Outcome:] Production of [documentation] which draws on the knowledge of the [group]".
Diversity in membership and capturing diversity in consumer and carer views	"[The group's values being] representative of both mental health consumers' and carers' views" (*Forward Plan*); "Staff and members' diversity of views ... make the [group's] voice stronger" (*Forward Plan*).
Energy and **enthusiasm** within the group.	"The aim ... is to define how [the group] and [the umbrella organization] will work together to develop a vibrant ... consumer and carer voice" (*Annual Report*); "The consultation [meeting] ... was anticipated enthusiastically by ... members"; "This ... policy ... was hotly debated by ... members".
The expectation that members be **ethical** and diligent, provide timely responses and be open and honest in their input and	Being timely and responsive to communication, open and honest input, act with "due care and diligence".

representation.	
The group's ability to **identify** the **required changes** in the mental health sector and raise awareness of these.	"The [group] values … being able to strategically identify where change within the mental health service system in needed"; "[Goal] To identify and raise awareness of mental health consumer and carer issues concerning privacy and confidentiality nationally".
Suggest and **identify solutions,** improvements and best practice for addressing deficiencies in the mental health sector and raising awareness of these.	"The [group] values being able to strategically identify … what a practical and innovative response might entail"; "To identify and raise awareness of National, state/territory and regional initiatives to improve mental health policy and practice in relation to privacy and confidentiality".
The group being an **independent** voice for consumers and carers.	"The [group] is funded through state, territory and Australian Government [government] contributions to be an independent voice for consumers and carers".
Having a membership that is **informed and skilled** in issues and activities relating to mental health reform.	"[The group's purpose is to] provide an informed … voice on consumer and carer issues"; The group offers a "considered national mental health consumer and carer voice".
Valuing **input and genuine participation** from consumers and carers in processes for developing services and policies.	"Because the [group] does not support tokenism, it has a policy of providing consumer and carer representatives only to bodies which remunerate for their expertise and services"; "The [group] was established … in recognition of the continued need for mental health consumer and carer involvement at the highest level of policy development".
Valuing services that protect **human rights and** adhere to principles of **social justice** and inclusion.	"Human rights are still a critical issue for mental health consumers and carers"; "[Goal:] Policies, practices and services that impact on the wellbeing of mental health consumers and carers will reflect and adhere to... the principles of social justice and social inclusion".
A style of communicating between members and with representatives of other bodies and partnerships based on **listening and respect**.	"[The group] listen[s] to the issues and concerns of our state/territory and stakeholder group representatives"; "The [group] values listening and learning from members"; "Speakers [should be] respectful and inclusive of other participants, including time to speak".
Valuing **partnerships and cooperation** between the group and representatives of other agencies.	"The [group] will work with and for the organizations that it represents"; "[The group aims to] enhance, promote and progress genuine national partnerships"; "The [group] provides a mechanism ... to foster

	partnerships and to ensure the input of consumers and carers into the activities of the mental health sector".
Valuing being a **unique, significant and influential** organization for change in the mental health sector.	"The aims of the [group] are to provide a … strong … voice on consumer and carer issues to government; "[The group aims] to be a powerful, respected … national voice for mental health consumers and carers"; "The [group] has identified a number of key values and principles that make its perspective unique and significant with the Australian policy environment"; "[Develop a] state / territory level lobbying plan".
Showing **unity**, as reflected in words such as combined, national and unified.	"The [group] values … developing a strong and united perspective representative of both mental health consumers' and carers' views"; "[Strategy:] Where possible the consumer and carer members will go together so that meetings are coordinated and a united front presented".

Table 7.8. *Number of times each value is referred to in key documents (Study 6)*

	Document						
Activity	Strategic Plan	Operating Guidelines	Forward Plan	Broch-ure	About	Annual Report	Doc. Total
Accountable	29	10	2	1	2	1	45
Consumer and carer experience	1	-	1	1	1	-	4
Diversity	-	2	2	1	-	-	5
Enthusiasm	-	1	-	-	-	1	2
Ethical	-	12	2	-	-	-	14
Identify required changes	12	1	1	3	3	2	22
Identify solutions	9	1	1	3	3	-	17
Independent	1	1	1	-	-	1	4
Informed and skilled	1	2	1	1	2	1	8
Input and genuine participation	21	14	7	11	15	5	73
Human rights and social justice	7	2	7	2	3	3	24
Listening and respect	-	4	4	3	4	-	15
Partnerships and cooperation	45	3	1	3	6	3	61
Unique, significant and influential	16	1	4	3	5	3	32
Unity	1	1	2	4	8	1	17
Total	143	55	36	36	52	21	343

Table 7.9. *Number of times each value is referred to in newsletters (Study 6)*

Activity	*Apr-May*	*Feb*	*June-July*	*Sep-Oct*	*Dec*	News Total	Activity Total[a]
	Newsletters						
Accountable	1	1	-	1	-	3	48
Consumer and carer experience	1	1	-	-	-	2	6
Diversity	-	-	-	-	-	0	5
Enthusiasm	-	-	1	1	-	2	4
Ethical	-	-	-	-	-	0	14
Identify required changes	1	-	2	-	-	3	25 (18)
Identify solutions	1	-	-	-	1	2	19 (15)
Independent	1	1	-	-	-	2	6
Informed and skilled	1	2	-	-	-	3	11
Input and genuine participation	4	2	5	5	-	16	89 (77)
Human rights and social justice	3	-	-	1	-	4	28 (17)
Listening and respect	-	-	-	-	-	0	15 (12)
Partnerships and cooperation	2	3	2	-	-	7	68 (64)
Unique, significant and influential	1	3	1	-	-	5	37 (33)
Unity	-	1	1	-	-	2	19 (15)
Total	16	14	12	8	1	53	394 (157)

Note. Document content is material from the umbrella organization's newsletters which relate specifically to the group. [a]Total number of value references in all documents and newsletters (Table 7.8 + Table 7.9). Numbers in brackets are corrected totals after taking into account repeated entries.

Members' Views on the Strengths of the Group

Some interviewees spontaneously alluded to previous conflict between members of the group and all indicated there were sometimes disagreements, due to the different backgrounds and views of members. Despite these differences, though, interviewees reported that members generally come to agreement when the group focuses on the shared themes of a particular issue. In this context of differences and consensus, interviewees viewed members' different backgrounds, expertise and views as a significant strength of the group. Specifically, interviewees reported that:

- the diversity in members' backgrounds, perspectives, training and skills allows members to learn from each other
- it was healthy to bring different backgrounds and different interpretations of lessons learned to the table
- having the combined knowledge of members helped the group to discover what the issues are that need to be addressed at the national level.

Interviewees also commented on the strong cohesive qualities of the group in that the combined or united voice the group provides helps it to be a stronger voice to influence change. Interviewees reported that:

- coming together as a group provides the potential to facilitate and be an influence for changes that are needed in service delivery and attitudes, including community attitudes
- having a combined voice where both consumers and carers are speaking from experience makes it harder for bureaucrats and clinicians to deny
- having members from different experiences (i.e., consumers and carers) and from different regions (i.e., different states) working jointly on the same issues results in a stronger voice
- representing a broader shared lived-experience view shows strength in a context which frequently plays consumers and carers off each other
- the group is robust enough to be able to make a point around a particular issue that includes both consumer and carer perspectives
- they felt privileged to be part of the group and were impressed by the intelligence and energy and work brought by members.

The structure of the group was also seen as a significant advantage in strengthening consumer and carer participation in mental health reform. Interviewees described with pride the group's unique role in bringing together consumers and carers nationally to discuss issues of concern in mental health. In order to provide this combined voice, a strong relationship between each member and the stakeholders in their state was considered necessary for members to effectively represent issues for their state. As such, interviewees believed this increased the group's ability to identify best practice and become aware of deficiencies in mental health systems.

Barriers and Difficulties Faced by Members

The same structure that presented advantages, however, also brought obstacles. Interviewees reported the following barriers faced by members:

- changes in membership, for example with representatives being replaced requires an adjustment period which often involves work being redone and projects put on hold
- heavy reliance on a few people to do a little bit too much
- life circumstances of members change so that they or a family member becomes unwell and they must pull back or resign, whether temporarily or for a longer period
- minimal opportunities for direct dialogue between the group and government committees about the job of the group and the relationship between the two
- not all members of the group have a formal relationship with their state mental health branch, so that two-way information and input between the group and some states is minimal
- occasional difficulty in establishing a clear purpose or direction
- the high level of commitment required to manage the workload and demands of working on the group means that some members are unable to always meet these standards.

One barrier facing members of the group was identified in one of the newsletters. This referred to members not receiving the remuneration promised for their participation and was considered a significant issue for consumer and carer representatives of the group.

Interviewees provided two suggestions for the group to overcome some of these barriers. These were for the group to be more focussed in its direction forward and in progressing issues and having members define the approach, issue or job in more detail before requesting assistance for follow-up.

Barriers to Mental Health Reform in General

Analysis of the documents revealed seven barriers and difficulties in mental health reform more generally. All of these appeared in newsletter material and referred to mechanisms that limit opportunities for consumer and carer participation (including a low number of agencies offering remuneration for representatives and limited opportunities for skills development and support), lack of awareness of consumer and carer issues on particular policies and approaches, slow progress in seeing the suggested changes be implemented and an approach in mental health sector that inhibits progress (such as a lack of commitment to implementation, little or no leadership and little or no provision of appropriate resources).

Interviewees identified the following barriers to mental health reform more generally.

- Bureaucratic practices in the development and evaluation of services that result in a limited understanding of the issues, more specifically:
    - a "defensive reasoning" approach that protects government, bureaucracies and services "at the expense of natural justice and truth and genuine learning" and which inhibits genuine progress
    - a change in mindset in the community and bureaucrats so that consumers and carers are no longer able to speak frankly about the issues that need to be addressed, for example being asked to "tone down" consumer and carer reports of services
    - evaluative processes for service outcomes, standards and policies that reflect government and service interests and not the interests of consumers and carers.
- Barriers surrounding funding and resources, including:
    - focussing on limited resources draws attention away from the potential to change and the discovery of new ways that are more cost effective and efficient than existing services

  - limited funding and resources for mental health means that providers cannot always "provide the type of service they would like to" and service developments are limited
  - some areas of mental health focus on funding rather than stopping to think about whether the current services are the most appropriate and effective possible.
- Insufficient acceptance of voice and input among government and service providers that presented in many different ways, including:
  - governments not taking on board the consumer and carer view in health planning means there is no real progress in mental health systems
  - local service providers and organizations that do not practice consumer and carer consultation at any level (for example, seeking the consumer and carer voice, consultation on service developments or service evaluation) even though they are there to support people and families affected by mental illness
  - local, state and national governments that do not seek or involve consumer and carer representatives in the decision making process
  - potential lack of knowledge at the local levels (government and service providers) that the consumer and carer voice is available
  - tokenism as opposed to true partnership, which involves giving the appearance of consumer and carer consultation without allowing them to have genuine input. Examples of tokenism are consulting after a policy has been completed, not taking on board the views expressed by consumer and carer representatives, or representatives not being given the opportunity to have a say despite being at a meeting. Interviewees reported that tokenism exists at "all levels" from policy and legislation, national, state and local service providers and governments to non-government organizations and public and private health systems.
- Lack of research that could provide a clear picture of "value for money" in terms of a variety of relevant outcomes from services and reform

- Lack of understanding in the community, health professionals and service providers about the reality about the impact of mental illness for individuals and families and the need for responsive services
- Lack of understanding in the community, health professionals and service providers about the positive impact that the consumer and carer voice can bring to service development, improvement and delivery for the access of all Australians
- Problems relating to the culture and approaches of mental health systems, more specifically:
    - a "shocking culture" in health service provider organizations in which mental health legislation is regularly breached and allows for the mistreatment of people with mental illness
    - a culture that holds no accountability for the treatment of people with mental illness and which has conditioned clinicians to be too frightened to take a stand over the care and rights of consumers
    - a patronising mental health system where the paid professionals assume they know better than the people receiving or seeking their services
    - attitudes that result in people with mental illness not receiving the same respect and care that all patients receive
    - carers being made to feel guilty for requesting and accessing services
    - outdated approaches and training of mental health professionals that focus on blame and judgment rather than inclusion and individuality.
- Problems with policy, including:
    - inconsistency of policies between different states and services, which makes it difficult for them to communicate
    - policies that do not have consequences or accountability for services that do not follow them
    - the temporary evaluation and monitoring of services which trial changes that are not backed by changes in policies and practice guidelines

    - stigma in the community, service providers and policy (see section below on stigma).
- A lack of leadership at the higher levels in mental health that would enable mental health reform to progress forward more directly. This is evidenced by:
    - ministers and governments avoiding decisions that show real support for mental health reform and genuine consumer and carer consultation in policy development, evaluation and delivery
    - very few people at the higher levels that really support consumer and carer participation.

Despite these barriers and demands, interviewees expressed a great deal of positivity about their work in the group and the existence of the group in general. Although members of the group became aware of the significant problems in the mental health systems, and were horrified by some of them, interviewees revealed they had also seen considerable accomplishments and believed their contribution to the group, and the group's contribution to mental health, could make a significant positive difference, "if we go forward and push and use our knowledge and energy and our skills and expertise [I think we can] make a significant difference on the national landscape which I hope then makes a significant difference on the personal landscape and individual communities" (quote from interviewee).

Members' Identification of Issues of Stigma

The issue of stigma appeared twice in the analysed documents. This issue reflected an aspiration for the community that "all levels of society will identify and address discrimination and stigmatization faced by mental health consumers and carers". The second occurrence named addressing stigma as a priority for 2009.

Interviewees often raised the stigma associated with mental illness as a significant issue for consumers and carers in requesting appropriate services and treatment, interacting in the community and advocating for mental health reform. Interviewees reported that stigma exists "across the board" including in the general community, among mental health providers, among agencies providing support and in policy development and bureaucracy. Interviewees strongly expressed the need to reduce stigma in order for consumers and carers to be treated with dignity and respect and be recognised and accepted for the input they can provide. Interviewees also reported that:

- people experiencing mental illness sometimes do not want to disclose because of stigma and their carers and family members also cannot disclose, “thus the secrecy and the shame and the hidden-ness remains”
- secrecy also means that when someone does experience mental health problems those around them do not know how to relate to that person or their family
- some people in the community do not know how to respond to people with mental health problems and so “those negative experiences for the consumer can make a reasonable day into an ordinary day”
- the community does not really understand what mental illness means for the consumers and carers who are affected by it.

In sum, the content analysis and interview material presented above provides a good picture of the workings of the group. Overall, it shows that the group’s goals are very much about being a strong voice for mental health consumers and carers and influencing positive changes in mental health policies, services and practices. The group’s activities (for example, representation, documenting consumer and carer views and consulting with members and the wider consumer and carer population) strongly supported those goals and it was clear that the group’s values (for example, valuing genuine input and participation, the group being accountable and influential and promoting justice, human rights and inclusive practices) were also highly consistent with the direction of the group. There was also strong consistency between the goals and values identified by the content analysis and those brought up by interviewees (note that interviewees did not often discuss the activities of the group as interviews tended to focus on other topics, however the activities that were discussed by interviewees were also consistent with those identified in the documents).

The findings presented above also show that a substantial part of the group’s activities is collaboration, consulting with consumers and carers and developing partnerships in the mental health sector and thus reflect that the group sees establishing strong partnerships as an effective approach to achieve its goals around influencing change in mental health.

FUTURE DIRECTIONS FOR THE GROUP AND MENTAL HEALTH REFORM IN CONTINUING TO INFLUENCE POSITIVE CHANGE

Interviews with some members provided the opportunity to expand on the findings above and sought members' views on the type of community they were aspiring to and the kinds of relationships and mechanisms needed within the mental health sector to achieve those aspirations.

Members' Views on the Group's Aspirations for the Community

Interviewees reported the following aspirations for the kind of community they would like to see.

- A community that reflects consumers and carers being recognised, valued and influential, specifically:
  - a community that has knowledge of what consumers and carers can bring and how that should inform and shape mental health systems
  - a community that respects and values the voice of consumers and carers and their "specialised expertise" so that the various systems actually seek out the views of consumers in carers as a matter of course
  - consumers and carers being active participators in mental health decision-making, implementation and evaluation processes
  - consumers and carers being heard and recognised by decision-makers at all levels, from government and local bodies that make decisions on a daily basis about the sort of service they provide, to providers of those services
  - consumers and carers being involved in the commentary and dialogue of critique for mental health systems
  - consumers and carers having a voice that is heard, respected and influential in the mental health sector

  - having people in higher level government and bureaucratic positions that want consumers involved and recognise the value in having consumers and carers helping to drive the reform agenda
  - more paid consumer and carer advocates across Australia where currently some states have them and others do not
  - recognising the right for mental health consumers and carers to be involved in providing input and developing the type of services received.
- A general approach in the community which reflects:
  - a community that does not have the problems of stigma associated with mental illness
  - a community where it is more acceptable to talk about mental illness in public
  - a far more tolerant society where people cared about each other
  - a world where consumers and carers are treated with dignity and respect
  - more knowledge and education about mental illness.
- Services that reflect best practice and provide the best care for people with mental illness and their families, including:
  - a society and health care system that reflects a "genuine learning environment" which recognises mistakes can happen and that we can learn important lessons from those mistakes to make improvements
  - more communication among services and mental health professionals in the treatment and care of a consumer
  - service systems that promote an environment which is safe for staff to admit when they have made or seen mistakes
  - services that show consistent good policies across the different states; at the moment there are considerable differences in services around Australia, for example "some states have paid official visitors for public and private mental health facilities, other states expect them to do it as volunteers and some states don't have it at all"
  - services that treat consumers and carers with respect and dignity

- strong networking across different services to maximise communication and build a unified approach in service delivery and consistency in policies.

Mechanisms Needed to Realise Aspirations for the Community

Interviewees reported that the following was needed in order to realise the aspirations for the community described above:

- a strong relationship between the group and Minister's departments to bring the consumer and carer view to the attention of the general public and influence change at the state and national levels
- carers and consumers being given the opportunity to be on an equal playing field with all other participants in committees, forums and discussions as well as during the process when policies are being formulated, designed and organized
- change that comes "from the top down", where those running the services and who are considered the experts show true leadership by demonstrating they are informed and take on board the voice of mental health consumers and carers
- change across the board so that attitudes and values of health staff is not limited to particular managers who "are motivated enough to inform themselves" of issues, particularly those of concern to consumers and carers
- consultation with consumers and carers from local levels and involvement from them in the development and evaluation of mental health services in their area
- interactions and working relationships based on understanding and respect
- members being informed and unified in what they give voice to
- members having regular contact with their state mental health services and access to the appropriate level of knowledge and data so the group is aware of what is happening in each state
- positive leadership at the management level within services, bureaucracy and government that leads change "forward in a positive sense rather than having people who just manage the state"

- public education about mental illness
- the group continues to keep pressure up on immediate stakeholders
- the group having a reliable two-way information stream with the Mental Health Standing Committee about planning, progress and opportunities that provide input
- the group having access to relationships with high level decision makers
- the group strengthening and developing partnerships with stakeholders and organizations as well as relationships with different sectors and levels of the government.

Overall, interviewees agreed strongly that having consumers, carers, health professionals, government bodies and other members of the general community working together would make a positive difference for change. Interviewees reported that the proposed set of relationships would:

- "be a useful way to step forward" to have consumers, carers and the government working together to influence the public
- "be the only way to drive sustainable advancements in any process"
- "be very positive for consumers"
- be of benefit because "all have a role to play", all have different views and "some people are better equipped to answer some questions whereas other people are better equipped to ask other questions"
- develop a sense of ownership by having all the stakeholders involved, "and positive change only occurs – in terms of culture change – if you have all the stakeholders involved and they have a sense of ownership, so you've got to have them all there, you got to have all the players at the table"
- develop an understanding and agreement of the sort of services desired and approaches towards achieving that
- involve people who are able to look forward into the future and think of new ways of delivering services; these ideas can be uncovered by "going out to grass-roots community and scratch[ing] around for real ideas"
- facilitate a better understanding of different perspectives

- facilitate dialogue and learning about the different perspectives and would give “a better chance of coming up with solutions if everybody plays a part in giving their perspective”
- help if it facilitates having more mental health providers that are “champions for consumer participation”
- help to achieve solutions and a change in culture in mental health systems that would also see more clinicians returning to the services and help address the shortage of clinicians
- help to build responsive and empathetic services that consumers would not be afraid of
- help to change the culture of mental health systems
- reflect “partnership, that’s true partnership”
- work by driving reform at the micro and macro levels, with approaches like that of the World Health Organization providing “good evidence that it would work … if you wanted to do something really really constructive than you would invite all of those parties to the table”.

As one interviewee stated, consumers, carers, government members, community members and health providers all have different views and knowledge and experience but “despite their slightly different views, they also tend to agree on a lot of things so that tendency to agree on a lot of things helps them to, like you say, work together towards what they're trying to achieve”.

Required Key Aspects for the Proposed Set of Relations

Interviewees described that the following mechanisms would be required for the proposed set of relations to work:

- “proper leadership” in relevant departments and government to value capturing the whole perspective and not just their own expertise
- change in attitudes and change in mindset towards the fact that the problem exists and needs fixing
- empowerment for the people that you bring to the table that they have the ability to actually help to create change
- preparedness for people making the decisions or running the services to take on board the messages they are receiving from others

- the political will to make real and positive change.

Roles for Community Members

Interviewees appeared somewhat split in their opinions when discussing roles for community members. Some interviewees felt that community members were unlikely to become involved if they did not have specific experiences that drove them. Other interviewees suggested that anyone who wanted to be involved should be involved as the changes that were being advocated were also relevant to them as consumers of health services in general. As one interviewee stated, “I’m sure they’re not coming to the table to make service worse, so why shouldn’t they be involved in helping, or assisting, in getting better services?”. Important provisos to this were that those from the general community were not relied on as the only consumer voice, those putting their hands up had commitment and skills and the overall message being expressed was not diluted by their involvement.

A hypothetical scenario described by one interviewee provides a good illustration of the perceived benefits of involving general community members in mental health reform:

> “If you were involved in a community group trying to build a ground for kids’ sports, would you exclude people that weren’t a parent of a kid that was going to have some benefit out of it? I don't think so. Wouldn't you be after the legal person and an accountant person that thinks it’s a damn good idea and that we should have that in our community? You would want to get as many people on board as you possibly can”.

DISCUSSION AND WAYS FORWARD

The findings presented above, drawn from content analysis of the documents and interview material, highlight three significant points. The first point is that, according to the members interviewed for this research project, stigma is a significant issue for mental health consumers and carers and this occurs at all levels of community, government and service delivery. This is certainly supported by research on consumer reports of stigma (e.g., Schulze & Angermeyer, 2003), however the findings of this research project demonstrate that people also come up against stigma within mental health reform. The academic literature also supports this finding (e.g., Happell & Roper, 2006b) and demonstrate that mental health advocacy groups face stigma as a significant obstacle in making forward progress. Once again, the issue of stigma has been highlighted and this emphasises the need for continuing to develop effective ways it can be overcome due to the impact stigma can have on individuals and groups as well as the difficulties it presents in effecting systemic and social change.

The second point emerging from this research project is that interviewees believe the stigma described above calls for leadership and change in the culture of the mental health sector so the changes requested by advocates can be made. When asked where this leadership comes from, interviewees thought it was mainly due to the motivation of individuals. While individual factors may well contribute, we have also shown that community members are more willing to be part of a movement for change when their contribution is defined in the context of a shared group opinion, that of supporters of mental health advocacy (Gee et al., 2007). These shared group opinions, or group memberships based on these opinions, are strong enough to drive social movements and mobilise change. These shared opinions do not rely only on people with specific experiences or categories of people, but extend to people beyond those experiences[6]. An example is that of the social movement to recognise the rights of gay men and lesbians. The people involved in this movement included homosexual people and their families and friends but people who had not had direct personal experience with issues facing homosexuals were also involved. Those without personal experience were involved because they shared the opinion that people should not be treated differently, and not have their rights revoked, because of sexuality, an opinion that is not limited only to people who are themselves homosexual.

That is one example, but the use of these group memberships in facilitating change occur frequently, whether in local communities or across nations. The same characteristics can be seen with those involved in mental health reform. Although the human movement has been driven largely by

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[6] This describes what the authors have termed opinion-based groups (see Bliuc et al., 2007; Gee et al., 2007).

mental health consumers and carers, the comments provided by interviewees in this project highlight that others also need to be on board for us to see the systemic changes being advocated. Overall, interviewees felt that, despite there being few leaders for change and despite the significant barriers that presented when members were working with health providers and members of government, significant and meaningful changes could still be brought about. As one interviewee stated, “I do have the privilege of sitting down with a lot of [service providers] and they all want better services too, I’ve actually yet to find one that says we want worse services”. Perhaps this captures a shared view of those in the mental health sector and mental health reform that reflects support for mental health advocacy.

The importance of relationships for the group was evident in the current findings and this is the third and final point emerging from this project. Material from content analysis and interviews provided evidence that members consider relationships, both within and beyond the group, to be particularly important in being able to effect meaningful and positive change. Interviewees appeared to place high importance on values that provided guidance for interactions between members, such as respectful communication, ensuring everybody has the opportunity to speak and recognising agreement on broader issues despite disagreement or differences within the group. In terms of relationships beyond the group, both document and interview content revealed a strong focus on building collaborative relationships and progressing “true” and equal partnerships. The degree of focus that the group places on relationships makes sense given that the structure of the group by its nature requires the successful workings of many relationships. From consumer and carer representatives from each state, to representatives from state and national consumer and carer groups, from partnerships with state, local and national government departments, to local, state and national service providers and from limited or ongoing relationships with health professional bodies to representation on committees and consultation groups that involve representatives from all of the above, the group is required to balance all of these very different relationships.

Given this focus, it is perhaps especially meaningful that all four interviewees believed a situation in which people with mental illness, carers, community members and health providers were working together for positive change would be effective, with one interviewee stating "I think it's the only way to drive sustainable advancements in any process". The structure and partnerships of the group as well as comments from interviewees indicating the group's interest in communicating well with the public and reducing stigma in the general community, certainly appear to support such an approach.

The suggested approach represents a *cooperative community* (Gee et al., 2007) and has been proposed as a potential way forward to continue effective progress in mental health reform. A cooperative community draws together all members with the shared view and shared cause to make positive change in mental health and relies on all members fulfilling important roles. In this way, the cooperative community draws on the unique skills, experience and knowledge brought by each member to achieve its aim. In a cooperative community, there is strength in unity and interdependence and through this, meaningful and effective change can occur. The cooperative community was represented diagrammatically in Figure 4 (Chapter 6) and is replicated below.

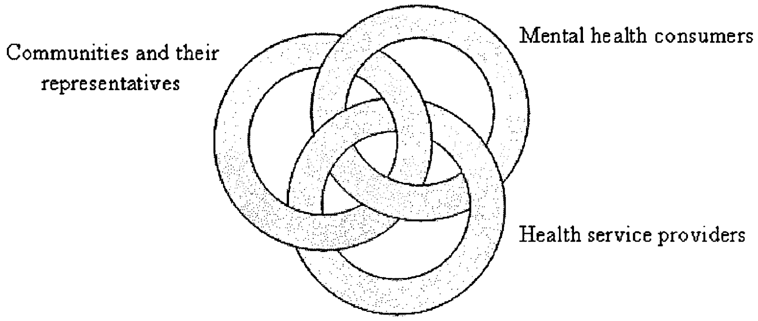

Figure 4. *A cooperative community for positive change.*

The group itself has applied the left and top rings in this set of relationships. Findings from this research project indicate that the group is working hard to add more rings and strengthen those links. Examination of the structure of the group and its partnerships, in conjunction with other findings from this project, allows us to define much more clearly the processes that may be involved in building a cooperative community for positive change in mental health. From these findings, we can step out those who would be involved in a successful cooperative community for creating positive change in mental health as it may apply to the group. Perhaps, then, a cooperative community model that may apply to the group would look something like Figure 5.

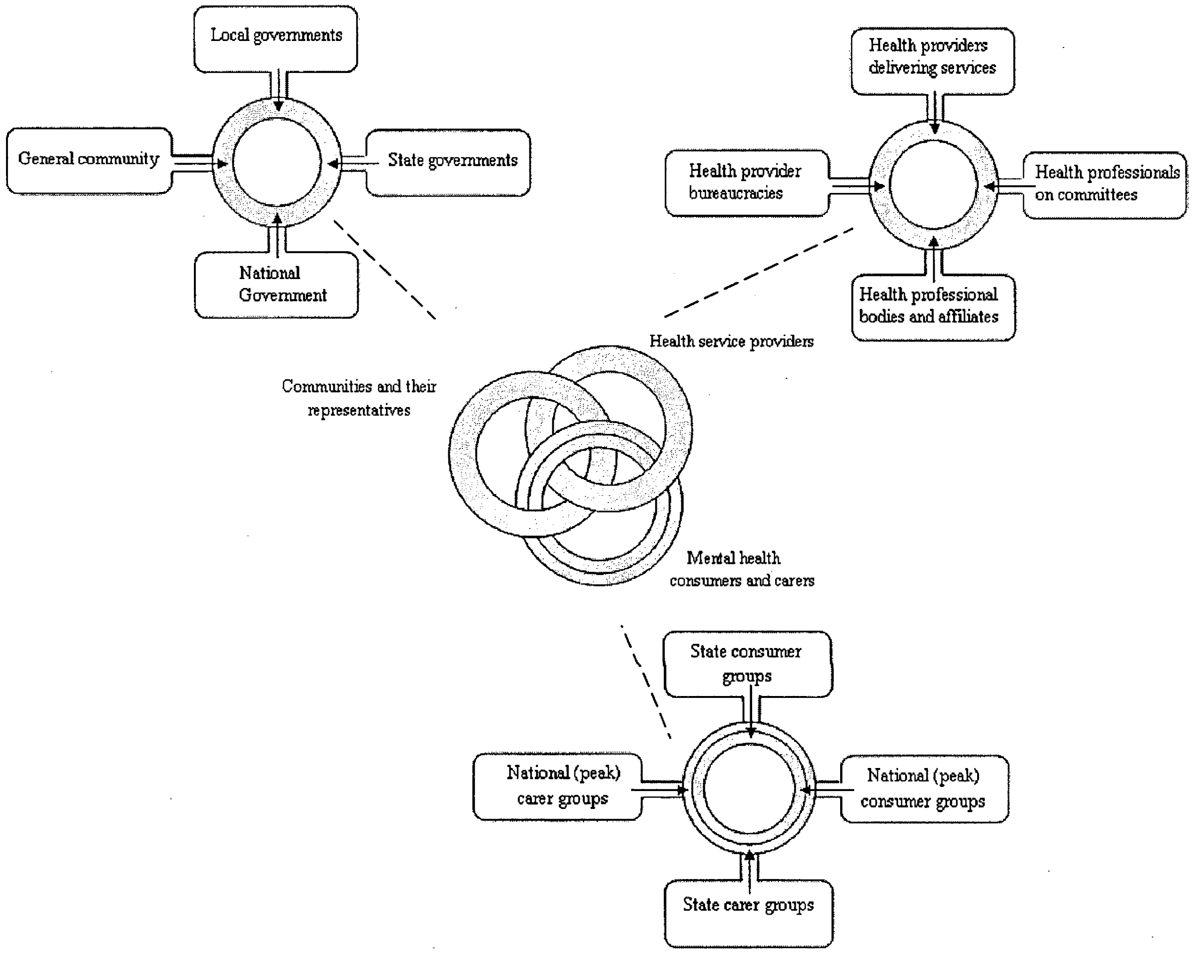

Figure 5. *A cooperative community for positive change in mental health applied to a mental health advocacy group.*

In this representation of the model, the three linked rings in the centre of the figure shows the relationship between consumers and carers more strongly, as developed by the group. That relationship is represented by a ring which reflects the joint approach of members of the group while maintaining their important distinct roles. The three diagrams in the outer part of the model define the different groups that may contribute to making up each of those three rings.

The visual representation of this model may help to step out and define the relationships of those involved in a cooperative community, while the characteristics that underpin those relations are defined through the values of the group described in this report, a shared opinion based on support for mental health advocacy and the values of a cooperative community, as defined above. Such a model could help to address the cultural changes desired, provide a meaningful context to define relationships between key players in mental health reform and therefore promote a positive and shared direction forward to achieve significant and meaningful change for the lives of people affected by mental illness.

DISCUSSION AND CONCLUSIONS FOR STUDIES 5 AND 6

Together, Studies 5 and 6 demonstrate that members of two mental health advocacy organizations strongly aspire to cooperation between people with mental disorders, health providers (and carers) and members of the public (and government) in advancing mental health reform. These two studies utilised content analyses and interviews to identify goals, actions, values and aspirations for change among members of two different types of mental health advocacy organizations: the first a consumer-run organization and the second organization consisting of consumers and carers.

Study 5 (Chapter 6) demonstrates that the consumer-run organization aspired to an integrative community characterised by open communication and cooperation between consumers, carers, health providers and government representatives in advancing mental health advocacy and for the benefit of people with mental disorders. Current networking and advocacy practices also reflect an ideology towards cooperation. Study 6 (Chapter 7) demonstrates that members of the organization run by consumers and carers also strongly held an ideology towards cooperation as being the most beneficial way to achieve the organization's aims for mental health reform. The structure of the organization underscores the presence of this ideology in activities that focus on developing collaborative and equal partnerships in the mental health sector.

These two studies therefore add to the findings of Studies 1–3 presented in this thesis to provide evidence for the proposal that aspirations for cooperation represent an ideology towards change among people who support mental health advocacy. Findings from Studies 1–3 indicate that nominal supporters of mental health advocacy, who are not active advocates for mental health reform, hold a shared ideology that endorses the development of a cooperative community as the required group actions for reducing stigma. Results of Studies 4 and 5 indicate that this ideology also applies to another subsection of people belonging to this opinion-based group of support for mental health advocacy: those who are actively involved in systemic mental health advocacy. While Studies 1 and 2 demonstrate that holding cooperation aspirations is an excellent predictor of positive beliefs, social interaction intentions and intended socio-political behaviours in support of mental health advocacy, Studies 4 and 5 suggest that this ideology is a strong driver for the actions of systemic mental health advocacy groups that aim to promote integration, encourage genuine consumer and carer participation and foster collaborative relationships. This reflects the broader aims of proponents of mental health advocacy described in Chapters 3 and 6: that people with mental disorders have something important to add to the design and implementation of social and health systems and should be involved in these decisions that affect them as a sociological group.

Results of the research presented in this thesis therefore indicate that an ideology representing a cooperative community that is characterised by equal partnerships and the integration of people with mental disorders into the debate is a stronger driver for positive beliefs and actions than identification as a mental health advocacy supporter alone. Both, however, hold up as strong predictors of action for nominal supporters and both inform the aims for mental health reform found among advocates. Results indicate, therefore, that holding a shared ideology that endorses the desired changes *in the context of* a shared group identity whereby mental health advocates and others from the general public and health sector recognise common cause, is a positive direction forward in producing change and reducing the stigma of mental disorders.

CHAPTER 8

COOPERATION TO ADVANCE MENTAL HEALTH ADVOCACY: GENERAL DISCUSSION AND CONCLUSIONS

In this thesis, I have argued that to successfully reduce the stigma of mental disorders we need methods that will address the structural manifestations of stigma. I presented five studies to investigate my proposal that cooperation between people who identify as supporters of mental health advocacy (specifically people with mental disorders and carers, health providers and members of the general public) is one method that can produce positive change. Recall that the research aims for this thesis were to:

1. Explore support for mental health advocacy among people who are not currently active advocates for mental health;
2. Define the psychological constructs involved in holding an orientation towards a cooperative community for positive social change;
3. Explore the perceived utility of this approach among members of the public, potential trainees and mental health advocates; and
4. Explore the practical applications of developing cooperative communities for positive change in mental health.

In relation to the first aim, Studies 1 and 2 (Chapter 4) demonstrate there are high levels of identification with the aims of mental health advocacy among people who are not current members of an advocacy network. More importantly, this social identification was associated with non-stigmatizing individual practices (i.e., positive beliefs and willingness for social interaction) and intended socio-political behaviours. Together, Studies 1 and 2 demonstrate that a pro-advocacy group identity could have positive implications for individual and social change practices that demonstrate a commitment to reducing stigma.

In exploring the second aim, the current research examined key components proposed to reflect an ideology related to that social identity. Results of Studies 2 and 3 show that a new construct designed to reflect aspirations for cooperation between people with mental disorders, health providers and members of the public adds to the prediction of positive beliefs, willingness for interaction and action intentions compared to existing social and community measures. These aspirations for cooperation reflect an ideology for change among people who report strong social identification as a supporter of mental health advocacy, as evidenced by strong correlations between the two constructs (*r*s range from .37 to .68, all *p*s < .001). Further, the aspirations measure adds significant unique prediction to individual and social change practices over identification as a supporter of mental health advocacy alone, suggesting that endorsement of this ideology could be a strong driver for change. Chapter 5 expanded on the theoretical underpinnings of the aspirations ideology and developed the argument that the cooperative community approach offers a unique contribution to group-oriented prejudice reduction strategies in the social-psychological literature in that it not only improves relations between groups (as prejudice reduction strategies do) but also presents the opportunity to achieve real social change to overcome the disadvantage of people with mental disorders (as can be achieved by collective action strategies). Thus, the development of a cooperative community may illustrate an approach that offers advantages of both types of strategies which, as Wright and Lubensky (2009) argue, emphasise very different social agendas.

In addressing the third research aim, exploring the perceived utility of cooperation in mental health, the findings of Studies 1 and 2 (mentioned above) that reveal a significant correlation between identification with the mental health advocacy movement and aspirations for a cooperative community indicate that the desire for cooperation is highly relevant to nominal supporters of the opinion-based group. Findings reveal that 92% of participants rated their own aspirations at five or higher on an 11-point scale (Study 3) and yielded means above 8 (Studies 1 and 2), indicating strong orientation towards cooperation for nominal supporters of mental health advocacy. These aspirations for the future strongly predict positive attitudes as well as intended social interaction and socio-political behaviours. The perceived desirability of cooperation was made more explicit with the use of a pictorial measure in Study 3 (Chapter 4), which revealed that cooperation was perceived to be a more effective set of relations to overcome stigma and produce positive change than other types of intergroup relations.

These findings on the perceived desirability of cooperation for people who are not active advocates (Studies 1–3) are consistent with findings from the final two studies with mental health advocates. Studies 4 (Chapter 6) and 5 (Chapter 7) demonstrate that members of advocacy organizations also appear to (a) strongly aspire to cooperation, (b) believe that cooperation would result in many benefits for people with mental disorders, carers and the mental health sector and (c) view cooperation as necessary to achieve the aims of their organization and of mental health advocacy. Importantly, these findings indicate that, although advocates are strongly focussed on upholding the rights of people with mental disorders, promoting consumer and carer participation and ensuring the use of social justice principles, they see this as occurring through consultation and collaboration within the mental health sector in truly equal partnerships. Findings from Studies 4 and 5 are therefore consistent with those of Studies 1–3 and support an argument contained in the social psychological literature that ideology – in this case, aspirations for cooperation – is one of the strongest drivers for group actions (Wright, 2009).

Finally, in relation to the fourth research aim, Chapter 5 presented a synthesis of the cooperative community approach and existing social-psychological approaches in order to explore some of the practical considerations of developing cooperative communities. These were further explored in the final two studies presented in this thesis which examined the goals, values, activities and aspirations of two different advocacy groups in the mental health sector. Study 4 (Chapter 6), conducted with consumer advocates, and Study 5 (Chapter 7), conducted with consumer and carer advocates, revealed that both advocacy organizations worked to develop collaborative partnerships with other consumer/carer agencies, government departments and health providers in order to work towards their aim to influence positive change. Both studies provide an illustration of the ways in which advocacy organizations aim to be influential in mental health advocacy through the values of participation, partnership and collaboration.

The practical applications of developing a cooperative community is perhaps demonstrated most clearly in Study 5 (Chapter 7), which provided the opportunity to further define the various contributors to a cooperative arrangement, including local, state and national government officers and consumer and carer groups, individual health providers, professional bodies and affiliates and health provider bureaucracies (see Figure 3, Chapter 5; Figure 5, Chapter 7). Thus collaboration with people from a number of levels within each sociological group contributes to the collaborative relationships proposed in a cooperative community. Advocates in Studies 4 and 5 also identified a number of key aspects required for the cooperative approach to work effectively in practice, including: articulating the characteristics that should be used to define the interactions (e.g., respect, listening and compassion); activities and opportunities for enhancing positive interactions (e.g., on committees, events in the mental health sector, networking activities); helpful psychological orientations towards the arrangement, including a preparedness for change and open mindedness; sufficient resources and structural support for the arrangement (e.g., leadership); and certainty in understanding the roles of each contributing member. These views provide valuable insights into the application and development of cooperative communities for positive change.

Overall, then, the five studies presented in this thesis show that aspirations for cooperation to advance mental health advocacy are strong among people who are and people who are not active advocates. Support for collective mental health advocacy (Stringfellow & Muscari, 2003) can therefore be understood as representing an opinion-based group (Bliuc et al., 2007; McGarty et al., 2009) whose membership consists of people from a range of sociological groups including people with mental disorders, carers, health providers and members of the public. This social identity represents a psychological group that crosses the boundaries imposed by existing social categories and this is illustrated by the omnibus advocacy groups (Lefley & Vogel-Scibilia, 2004) that contain people with various experiences and knowledge of mental disorders such as consumers, family members and members of the general public. However, while membership of this social identity denotes a shared opinion that people with mental disorders should not be discriminated against and additionally encourages group-endorsed actions to overcome that stigma (such as positive beliefs, social interaction and socio-political behaviours), this social identity does not alone define the driving orientation for how to go about achieving that aim.

In other words, while an opinion-based group understanding of social identity proposes that people from a number of different sociological groups can share a social identity based on an anti-discrimination opinion (such as that found in support for mental health advocacy), the members of that group may have a number of different views about the most effective or desirable way to eradicate discrimination. Thus, while there is general consensus among ingroup members that prejudice and discrimination against people with mental disorders should be eradicated, there may be less consensus in conceptualising that stigma, about what contributes to or perpetuates it, and/or in identifying solutions that will effectively reduce it. This, one may argue, is likely to differ according to whether you are a member of the stigmatizing or non-stigmatizing group.

In addressing this theoretical issue (introduced in Chapter 3), the current research identified an ideological basis, or psychological orientation, towards cooperation that people committed to mental health advocacy held regardless of whether they were nominal supporters or active advocates. Aspirations for cooperation may be an example of a shared group ideology of the type described by van Zomeren and Spears (2009) and Wright (2009) in the sense that they (a) reflect judgments of shared morality, in this case about inclusion, participation and involvement; and (b) are a strong driver for people committed to the aims of mental health advocacy to engage in group-based (collective) actions. Thus, while the basis for the social identity that brings members of these different sociological groups together reflects the shared opinion that people with mental disorders should not be discriminated against – and as such this shared opinion provides a vehicle whereby the different stakeholders in mental health may experience a shared social identity – the fundamental group values of integration, collaboration and participation articulate the desired changes for movement in a positive direction. The current research therefore provides an illustration of the different, though related, social psychological constructs of identification with an opinion-based group, an ideology or orientation towards a particular direction based on shared group values and the relationship between the two in understanding group actions and social change.

Turning now to consider the different sociological groups proposed to be the main contributors to a cooperative community, the current research has demonstrated the existence of aspirations for cooperation among two groups considered to be stakeholders in mental health: members of the public who are nominal supporters of mental health advocacy and active consumer and carer advocates for mental health. By aspiring strongly to a cooperative community and reporting willingness for social interaction and socio-political action, nominal supporters have demonstrated a commitment to work with people who are directly affected by stigma. Similarly, consumer and carer advocates have demonstrated a commitment to work with others to address the problem. Having demonstrated these important findings, it is important to explore the views of other mental health stakeholders who have significant roles in a cooperative community. Specifically, although Study 2 includes some health and community service workers among nominal supporters, the aspirations and views of health providers have not been explored in the current research. Comments from some advocates in Studies 4 and 5 reveal that they suspect many health providers would also aspire to a cooperative arrangement. This would be a valuable direction for future research in aiming to facilitate the development of a cooperative community in the mental health sector and is perhaps a next step in exploring ways to promote mental health reform.

Funk et al. (2005) and Happell and Roper (2006b) have offered suggestions for the ways government officials can support positive change in mental health reform to incorporate greater consumer and carer participation in government policies and practices and show stronger support of mental health organizations. However, Schulze (2007) has argued that governments may be more strongly (and quickly) encouraged to support reform when united advocacy efforts that aim to influence change also involve pressure from health professionals who work within the service systems. Exploring health providers' views on cooperation for change will therefore be valuable to identify issues and encourage mobilisation towards social change among health providers to advance the cause of collective mental health advocacy and address the structural manifestations of the stigma of mental disorders. Foulks (2000) agrees, however recognises this requires that health providers seek out and join advocacy groups and projects. He states:

> Developing effective advocacy coalitions requires more than the common cause of advocacy for better treatments. Effective coalitions are based additionally on confidence and trust built by ongoing communication and working together. (p. 365)

The research presented in this thesis shows there is support for this belief amongst both nominal supporters and current advocates for mental health. However I would go on to argue, in the tradition of Allport (1954) and Sherif (1970), that common cause is a vital precondition for building the type of "effective coalitions" to which Foulks refers. This common cause reflects the shared social identity explored in this thesis, reflecting an opinion-based group of shared support for collective mental health advocacy. It is this social identity that endorses a shared ideology for cooperation as a desirable way forward in achieving positive change for mental health advocacy. It is also an ideology that specifies the characteristics required to achieve that arrangement, such as the trust, communication, cooperation and respect referred to by Foulks. Both identity and ideology are required to mobilise social change in the name of mental health advocacy and thus to reduce the individual and structural stigma of people with mental disorders.

RESEARCH LIMITATIONS AND FUTURE DIRECTIONS

I have already noted that future research on the development of a cooperative community should explore aspirations for cooperation held by health providers. Specifically, mixed quantitative and qualitative methods such as those utilised in the current research can be used to explore aspirations for cooperation held by individual health providers and those who develop mental health services. This would add to the views of mental health advocates in the current research, explore the views of clinicians and management in the mental health system about the approach's potential to produce positive change in the mental health sector and receive feedback on key characteristics and mechanisms they believe will be required to make it work. The review of collective mental health advocacy and the views of mental health advocates presented in this thesis highlight the importance of consumer perspectives, partnerships and cooperation in the mental health sector to ensure the development of services that meet the needs of consumers, are effective in meeting clinical objectives and are cost-effective. The current findings therefore have implications for the training and professional development of health providers in building a culture in which it is important for professionals to see themselves in collaborative partnerships with consumers and the community. This collaboration is commonly found in individual practices between clinicians and consumers in developing treatment plans tailored to the individual consumer. It is also echoed in the specific treatment practices and therapeutic programs, reviewed in Chapter 2, that clinicians may utilise to assist individual clients to overcome the effects of stigma. However, these individual approaches can be used in conjunction with other practices in which health providers work with consumers to address stigma on a broader systemic level. It is the latter type of collaborative partnerships between consumers, professionals and policy makers that is endorsed by people who aspire to a cooperative community. Future research that provides a better understanding of the barriers and potential of cooperation identified by health providers is essential to develop specific programs to implement positive change.

One method that was not the focus of the current research was to explore aspirations and social identification over time. That is, (how) do aspirations and identification with the opinion-based group change over time and which factors strengthen this commitment for change? The current findings suggest that the cooperative community approach has implications for training programs for professionals, as described above, in promoting a focus on partnerships to advance collective advocacy and these may also extend to training programs delivered to community and consumer advocacy groups. For example, it may be beneficial for community programs to emphasise the role of supportive community members in contributing to collective mental health advocacy (along the same lines as that described in the information provided to participants in Studies 1 and 2, Chapter 4) and for consumer advocacy training to outline the cooperative community approach as one method to achieve the aims of mental health advocacy. However, more research is required to ascertain whether such programs would be beneficial and thus future research investigating aspirations and identification over time, and the factors that influence them, would be helpful in developing these interventions. One direction for future research in line with this is to explore ways to boost aspirations for change and social identification.

Previous research demonstrates that participation in positive, focussed group interaction may be beneficial. Thomas and McGarty (2009) demonstrated that opinion-based group interaction, in which participants suggested and agreed on strategies they believed would be effective in boosting support for international aid, resulted in stronger identification with the cause and willingness to engage in collective action. These findings are in line with those of Khalaf (2002) and my earlier research (described briefly in Chapter 4; see also Gee et al., 2007, in Appendix A), which demonstrate that participation in mental health advocacy discussion groups resulted in stronger intentions and willingness to engage in collective action. In describing the inductive (bottom-up) process of their identity formation model, Postmes, Haslam & Swaab (2005; see also Chapter 5) argue that communication between group members is required to discuss, debate, negotiate and reach consensus on group-based norms (e.g., actions, values, attitudes) and thus construct group identity. They offer their own research on small group discussions (e.g., online and in person) to demonstrate the role of this interaction. Future research could therefore examine the role of small group interaction among supporters of mental health advocacy in forming or building aspirations for cooperation – an orientation or ideology held by supporters of mental health advocacy – and in boosting commitment to the development of a cooperative community. Additionally, in measuring outcomes, future research in this area should explore whether the intended behaviours reported by participants in the current research lead to actual behavioural change.

Along similar lines, Omoto and Snyder (2010) have recently examined the effects of an intervention designed to boost psychological sense of community for communities affected by HIV/AIDS. Recall from Chapter 5 that the recently expanded psychological sense of community measure (the original measure developed by Omoto & Malsch, 2005) has some similarities to the aspirations for a cooperative community measure introduced in this thesis. Specifically, the two measures share some empirical and conceptual overlap in that they both strongly predict positive beliefs, social interaction and socio-political action intentions (Study 2, Chapter 4) and both reflect a vision of looking forward to a better future and the desire for collective efforts. Although the aspirations measure captures more specific factors of these two components by defining *what* is the desired change, *who* should be involved and *how* to achieve that change, the work by Omoto and Snyder provides evidence on methods that may enhance this general orientation for the future. Their results (described briefly in Omoto & Snyder, 2010) indicate that psychological sense of community may be enhanced by workshops that involve group exercises focused on building the six facets of psychological sense of community: knowledge of the existence of a HIV/AIDS community and its members, identification and connection with that community, a belief that working together will accomplish more than individuals and wanting to establish an enduring and successful community for the future. The exact findings are not clear from Omoto and Snyder's brief outline, however their research provides encouraging findings and implications for training programs that may boost knowledge and positive attitudes about stigmatized persons in addition to fostering a helpful orientation towards positive change.

Also in exploring the nature of aspirations for cooperation over time, future research could explore how these views are affected by the negative public images of mental disorders that are found in the media. Thus, we must return to the examples and sources of stigma presented in Chapter 2 to consider not only how the current method of cooperation may contribute to the reduction of stigma but how the existence of stigma in the first place may undermine aspirations and support for collective mental health advocacy explored in this thesis. For example, the media is believed to perpetuate stigma by presenting negative views of people with mental disorders as being passive and disorganized and this is directly at odds with the attitudes and behaviours that are endorsed in the context of collective mental health advocacy. The effects of these existing stigma sources should be examined in order to better understand how aspirations for cooperation and commitment to mental health advocacy may be sustained among members of the public, health providers and people with mental disorders in order to realise the desired changes.

As a final consideration of limitations of the current research and possible future directions, this thesis has presented aspirations for cooperation that has been conceptualised as capturing an *ideology* for positive change. While this term has been used in a social-psychological context, it is possible that in communicating to the community and mental health sector, framing aspirations for cooperation as an "ideology" for change may be met with resistance by those who attach negative connotations to the term. For example, some may interpret an "ideology" negatively as to reflect a doctrine in opposition to the free thought valued in Western cultures. Thus future applications of the cooperative community approach would need to be aware of the potential problems in using this terminology in certain communities.

CONCLUSIONS OF CURRENT RESEARCH

In conclusion, the current research has drawn from clinical and social psychological methods and provides empirical evidence to support my proposal that cooperation in the context of a shared identity may be effective in reducing the structural stigma of mental disorders that has been largely unaddressed by stigma research. In an attempt to explore the actions of people who support the mental health advocacy movement, the current approach has drawn on understanding social psychological group memberships from a social identity perspective (Tajfel & Turner, 1979/1986; Turner et al., 1987) and in particular a recent contribution by Bliuc et al (2007; see also McGarty et al., 2009) which proposes that social identities can be based on a shared opinion. Current findings reveal strong identification with support for mental health advocacy among people who are not already active advocates for mental health demonstrating it to be a plausible opinion-based social identity of the form described by Bliuc et al. (2007) and McGarty et al. (2009).

Following arguments by van Zomeren and Spears (2009) and Wright (2009) in conceptualising shared group ideology, aspirations for a cooperative community were shown to be high among people committed to the aims of mental health advocacy (i.e., the opinion-based group), whether nominal supporters or active advocates. Aspirations for cooperation represent an articulation of the desired changes for how to go about reducing discrimination towards people with mental disorders. These aspirations represent a shared group ideology held by supporters of collective mental health advocacy that is a strong driver for change.

Further, both of these social-psychological constructs – social identification with collective mental health advocacy and aspirations for cooperation – were significant predictors of practices frequently measured in stigma research as representing commitment to stigma reduction (i.e., positive beliefs about people with mental disorders, reduced social distance) as well as intended socio-political behaviours revealing willingness to engage in collective action on behalf of the group.

The research and arguments developed in this thesis therefore add a unique contribution to the literature on stigma reduction, prejudice reduction and collective action research in that it offers a model for reducing stigma that articulates positive desired changes and builds on social identity and intergroup relations models. The proposed cooperative community approach has been shown in this thesis to have significant potential for effectively reducing the structural stigma of mental disorders identified in the literature and, as demonstrated by findings of current studies with mental health advocacy organizations, holds up as being relevant and applicable to the mental health sector.

Finally, the current research provides an illustration of the relationship between opinion-based group identity and a group-based ideology for change in driving positive social change in the mental health domain. Following McGarty et al.'s (2009) line of argument, participation in mental health advocacy action groups can be explained by the commitment of people to seek avenues that will crystallise their opinion into a new united group. That is, action groups can be understood as emerging from a broader shared identity of an opinion-based group. The research presented in this thesis goes much further to suggest that social identities based on shared opinion may be harnessed to a broader shared ideology that helps to galvanise support for social change amongst people who might otherwise be divided..

REFERENCES

ACT Mental Health Consumer Network (n.d.). *A Brief History of the Network.* Retrieved 11 June 2010 from http://www.actmhcn.org.au/cms/media/documents/brief_history_of_network_revised_oct_25.doc

Alexander, L.A., & Link, B.G. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health, 12*, 271–289.

Allport, G.W. (1954). *The Nature of Prejudice.* Cambridge, MA: Addison-Wesley.

Angermeyer, M.C., Matschinger, H., & Corrigan, P.W. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: Testing a model using data from a representative population survey. *Schizophrenia Research, 69*, 175–182.

Angermeyer, M.C., Schulze, B., & Dietrich, S. (2003). Courtesy stigma: A focus group study of relatives of schizophrenia patients. *Social Psychiatry and Psychiatric Epidemiology, 38*, 593–602.

Aron, A., Aron, E.N., & Smollan, D. (1992). Inclusion of Other in the Self scale and the structure of interpersonal closeness. *Journal of Personality and Social Psychology, 63*, 596–612.

Baldwin, M.L., & Marcus, S.C. (2006). Perceived and measured stigma among workers with serious mental illness. *Psychiatric Services, 57*, 388–392.

Barney, L.J., Griffiths, K.M., Jorm, A.F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry, 40*, 51–54.

Bartunek, J.M., Foster-Fishman, P.G., and Keys, C.B. (1996). Using collaborative advocacy to foster intergroup cooperation: A joint insider-outsider investigation. *Human Relations, 49*, 701–733.

Beers, C.W. (1952). *A Mind That Found Itself.* New York: Doubleday & Co. (Original work published 1908.)

Bell, J.S., Johns, R., Rose, G., & Chen, T.F. (2006). A comparative study of consumer participation in mental health pharmacy education. *The Annals of Pharmacotherapy, 40*, 1759–1765.

Beltran, R.O., Scanlan, J.N., Hancock, N., & Luckett, T. (2007). The effect of first year mental health fieldwork on attitutdes of occupational therapy students towards people with mental illness. *Australian Occupational Therapy Journal, 54*, 42–48.

Björkman, T., Angelman, T., & Jönsson, M. (2008). Attitudes towards people with mental illness: A cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences, 22*, 170–177.

Bliuc, A.-M., McGarty, C., Reynolds, K., & Muntele, D. (2007). Opinion-based group membership as a predictor of commitment to political action. *European Journal of Social Psychology, 37*, 19–32.

Brockington, I.F., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry, 162*, 93–99.

Caldwell, T.M., & Jorm, A.F. (2001). Mental health nurses' beliefs about likely outcomes for people with schizophrenia or depression: A comparison with the public and other healthcare professionals. *Australian and New Zealand Journal of Public Health, 10*, 42–54.

Cameron, J.E. (2004). A three-factor model of social identity. *Self and Identity, 3*, 239–262.

Cameron, J.E., & Nickerson, S.L. (2009). Predictors of protest among anti-globalization demonstrators. *Journal of Applied Social Psychology, 39*, 734–761.

Camp, D.L., Finlay, W.M.L., & Lyons, E. (2002). Is low self esteem an inevitable consequence of stigma? An example from women with chronic mental health problems. *Social Science & Medicine, 55*, 823–834.

Castaneda, D., & Sommer, R. (1989). Mental health providers' attitudes toward the family's role in care of the mentally ill. *Hospital & Community Psychiatry, 40*, 1195–1197.

Centers for Disease Control and Prevention (2007). *HIV/AIDS Surveillance Report, 19*. Atlanta: Department of Health and Human Services. URL: http://www.cdc.gov/hiv/topics/surveillance/resources/reports/

Chaplin, R. (2000). Psychiatrists can cause stigma too. *British Journal of Psychiatry, 177*, 467.

Coats, S., Smith, E.R., Claypool, H.M., & Banner, M.J. (2000). Overlapping mental representations of self and in-group: reaction time evidence and its relationship with explicit measures of group identification. *Journal of Experimental Social Psychology, 36*, 304–315.

Constantino, V., & Nelson, G. (1995). Changing relationships between self-help groups and mental health professionals: Shifting ideology and power. *Canadian Journal of Community, 14*, 55–70.

Corrigan, P.W. (1998). The impact of stigma on severe mental illness. *Cognitive & Behavioral Practice, 5*, 201–222.

Corrigan, P.W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*, 48–67.

Corrigan, P.W., Edwards, A.B., Green, A., Diwan, S.L., & Penn, D.L. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin, 27*, 219–225.

Corrigan, P.W., Green, A., Lundin, R., Kubiak, M.A., & Penn, D.L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services, 52*, 953–958.

Corrigan, P.W., & O'Shaughnessy, J.R. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist, 42*, 90–97.

Corrigan, P.W., & Penn, D.L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*, 765 – 776.

Corrigan, P.W., River, L.P., Lundin, R.K., Penn, D.L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H., &

Kubiak, M.A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*, 187–195.

Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., et al. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin, 28*, 293–309.

Corrigan, P.W., Slopen, N., Gracia, G., Phelan, S., Keogh, C.B., & Keck, L. (2005). Some recovery processes in mutual-help groups for persons with mental illness; II: Qualitative analysis of participant interviews. *Community Mental Health Journal, 41*, 721–735.

Corrigan, P.W., & Watson, A.C. (2002). The paradox of self stigma and mental illness. *Clinical Psychology: Science and Practice, 9*, 35–53.

Corrigan, P.W., Watson, A.C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology, 25*, 875–884.

Corrigan P.W., Watson, A.C., Gracia, G., Slopen, N., Rasinski, K., & Hall, L.L. (2005). Newspaper stories as measures of structural stigma. *Psychiatric Services, 56*, 551–556.

Corrigan, P.W., Watson, A.C., Heyrman, M.L., Warpinski, A., Gracia, G., Slopen, N., & Hall, L.L. (2005). Structural stigma in state legislation. *Psychiatric Services, 56*, 557–563.

Couture, S.M., & Penn, D.L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health, 12*, 291–305.

Coverdale, J.H., Nairn, R., & Claasen, D. (2002). Depictions of mental illness in print media: a prospective national sample. *Australian & New Zealand Journal of Psychiatry, 36*, 697–700.

Davidson, W.B., & Cotter, P.R. (1986). Measurement of sense of community within the sphere of city. *Journal of Applied Social Psychology, 16*, 608–619.

Davidson, W.B., & Cotter, P.R. (1989). Sense of community and political participation. *Journal of Community Psychology, 17*, 119–125.

Davidson, W.B, & Cotter, P.R. (1993). Psychological sense of community and support for public school taxes. *American Journal of Community Psychology, 21*, 59–66.

De Cremer, D. (2004). The closer we are, the more we are alike: The effect of self-other merging on depersonalized self-perception. *Current Psychology, 22*, 316–325.

Dixon, L., Adams, C., & Lucksted, A. (2000). Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin, 26*, 5–20.

Dovidio, J.F., Gaertner, S.L., & Saguy, T. (2007). Another view of "we": Majority and minority group perspectives on a common ingroup identity. *European Review of Social Psychology, 18*, 296–330.

Dovidio, J.F., Gaertner, S.L., & Saguy, T. (2009). Commonality and the complexity of "we": Social attitudes and social change. *Personality and Social Psychology Review, 13*. doi: 10.1177/1088868308326751

Dovidio, J.F., Gaertner, S.L., Shnabel, N., Saguy, T., & Johnson, J. (2010). Recategorization and prosocial behavior: Common in-group identity and a dual identity. In S. Stürmer & M. Snyder (Eds), *The Psychology of Prosocial Behavior* (pp. 191–207). Malden, MA: Wiley-Blackwell.

Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health, 14*, 471–481.

Falloon, I.R.H., Held, T., Coverdale, J.H., Roncone, R., & Laidlaw, T.M. (1999). Family interventions for schizophrenia: A review of long-term benefits of international studies. *Psychiatric Rehabilitation Skills, 3*, 268–290.

Farina, A., Holland, C.H., & Ring, K. (1966). Role of stigma and set in interpersonal interaction. *Journal of Abnormal Psychology, 71*, 421–428.

Foulks, E.F. (2000). Advocating for persons who are mentally ill: A history of mutual empowerment of patients and profession. *Administration and Policy in Mental Health, 27*, 353–367.

Frese, F.J., & Davis, W.W. (1997). The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology – Research and Practice, 28*, 243–245.

Fulford, K.M. (1998). Replacing the Mental Health Act 1983? How to change the game without losing the baby with the bath water or shooting ourselves in the foot. *Psychiatric Bulletin, 22*, 666–670.

Fung, K.M.T., Tsang, H.W.H., & Corrigan, P.W. (2008). Self-stigma of people with schizophrenia as predictor of their adherence to psychosocial treatment. *Psychiatric Rehabilitation Journal, 32*, 95–104.

Funk, M., Minoletti, A., Drew, N., Taylor, J., & Saraceno, B. (2005). Advocacy for mental health: roles for consumer and family organizations and governments. *Health Promotion International, 21*, 70–74.

Gaertner, S.L., & Dovidio, J.F. (2000). *Reducing Intergroup Bias: The Common Ingroup Identity Model.* Philadelphia, PA: Psychology Press.

Gaertner, S.L., Dovidio, J.F., Anastasio, P.A., Bachman, B.A., & Rust, M.C. (1993). The Common Ingroup Identity Model: Recategorization and the reduction of intergroup bias. *European Review of Social Psychology, 4*, 1–26.

Gaertner, L., & Schopler, J. (1998). Perceived ingroup entitativity and intergroup bias: an interconnection of self and others. *European Journal of Social Psychology, 28*, 963–980.

Gee, A., Khalaf, A., & McGarty, C. (2007). Using group-based interaction to change stereotypes about people with mental disorders. *Australian Psychologist, 42*, 98–105.

Gee, A., & McGarty, C. (2010). *Aspirations for a cooperative community and support for mental health advocacy: A shared orientation of an opinion-based group*. Manuscript submitted for publication.

Glick, I.D., & Dixon, L. (2002). Patient and family support organization services should be included as part of treatment for the severely mentally ill. *Journal of Psychiatric Practice, 8*, 63–69.

Gonzalez-Pinto, A., Gonzalez, C., Enjuto, S., Fernandez de Corres, B., Lopez, P., Palomo, J., Gutierrez, M., Mosquera, F., Perez de Heredia, J.L. (2004). Psychoeduation and cognitive-behavioral therapy in bipolar disorder: An update. *Acta Psychiatrica Scandinavica, 109*, 83–90.

Graf, J., Lauber, C., Nordt, C., Rüesch, P., Meyer, P.C., & Rössler, W. (2004). Perceived stigmatization of mentally ill people and its consequences for the quality of life in a Swiss population. *Journal of Nervous and Mental Disease, 192*, 542–547.

Green, G., Hayes, C., Dickinson, D., Whittaker, A., & Gilheany, B. (2003). A mental health service users perspective to stigmatization. *Journal of Mental Health, 12*, 223–234.

Griffiths, K.M., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A.F., Nakane, H. (2006). Stigma in response to mental disorders: A comparison of Australia and Japan. *BMC Psychiatry, 6*: 21. doi: 10.1186/1471-244X-6-21

Hanson, M.D., Johnson, S., Niec, A., Pietrantonio, A.M., MacMillan, B.H.H., Eva, K.W. (2008). Does mental illness sitgma contribute to adolescent standardized patients' discomfort with simulations of mental illness and adverse psychosocial experiences? *Academic Psychiatry, 32*, 98–103.

Happell, B., & Roper, C. (2003). The role of the mental health consumer in the education of postgraduate psychiatric nursing students: The students' evaluation. *Journal of Psychiatric and Mental Health Nursing, 10*, 343–350.

Happell, B., & Roper, C. (2006a). The myth of representation: The case for consumer leadership. *Australian e-Journal for the Advancement of Mental Health, 5*. Retrieved from http://www.auseinet.com/journal/vol5iss3/happell.pdf

Happell, B., & Roper, C. (2006b). When equality is not really equal: affirmative action and consumer participation. *Journal of Public Mental Health, 5*, 6 – 11.

Haslam, S. A. (2004). *Psychology In Organizations: The Social Identity Approach* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Haslam, S.A., Eggins, R.A., & Reynolds, K.J. (2003). The ASPIRe model: Actualizing social and personal identity resources to enhance organizational outcomes. *Journal of Occupational and Organizational Psychology, 76*, 83–113.

Haslam, S.A., & Parkinson, B. (2005). Pulling together or pulling apart? Towards organic pluralism in social psychology. *The Psychologist, 18*, 550–552.

Hewstone, M., & Brown, R. (1986). Contact is not enough: An intergroup perspective on the 'contact hypothesis'. In M. Hewstone & R. Brown (Eds.), *Contact and Conflict in Intergroup Encounters* (pp. 1–44). Oxford, England: Basil Blackwell.

Hinshaw, S.P., & Cicchetti, D. (2000). Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy. *Developmental and Psychopathology, 12*, 555–598.

Hocking, B. (2003). Reducing mental illness stigma and discrimination: Everybody's business. *Medical Journal of Australia, 178*, 47–48.

Holmes, E.P., Corrigan, P.W., Williams, P., Canar, J., & Kubiak, M.A. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin, 25*, 447–456.

Holmes, E.P., & River, L.P. (1998). Individual coping strategies for coping with the stigma of severe mental illness. *Cognitive and Behavioral Practice, 5*, 231–239.

Hugo, C.J., Boshoff, D.E.L., Traut, A., Zungu-Dirwayi, N., & Stein, D.J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry and Psychiatric Epidemiology, 38*, 715–719.

Hyler, S.E., Gabbard, G.O., & Schneider, I. (1991). Homicidal maniacs and narcissistic parasites: Stigmatization of mentally ill persons in the movies. *Hospital and Community Psychiatry, 42*, 1044–1048.

Jorm, A.F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry, 77*, 396–401.

Jorm, A.F., & Griffiths, K.M. (2008). The public's stigmatizing attitudes towards people with mental disorders: How important are biomedical conceptualizations? *Acta Psychiatrica Scandinavica, 118*, 315-321.

Jorm, A.F., & Kelly, C.M. (2007). Improving the public's understanding and response to mental disorders. *Australian Psychologist, 42*, 81–89.

Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry, 33*, 77–83.

Kaufmann, C.L. (1999). An introduction to the mental health consumer movement. In A.V. Horwitz & T.L. Scheid (Eds), *A handbook for the study of mental health: Social contexts, theories, and systems* (pp. 493-507). New York: Cambridge University Press.

Khalaf, A. (2002). *An effective stereotype change program for mental disorders*. Unpublished manuscript, The Australian National University, Canberra, ACT, Australia.

Klandermans, B. (2002). How group identification helps to overcome the dilemma of collective action. *American Behavioral Scientist, 45*, 887–900.

Kleim, B., Vauth, R., Adam, G., Stieglitz, R.-D., Hayward, P., & Corrigan, P. (2008). Perceived stigma predicts low self-efficacy and poor coping in schizophrenia. *Journal of Mental Health, 17*, 482–491.

Knight, M.T.D., Wykes, T., & Hayward, P. (2006). Group treatment of perceived stigma and self-esteem in schizophrenia: A waiting list trial of efficacy. *Behavioural and Cognitive Psychotherapy, 34*, 305–318.

Kondrat, D.C., & Teater, B. (2009). An anti-stigma approach to working with persons with severe mental disability: Seeking real change through narrative change. *Journal of Social Work Practice, 23*, 35–47.

Koro-Ljungberg, M., & Bussing, R. (2009). The management of courtesy stigma in the lives of families with teenagers with ADHD. *Journal of Family Issues, 30*, 1175–1200.

Lawrie, S.M., Martin, K., McNeill, G., Drife, J., Chrystie, P., Reid, A., Wu, P., Nammary, S., & Ball, J. (1998). General practitioners' attitudes to psychiatric and medical illness. *Psychological Medicine, 28*, 1463–1467.

Leach, C.W., van Zomeren, M., Zebel, S., Vliek, M., Pennekamp, S.F., Doosje, B. Ouwerkerk, J.P., & Spears, R. (2008). Group-level self-definition and self-investment: A hierarchical (multi-component) model of in-group identification. *Journal of Personality and Social Psychology, 95*, 144–165.

Lee, S., Lee, M.T.Y., Chiu, M.Y.L., & Kleinman, A. (2005). Experience of social stigma by people with schizophrenia in Hong Kong. *British Journal of Psychiatry, 186*, 153–157.

Lefley, H.P., & Vogel-Scibilia, S. (2004). Consumer advocacy and self-help: Interface with professionals. In S. Johnson and R.L. Leahy (Eds), *Psychological Treatment of Bipolar Disorder* (pp. 286–304). New York: Guilford Press.

Levine, M., Toro, P.A., & Perkins, D.V. (1993). Social and community interventions. *Annual Review of Psychology, 44*, 525–558.

Lewin, K. (1947). Group decision and social change. In T.M. Newcomb & E.L. Hartley (Eds), *Readings in social psychology: Prepared for the Committee on the Teaching of Social Psychology of the Society for the Psychological Study of Social Issues* (pp. 330–344). New York: Henry Holt and Company.

Link, B.G. (2001). Stigma: Many mechanisms require multifaceted responses. *Epidemiologia e Psichiatria Sociale, 10*, 8–11.

Link, B.G., Mirotznik, J., & Cullen, F.T. (1991). The effectiveness of stigma coping orientations: Can negative consequences of mental illness labelling be avoided? *Journal of Health and Social Behavior, 32*, 302–320.

Link, B.G., & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363 – 385.

Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A., & Pescosolido, B.A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89*, 1328–1333.

Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*, 177–190.

Lyons, M., & Ziviani, J. (1995). Stereotypes, stigma, and mental illness: Learning from fieldwork experiences. *The American Journal of Occupational Therapy, 49*, 1002–1009.

Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *Journal of Health and Social Behavior, 39*, 335–347.

McGarty, C. (2006). Hierarchies and groups: The roles of salience, overlap, and background knowledge in selecting meaningful social categorizations from multiple alternatives. In R. J. Crisp & M. Hewstone (Eds.), *Multiple Social Categorization: Processes, Models and Applications* (pp. 25–49). New York: Psychology Press.

McGarty, C., Bliuc, A-M., Thomas, E.F., & Bongiorno, R. (2009). Collective action as the material expression of opinion-based group membership. *Journal of Social Issues, 65*, 839–857.

McGarty, C., Haslam, S., Hutchinson, K.J., & Turner, J.C. (1994). The effects of salient group memberships on persuasion. *Small Group Research, 25*, 267–293.

McGarty, C., & Smithson, M.J. (2005). Independence and nonindependence: A simple method for comparing groups using multiple measures and the binomial test. *European Journal of Social Psychology, 35*, 171–180.

McKay, D. (2000). Stigmatizing pharmaceutical advertisements. *British Journal of Psychiatry, 177*, 467–468.

Mental Health America. (2010). *History of the Organization and the Movement.* [27 April 2010]. http://www.mentalhealthamerica.net/index.cfm?objectId=DA2F000D-1372-4D20-C8882D19A97973AA

Mino, Y., Yasuda, N., Tsuda, T., & Shimodera, S. (2001). Effects of a one-hour educational program on medical students' attitudes to mental illness. *Psychiatry and Clinical Neurosciences, 55*, 501–507.

Mond, J.M., Robertson-Smith, G., & Vetere, A. (2006). Stigma and eating disorders: Is there evidence of negative attitudes towards anorexia nervosa among women in the community? *Journal of Mental Health, 15*, 519–532.

Mummendey, A., & Wenzel, M. (1999). Social discrimination and tolerance in intergroup relations: Reactions to intergroup difference. *Personality and Social Psychology Review, 3*, 158–174.

Musgrove, L., & McGarty, C. (2008). Opinion-based group membership as a predictor of collective emotional responses and support for pro- and anti-war action. *Social Psychology, 39*, 37–47.

National Mental Health Education and Training Advisory Group [NMHETG]. (2002). *National Practice Standards for the Mental Health Workforce.* Commonwealth Department of Health and Ageing, Commonwealth of Australia.

Retrieved from http://www.mentalhealth.gov.au/mhinfo/ems/work.htm: National Mental Health Strategy,

Nadler, A., & Liviatan, I. (2006). Intergroup reconciliation: Effects of adversary's expressions of empathy, responsibility, and recipients' trust. *Personality and Social Psychology Bulletin, 32*, 459–470.

Norvilitis, J. M., Scime, M., & Lee, J. S. (2002). Courtesy stigma in mothers of children with attention deficit/hyperactivity disorder: A preliminary investigation. *Journal of Attention Disorders, 6*, 61–68.

O'Brien, L.V., & McGarty, C. (2009). Political disagreement in intergroup terms: Contextual variation and the influence of power. *British Journal of Social Psychology, 48*, 77–98.

Omoto, A.M., & Malsch, A.M. (2005). Psychological sense of community: Conceptual issues and connections to volunteerism-related activism. In A. M. Omoto (Ed.), *Processes of Community Change and Social Action* (pp. 83–103). Mahwah, NJ: Erlbaum.

Omoto, A.M., & Snyder, M. (1995). Sustained helping without obligation: Motivation, longevity of service, and perceived attitude change among AIDS volunteers. *Journal of Personality and Social Psychology, 68*, 671–686.

Omoto, A.M., & Snyder, M. (2010). Influences of psychological sense of community on voluntary helping and prosocial action. In S. Stürmer & M. Snyder (Eds), *The Psychology of Prosocial Behavior* (pp. 223–243). Malden, MA: Wiley-Blackwell.

Parker, G., Lee, C., Chen, H., Kua, J., Loh, J., & Jorm, A.F. (2001). Mental health literacy stigma of general practitioners: A comparative study in Singapore and Australia. *Australasian Psychiatry, 9*, 55–59.

Penn, D.L., & Corrigan, P.W. (2002). The effects of stereotype suppression on psychiatric stigma. *Schizophrenia Research, 55*, 269–276.

Penn, D.L., Guynan, K., Daily, T., Spaulding, W.D., Garbin, C.P., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin, 20*, 567–578.

Phelan, J.C., Link, B.G., Stueve, A., & Pescosolido, B.A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health & Social Behavior, 41*, 188–207.

Postmes, T., Haslam, S.A., & Swaab, R.I. (2005). Social influence in small groups: An interactive model of social identity formation. *European Review of Social Psychology, 16*, 1–42.

Postmes, T., Spears, R., Lee, A.T., & Novak, R.J. (2005). Individuality and social influence in groups: inductive and deductive routes to group identity. *Journal of Personality and Social Psychology, 89*, 747–763.

Quinn, D.M., & Chaudoir, S.R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97*, 534–651.

Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing, 16*, 279–284.

Read, J. (2007). Why promoting biological ideology increases prejudice against people labelled “schizophrenic”. *Australian Psychologist, 42*, 118–128.

Reaume, G. (2002). Lunatic to patient to person: Nomenclature in psychiatric history and the influence of patients’ activism in North America. *International Journal of Law and Psychiatry, 25*, 405–426.

Richmond, I.C., & Foster, J.H. (2003). Negative attitudes towards people with co-morbid mental health and substance misuse problems: An investigation of mental health professionals. *Journal of Mental Health, 12*, 393–403.

Rickwood, D., Cavanagh, S., Curtis, L., & Sakrouge, R. (2004). Educating young people about mental health and mental illness: Evaluating a school-based programme. *International Journal of Mental Health Promotion, 6,* 23–32.

Riebschleger, J. (2001). What do mental health providers really think of family members of mental health patients? *American Journal of Orthopsychiatry, 71,* 466–472.

Roth, D., Antony, M.M., Kerr, K.L., & Downie, F. (2000). Attitudes toward mental illness in medical students: Does personal and professional experience with mental illness make a difference? *Medical Education, 34,* 234–236.

Rusch, L.C., Kanter, J.W., Angelone, A.F., & Ridley, R.C. (2008). The impact of In Our Own Voice on stigma. *American Journal of Psychiatric Rehabilitation, 11,* 373–389.

Rüsch, N., Hölzer, A., Hermann, C., Schramm, E., Jacob, G.A., Bohus, M., Lieb, K., & Corrigan, P.W. (2006). Self-stigma in women with Borderline Personality Disorder and women with Social Phobia. *The Journal of Nervous and Mental Disease, 194,* 766–773.

Rüsch, N., Lieb, K., Bohus, M., & Corrigan, P.W. (2006). Self-stigma, empowerment and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services, 57,* 399–402.

Russel, E.M. (1918). The origin, organization and scope of the Canadian National Committee for Mental Hygiene. *The Canadian Medical Association Journal,* 538–546. URL: (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1585174/pdf/canmedaj00353-0081.pdf) (26 March 2010).

SANE Australia. (2010a). *StigmaWatch Statistics.* Retrieved from http://www.sane.org/stigmawatch/stigmawatch/stigmawatch_statistics.html

SANE Australia. (2010b). *About SANE.* Retrieved from http://www.sane.org/about_sane/about_sane.html

Sarbin, T.R., & Mancuso, J.C. (1970). Failure of a moral enterprise: Attitudes of the public toward mental illness. *Journal of Consulting and Clinical Psychology, 35,* 159–173.

Sartorius, N. (2002). Iatrogenic stigma of mental illness. *British Medical Journal, 324*, 1470–1471.

Scharer, K. (2002). What parents of mentally ill children need and want from mental health professionals. *Issues in Mental Health Nursing, 23*, 617–640.

Scheerder, G., De Coster, I., & Van Audenhove, C. (2009). Community pharmacists' attitude toward depression: A pilot study. *Research in Social & Administrative Pharmacy, 5*, 242–252.

Schofield, J.W. (1986). Causes and consequences of the colorblind perspective. In J.F. Dovidio & S.L. Gaertner & (Eds), *Prejudice, Discrimination and Racism* (pp. 231–253). San Diego, California: Academic Press.

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19*, 137–155.

Schulze, B., & Angermeyer, M.C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Science and Medicine, 56*, 299–312.

Sherif, M. (1970). *Group Conflict and Co-Operation: Their Social Psychology*. London: Routledge & Kegan Paul Ltd.

Sherif, M., Harvey, O.J., White, B.J., Hood, W.R., & Sherif, C.W. (1961). *Intergroup Conflict and Cooperation: The Robbers Cave Experiment.* Norman, Oklahoma: Institute of Group Relations, University of Oklahoma.

Sieff, E.M. (2003). Media frames of mental illnesses: The potential impact of negative frames. *Journal of Mental Health, 12*, 259–269.

Simon, B., Stürmer, S., & Steffens, K. (2000). Helping individuals or group members? The role of individual and collective identification in AIDS volunteerism. *Personality and Social Psychology Bulletin, 26*, 497–506.

Stringfellow, J.W., & Muscari, K.D. (2003). A Program of Support for Consumer Participation in Systems Change: The West Virginia Leadership Academy. *Journal of Disability Policy Studies, 14*, 142–147.

Stürmer, S., & Kampmeier, C. (2003). Active citizenship: The role of community identification in community volunteerism and local participation. *Psychologica Belgica, 43*, 103–122.

Subasic, E., Reynolds, K. J., & Turner, J. C. (2008). The political solidarity model of social change: Dynamics of self-categorization in intergroup power relations. *Personality and Social Psychology Review, 12*, 330–352.

Szasz, T.S. (1974). *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices*. London: Routledge & Kegan Paul.

Tajfel, H., & Turner, J.C. (1979/1986). The social identity theory of intergroup behavior. In S. Worchel & W.G. Austin (Eds), *Psychology of Intergroup Relations (*2nd ed; pp. 7–24*)*. Chicago: Nelson-Hall. (Original work published 1979.)

Taylor, S.M., & Dear, M.J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin, 7*, 225–240.

Thomas, E.F., & McGarty, C. (2009). The role of efficacy and moral outrage norms in creating the potential for international development activism through group-based interaction. *British Journal of Social Psychology, 48*, 115–134.

Turner, J. C. (1982). Towards a cognitive redefinition of the group. In H. Tajfel (Ed.), *Social identity and intergroup relations* (pp. 15– 40). Cambridge: Cambridge University Press.

Turner, J.C., Hogg, M.A., Oakes, P.J., Reicher, S.D., & Wetherell, M.S. (1987). *Rediscovering the Social Group: A Self Categorization Theory*. Oxford: Blackwell.

Turner, J.C., & Reynolds, K.J. (2001). The social identity perspective in intergroup relations: Theories, themes and controversies. In R. Brown & S.L. Gaertner (Eds), *Blackwell Handbook of Social Psychology: Intergroup Processes* (pp. 133–152). Massachusetts, USA: Blackwell.

Üçok, A., Polat, A., Sartorius, N., Erkoç, S., & Atakli, C. (2004). Attitudes of psychiatrists toward patients with schizophrenia. *Psychiatry and Clinical Neurosciences, 58*, 89–91.

Üçok, A., Soygür, H., Atakli, C., Kuşcu, K., Sartorius, N., Duman, Z.C., Polat, A., & Erkoç, S. (2006). The impact of antistigma education on the attitudes of general practitioners regarding schizophrenia. *Psychiatry and Clinical Neurosciences, 60,* 439–443.

Van Dorn, R.A., Swanson, J.W., Elbogen, E.B., & Swartz, M.S. (2005). A comparison of stigmatizing attitudes toward persons with schizophrenia in four stakeholder groups: Perceived likelihood of violence and desire for social distance. *Psychiatry, 68,* 152–163.

Van Zelst, C. (2009). Stigmatization as an environmental risk in schizophrenia: A user perspective. *Schizophrenia Bulletin, 35*, 293–296.

van Zomeren, M., & Spears, R. (2009). Metaphors of protest: A classification of motivations for collective action. *Journal of Social Issues, 65*, 661–679.

Vauth, R., Kleim, B., Wirtz, M., & Corrigan, P.W. (2007). Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia. *Psychiatry Research, 150,* 71–80.

Vibha, P., Saddichha, S., & Kumar, R. (2008). Attitudes of ward attendants towards mental illness: Comparisons and predictors. *International Journal of Social Psychiatry, 54,* 469–478.

Volmer, D., Mäesalu, M., & Bell, J.S. (2008). Pharmacy students' attitudes toward and professional interactions with people with mental disorders. *International Journal of Social Psychiatry, 54,* 402–413.

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin, 25,* 457–478.

Watson, A.C., & Corrigan, P.W. (2005). Challenging public stigma: A targeted approach. In P.W. Corrigan (Ed.), *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change* (pp. 281–295). Washington, DC: American Psychological Association.

Watson, A.C., Corrigan, P.W., Larson, J.E., & Sells, M. (2007). Self-stigma in people with mental illness. *Schizophrenia Bulletin, 33,* 1312–1318.

Weiner, B., Perry, R.P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55,* 738–748.

Wilson, C., Nairn, R., Coverdale, J.H., & Panapa, A. (1999). Mental illness depictions in prime-time drama: identifying the discursive resources. *Australian and New Zealand Journal of Psychiatry, 33*, 232–239.

Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996). Community attitudes to mental illness. *British Journal of Psychiatry, 168*, 183–190.

Wood, A.L., & Wahl, O.F. (2006). Evaluating the effectiveness of a consumer-provided mental health recovery education presentation. *Psychiatric Rehabilitation Journal, 30*, 46–53.

World Health Organization (2003). *Advocacy For Mental Health* (mental health policy and service guidance package). World Health Organization. Obtained from: URL: (http://www.who.int/mental_health/resources/en/Advocacy.pdf) (16 October 2009).

Wright, F.H., & Shrader, R.R. (1965). Influence of open and closed mental hospitals on attitudes in the United States and Britain. *Journal of Counseling Psychology, 12*, 372–378.

Wright, S.C. (2001). Strategic collective action: Social psychology and social change. In R. Brown & S. Gaertner (Eds.), *Blackwell Handbook of Social Psychology: Intergroup Processes, 4* (pp. 409–430). Oxford, UK: Blackwell Press.

Wright, S.C. (2009). The next generation of collective action research. *Journal of Social Issues, 65*, 859–879.

Wright, S.C., & Lubensky, M.E. (2009). The struggle for social equality: Collective action versus prejudice reduction. In S. Demoulin, J. Leyens, & J. F. Dovidio (Eds.), *Intergroup Misunderstandings: Impact of Divergent Social Realities* (pp. 291-310). New York: Psychology Press.

APPENDICES

APPENDIX A: USING GROUP-BASED INTERACTION TO CHANGE STEREOTYPES ABOUT PEOPLE WITH MENTAL DISORDERS

Appendix A presents a published paper that introduces some of the ideas presented in this thesis. This paper presents a short review of stigma research, a brief outline of Study 1 of this thesis (Study 2 in this paper) and introduces the cooperative community approach for stigma reduction to the psychological literature. Paragraphs relating to the empirical/conceptual developments that contributed to the development of the group-based discussion method, Khalaf's data, description of the method and the explanation of results represent contributions by my supervisor (C. McGarty) and colleague (A. Khalaf). The reference for this paper is:

- Gee, A., Khalaf, A., & McGarty, C. (2007). Using group-based interaction to change stereotypes about people with mental disorders. *Australian Psychologist, 42*, Special Issue "Lay conceptions of mental disorder", 98–105.

Abstract

A large body of research has examined intervention methods designed to improve attitudes towards people with mental disorders, in particular education, contact and protest. After a short review of these interventions, this paper provides a brief introduction to a new intervention that involves group-based discussion to strengthen commitment to the aims of the mental health advocacy movement. Research to date demonstrates it produces significant and lasting positive change in attitudes and willingness to participate in future action to promote the aims. Ongoing research examines the required conditions for the intervention and explores its potential to develop a cooperative community in which more members of the community,

professionals and people with mental disorders work together to achieve common goals in reducing stigma.

Using Group-Based Interaction to Change Stereotypes About People With Mental Disorders.

Stigma is a process of labelling, stereotyping, separation, status loss and discrimination (Link & Phelan, 2001). Examples of the stigma encountered by people with mental disorders are easy to find. Think, for example, of television shows you may have seen that present people with mental disorders as incompetent, laughable or (most commonly) dangerous. You may have even seen pharmaceutical advertisements that perpetuate such negative views of people with mental disorder (McKay, 2000).

Given this widespread stigma it is not surprising there have been sustained attempts to overcome this problem. In this paper, we provide an overview of three methods of intervention that have been examined in the research literature. We then discuss our own intervention program, which involves building on people's willingness to commit to defeating stigma. We also explore the potential of this intervention to help create the conditions for overcoming stigma by promoting wide and deeper ongoing cooperation between consumers, professionals and other members of the community. Before doing so, however, it is useful to explore some problematic aspects of stigma.

Why Stigma is a Problem

Community attitudes exist about people with mental disorders that are powerful, negative and false. This is widely recognised as an important issue due to its potential negative impact on the stigmatized group in many areas of life (e.g., see Corrigan & Watson, 2002; Link & Phelan, 2001). Negative effects may include difficulty in gaining employment, housing, and access to adequate services (e.g., by lack of funding, Corrigan, 1998; Corrigan, Green et al., 2001; Link, 2001) as well as reluctance to seek and cooperate with treatment (Hocking, 2003). They may also experience lowered self-esteem and self-efficacy (Markowitz, 1998), loneliness, hopelessness and distress (Hocking, 2003), secrecy about their illness and avoidance of social contacts

(Wahl, 1999), and even suicide for some (Hocking, 2003). Indeed, some people with severe mental disorder even state that the prejudice associated with their illness is as distressing as the symptoms themselves (Hocking, 2003).

Such effects can occur due to *anticipated* as well as experienced stigma (Green et al., 2003; Markowitz, 1998), suggesting that over-emphasising stigmatizing attitudes from the community should be avoided, as these too can have negative consequences (Green et al., 2003). It is also important to note that some people with mental disorders may never encounter stigma or will not experience the negative effects of stigma that have been described (Camp, Finlay, & Lyons, 2002; Corrigan & Watson, 2002). Thus, although we should be sensitive to these issues, we should also ensure not to assume that such effects are inevitable.

The stigma associated with mental disorder is a problem that can be addressed using perspectives from many fields in psychology. As professionals interested in human behaviour, we want to better understand the process of stigma and relevant constructs (e.g., categorization, stereotyping and intergroup relations), the context in which it occurs (e.g., public or occupational settings), and the effect it has on stigmatized groups and individuals (at personal, social and occupational levels). We must understand these concepts to develop and deliver effective methods to reduce the occurrence and impact of stigma in these areas, whether we target these at communities, managers, professionals, families, individuals, or the clinical population.

Negative attitudes of the community are probably the most recognised source of stigma for people with mental disorders and indeed a voluminous body of research exists that investigates these attitudes (e.g., see Brockington, Hall, Levings, & Murphy, 1993; Holmes et al., 1999; Hugo et al., 2003; Wolff, Pathare, Craig, & Leff, 1996). However, there are some suggestions that the attitudes of professionals towards people with mental disorders can also be very negative. Consumer accounts of stigma experiences reveal that interactions with mental health professionals can provide stigmatizing experiences (Angermeyer, Schulze, & Dietrich, 2003; Schulze & Angermeyer, 2003; Wahl, 1999).

Professionals may even be more negative than general community on some dimensions. For example, Caldwell and Jorm (2001) found that mental health professionals expected a person with schizophrenia to be more likely to be violent, abuse drugs and alcohol, and have poor friendships than did a general community sample (see also Jorm et al., 1999). Having highly negative expectations based solely on a diagnosis can result in professionals facilitating an expectation of negative long-term prognosis and subsequently, people with mental disorders may be encouraged by mental health providers to set smaller goals than they are potentially able to achieve (Frese & Davis, 1997; Wahl, 1999). Consumers may be constrained by the attitudes of professionals and if this is tainted with overly negative beliefs about outcomes, the reality that many people with mental disorder can effectively manage their symptoms and experience fulfilling lives is not offered. It is even the case that some professions attempt to restrict those with personal experience of mental disorder from working in the field (Corker, 2001).

Some argue that the careless use of diagnostic labels also contributes to stigmatization; this may involve diagnosis after short consultations which are then communicated to other workers who are not familiar with the intended implications and definition of the term (Sartorius, 2002).

Given the widespread negative attitudes observed in the community and amongst professionals it is no surprise that many interventions to create more positive attitudes have been trialled. In the next section we consider some of these interventions.

Interventions for the Reduction Of Stigma

Interventions designed to minimise the presence and impact of stigma generally fit into three broad categories thoroughly investigated in research: education, contact and protest.

Education strategies were developed to provide information that would increase awareness, understanding and knowledge in the community and counteract widely held false beliefs (Corrigan & Penn, 1999; Jorm, 2000). On the whole, research suggests that short education programs can be effective in producing positive change, however small and variable effects have been demonstrated that have not always been validated in longitudinal designs (e.g., see Corrigan & Penn, 1999; Holmes et al., 1999). Longer education programs, too, have mixed results. For example, Holmes et al. (1999) investigated the effectiveness of a 16-week program on "severe mental illness and psychiatric rehabilitation" for attitudes among psychology students. Although there was improvement in some attitudes for these students compared to those participating in a "general psychology" introductory course, these did not reach statistical significance.

Another study investigated the effects of a one-hour long lecture (covering access to mental health care and providing a case example) on attitudes among Japanese medical students (Mino, Yasuda, Tsuda, & Shimodera, 2001). Improvement in some attitudes was demonstrated (e.g., perceived independence in social life), however, overall there was improvement on only half of the total attitude measures (15 out of 33 items). Neither of these two studies employed a follow-up to investigate the longer-term effects of the programs. Although several campaigns provide quality information on symptoms, early detection and available treatments for mental health issues to the public, research suggests that education alone may not be enough.

Contact strategies involve people with personal experience of mental disorder meeting with members of the public to provide a unique perspective, break down unfamiliarity and disconfirm negative beliefs. The effect of contact on attitudes towards people with mental disorders has been investigated with both retrospective and prospective studies, and have generally been found to be positive (for an excellent review see Couture & Penn, 2003). Retrospective studies investigating the relationship between previous contact with persons with mental disorders and current attitudes generally indicate that prior contact does lead to more positive attitudes on dimensions such as perceived dangerousness, fear, and social distance (Alexander & Link, 2003; Corrigan, Edwards et al., 2001; Corrigan, Green et al., 2001).

In one experimental study, the effectiveness of contact as an intervention was compared with education for subsequent attitudes, intended social distance and helping behaviour (Corrigan et al., 2002). The education intervention involved a 20-minute presentation that corrected common myths about mental illness using research findings (for example that people with mental disorders are no more violent than average citizens), which was followed by five-minute discussion. The contact intervention involved a 20-minute presentation by a person with a serious mental disorder about their experiences, also followed by five-minute discussion. Results showed that contact had the greatest positive effects for attitudes (e.g., dangerousness and avoidance), emotions (e.g., anger and fear), social distance and size of donation to a mental health advocacy organization; importantly, these effects were maintained at one-week follow up whereas many improvements from education had dissipated. Studies such as this demonstrate that people with mental disorders themselves are a valuable resource in reaching the public on the issue of stigma associated with mental disorder.

Contact interventions have also been applied to trainee professionals. For example, a new psychiatric teaching style that was more interactive and increased direct patient contact was compared with the traditional style of lectures and patient contact to examine the effects on attitudes among fourth-year medical students (Baxter, Singh, Standen, & Duggan, 2001; Singh, Baxter, Standen, & Duggan, 1998). There were no differences between the two teaching styles with students from both groups showing significant improvement in attitudes upon completing the modules. However, a concerning aspect is that attitudes one year later (the final year of study) were more negative than at baseline.

This study suggests that increased contact with people with mental disorders might be better used in presenting consumer perspectives rather than merely increasing contact in the role of patients. Such techniques have been utilised, with one postgraduate training program appointing a consumer-academic to provide input to the curriculum of psychiatric nursing students and teach the consumer perspective (Happell & Roper, 2003). Program evaluation by the students reflected primarily positive feedback on the program, resulting in greater awareness of issues and reflection on their practice.

A third method to reduce negative attitudes is protest (stereotype suppression), which involves mental health groups and others openly challenging negative portrayals and behaviour towards people with mental disorder that perpetuate negative attitudes (Corrigan & Penn, 1999). Typically, these protests target the media and government policies. Protest at the individual level is referred to as stereotype suppression and involves individuals being instructed to inhibit negative beliefs so as not to express or perpetuate them (Corrigan & Penn, 1999). Although social protest has been effective in improving conditions for people with mental disorder (for example governmental policies and treatment availability), and has had some success with producing more sensitive media reporting, research investigating suppression at the individual level has been mixed. This body of research suggests there are potential "rebound effects" such that behaviour reflects the original inhibited negative attitudes or individuals do not process further information relating to the target group, including information that contradicts their negative views (Corrigan & Penn, 1999). The research literature thus provides modest evidence for the effectiveness of education, contact and suppression intervention methods. There are nevertheless numerous examples of public campaigns which have tried to build on the ideas in this research. Examples are online resources *beyondblue* (http://beyondblue.org), which provides information to increase awareness about mental disorders in the community, *Mental Illness Education ACT* in which volunteers with personal experience meet with school and community groups to discuss the issues, and SANE's *StigmaWatch* campaign (http://sane.org), which monitors and promotes sensitive reporting of mental disorder in the media. However, the extent to which the intervention methods produce behavioural change, or the extent to which positive effects are maintained over time, is difficult to establish.

Introducing a Group-Based Interaction Intervention

We have developed a group-based interaction intervention that produces positive attitude change by increasing commitment to mental health advocacy. Our program has targeted introductory psychology students, not purely for the conventional pragmatic reasons but because this is a population of trainee professionals who have some likelihood of coming into contact with people with mental disorders as professionals, or who may, by virtue of their education in psychology come to be a conduit for the proliferation of ideas about people with mental disorders in the community.

This program involves getting participants to "sign on" as a supporter of the mental health advocacy movement and then engaging them in a planning session with other supporters where they come to agree on ways to work towards achieving the aims of the movement. This generally involves communication of the group strategies to a wider relevant audience, such as developing content for a web page or community newsletter.

This method capitalises on two empirical and conceptual developments. The first is the nature of the social category of mental disorder. Work by Haslam and colleagues (e.g., Haslam & Ernst, 2002) which has conceptualised social categories in terms of psychological essentialism (associated with natural kind status, i.e., having unique and intrinsic similarities) and entitativity (associated with coherence of a category) suggested that these dimensions were also useful for understanding variations in lay perceptions of mental disorders. Khalaf (2002) has suggested, however, that these two dimensions of essentialism and entitativity qualities need to be supplemented by a consideration of collective qualities. Her argument, based on self categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987), is that collective qualities which are conventionally associated with group formation, such as organization, cooperation, interdependence, and a sense of social identity also play an important role. Research by Khalaf demonstrated that perceptions of mental disorder categories of schizophrenia, depression and anxiety were uniformly low in these collective qualities when compared with other social categories. The mental disorder categories were somewhat variable in terms of the dimensions of naturalness and entitativity. While this points to the utility of these constructs in accounting for variations in perceptions of mental disorders it does suggest that collective qualities are distinct from entitativity and naturalness (at least as defined by Haslam and colleagues). This understanding of mental illness categories allow us to propose an alternative program for stereotype change based on increasing perceptions of positive collective qualities.

We felt that there was a prospect for positive change if members of the community could come to perceive people with mental disorders as part of a broader movement, (a) that achieved positive socially desirable outcomes and (b) that those members of the community could see themselves as part of; in other words, seeing themselves as having common cause with people with mental disorders.

Of course such collective qualities surrounding mental disorder already exist in the form of the mental health advocacy movement which involves positive norms, values and members who are active in the organization. These advocacy groups promote political and social change for the fair treatment of people affected by severe mental disorder in the community (Levine, Toro, & Perkins, 1993). The ACT Mental Health Consumer Network (http://www.actmhcn.org.au), for example, is run by consumers and aims to fight stigma and discrimination, promote the needs of mental health consumers, advance the dignity, knowledge and respect of consumers, and encourage participation and influence within the community. We reasoned that by making people aware of the aims of this movement we could create the conditions for a common cause.

The second empirical/conceptual resource we brought to this question is what Bliuc, McGarty, Reynolds, & Muntele (in press) call *opinion-based groups*. Examples might be pro-life and pro-choice or anti-War. These are groups which need be defined by no more than a shared opinion, that is, where people see themselves as sharing a social identity with other people who hold the same opinion. The argument is that seeing oneself as a member of an opinion-based group is functionally different from just observing that we (coincidentally) hold the same opinion as somebody else, and that this recognition of the collective nature of these common opinions is a foundation for social action. Bliuc et al. have found that identification with (or commitment to) political opinion-based groups is an excellent and highly significant predictor of intentions to take social action with R^2s of approximately .6 in two studies.

In the case of attitudes towards mental disorders we have found that, after hearing about the aims of the mental health advocacy movement in combating stigma, virtually all introductory psychology students are prepared to define themselves as supporters of this movement.

A typical study run in this program therefore involves recruiting participants to engage in a discussion about attitudes towards people with mental disorders. On attending the session participants are given information about the mental health advocacy movement, namely how people with mental disorder participate in helping set up support networks, as well as the goals of the advocacy movement in combating stigma and discrimination. We tend to find that most introductory psychology students are relatively unaware of this movement but, after they hear about it, virtually all (more than 99%) of introductory psychology students we sampled were prepared to define themselves as supporters of this movement.

We argue that providing such information about the collective qualities of mental disorder, and then allowing participants to define themselves as supporters of mental health advocacy, encourages membership of the advocacy movement in which positive change is a core value and identity. As such, the next step is for participants to nominate whether they consider themselves to be supporters of the aims of the movement or not.

Following this self-assignment to the opinion-based group we ask participants to engage in a planning session (of between 20 and 40 minutes) involving 4 to 10 people who are have endorsed the mental health advocacy cause, where they consider ways of combating prejudice towards, and reducing discrimination against, people with mental disorders on campus. The planning sessions involve coming up with a group-endorsed strategy that they write down as a contribution which are then consolidated and published on a website or submitted to a student or community newspaper. Examples of typical group strategies are:

1. "Mental Health Awareness Week" to raise awareness about issues surrounding mental health, provide information about mental disorders and support networks, and promote understanding and positive attitudes. It involves: (a) barbeques to attract attention and promote awareness; (b) posters, show bags and giveaways with slogans, facts and information about mental health and treatment; and (c) fundraising activities to support university activities or community organizations (e.g., masquerade balls,

rock climbing, competitions, raffles, movie showings, concerts, plays).

2. Establishment of a support network (e.g., online discussion or "escape room") for students experiencing mental health problems or who are concerned about friends or family.
3. Integrate the subject of mental health into various faculties on campus and provide seminars about mental health issues and available support.
4. Learn about mental disorders from a personal perspective (e.g., consumers, carers, advocates, friends and family) through meetings, talks and activities.
5. Disclosure from influential people (e.g., professors, academics and celebrities) who have experienced mental disorder.
6. Establish a university committee to represent the needs of those who require help and organize the promotion and awareness activities of mental health on campus.

At the end of the discussion (and where possible at least a month later) we measure attitudes towards people towards mental disorders (in terms of beliefs, affect and behavioural intentions) as well as identification with the mental health advocacy movement and intentions to take action as part of that movement. We compare these responses with control groups and have shown that participation in this intervention results in substantial positive change on these measures and this change is maintained over a period measured by follow-up, up to eight weeks after discussion (Gee, 2004; Khalaf, 2002). These results come from two studies, the first by Khalaf (2002) and the second by Gee (2004).

Khalaf's study comprised a longitudinal design of four phases, at Time 1 participants were randomly assigned to one of three information conditions (identification with advocacy group plus positive information, information alone and control) before completing dependent measures. Participants then engaged in the group-based interaction over two sessions (Time 2 and 3) 4 weeks apart and then were retested on a third occasion (Time 4). Table 1 illustrates positive increases in cognitive beliefs, affective responses and behavioural intentions and the size of these effects which were sustained over three months.

Table 1. *Effect sizes (η^2) for differences between information and control condition (Khalaf, 2002)*

	Pre-test (effect of information only) ($N = 157$)	Post-test (effect of group discussion across time) ($N = 116$)
Cognitive beliefs about people with mental disorder	.22**	.22**
Positive affect towards people with mental disorder	.06*	.33**
Negative affect towards people with mental disorder	.05*	.18**
Behavioural intentions (willing to partake in collective action in mental health advocacy)	NA	.68***

Note. NA = not applicable.
$^*p < .05$, $^{**}p < .01$, $^{***}p < .001$

In Gee's study participants received information at Time 1 and categorized themselves in relation to the mental health advocacy identity. They then participated in group-based interaction at Time 2 (two to five weeks later) and completed the measures for a final time at Time 3 (again two to five weeks later). Responses of these participants were compared with that of a control condition, who received no intervention. As can be seen in Table 2 there were significant and moderate to large sustained increases in behavioural intentions and identification with the mental health advocacy movement.

Table 2. *Effect sizes (η^2) for differences between group discussion and control condition (Gee, 2004)*

	Post-test (N = 25)	Delayed post-test (N = 18)
Identification with mental health advocacy	.13	.27*
Behavioural intentions (social interaction)	.17*	.43**

Note. *$p < .05$, **$p < .01$

There are two broad classes of explanation for the effect. The first is our (preferred) normalisation account. Normalisation (or norm formation) could be understood in terms of a range of theories (e.g., as per various accounts of group polarization and of participatory decision making) but we couch our account in self-categorization theory terms. Participants who identify as members of an opinion-based group seek to reach consensus about norms for this (rather diffuse) group. In a sense participants are asked to play a leadership role for their group in articulating the norms for the movement in a positive, validating and rewarding way. Positive participation and increased identification seemed to produce increased commitment to the group's attitudinal, emotional and behavioural norms that they have articulated.

The second broad explanation is in terms of post-decisional pressures to remain consistent with that earlier decision. It is perhaps not surprising that participants (publicly committed to advocating action) should also be privately committed to the same position especially under conditions where a lack of consistency can be displayed to the experimenter. In ongoing research, we are seeking to establish which of these explanations has more merit but the intervention looks to be effective in either case.

Despite some empirical successes we have found some cases where the intervention is not effective. Gee (2005) found (consistent with Stone, 2004) that group-based interaction did not produce substantial positive change when applied to a class setting (incorporated into first year university laboratory classes). This suggests that some element of voluntaristic participation for the intervention may be required for it to be effective.

This, of course, brings up the question of whether this intervention merely improves the already positive attitudes in those who participate. Our aim for the intervention at this stage of development is to change the way people view themselves and others in relation to people with mental disorders. We anticipate this can be done by increasing commitment to mental health advocacy and coming to a position where those who have participated become more involved to influence the community (for example through stigma challenging behaviours – whether at an interpersonal, community wide or political level). In doing so, we aim to work towards the development of a cooperative community in which people with mental disorders, professionals and community members work actively together for the purposes of improving conditions, reducing stigma and providing an integrative and supportive community for people with mental disorders.

Towards a Cooperative Community

The research described early in this paper suggests that the current societal relationship between people with mental disorders, health professionals and other community members is one where opportunities are limited for people with mental disorders. These three groups exist within society with few members from each group being involved in (or even understanding the potential of) mental health advocacy. These groups, although in frequent contact (and professionals working hard with individuals to improve personal circumstances) are clearly separate.

People with mental disorders, through limited opportunities and restricted access to community resources (a result of negative attitudes) are marginalized and excluded, while the advocacy movement attempts to change that, by bringing them closer together to become more connected with other groups through intervention campaigns (for example mass information delivery), influencing policy and funding for mental health and community services and developing practice guidelines for professionals (for example, see Mental Health Council of Australia, 2000).

A cooperative community occurs through expanding involvement in values consistent with the advocacy movement so that greater numbers of the community, professional and consumer groups become committed to the aims of mental health advocacy. In other words, there is the prospect of producing benefits by having people with mental disorders, professionals and other community members see themselves as sharing a common cause in combating negative attitudes. These groups would then be working together for the same cause: effectively crafting a cooperative identity. It results in a more cooperative, integrated and interdependent community.

Some of the benefits of this type of community will occur for all groups involved. People with mental disorders see this increased involvement in mental health advocacy by others who see the central values of mental health advocacy as meaningful, valuable, and desirable. Therefore, they may see the community and mental health system more positively – as less exclusionary and more supportive, and they see that advocacy is efficacious in improving attitudes of the community and increasing awareness of relevant issues. They may also experience mental health benefits by becoming aware that the community and professionals are supporting them, and from greater community and perhaps greater advocacy involvement. Thus developing a community that people with mental disorders may want to become more actively involved in, with community activities and self-help groups, through which the sense of isolation may be reduced.

The practice of professionals can benefit from the proposed state of affairs by learning a consumer perspective from those promoting mental health advocacy, which may lead to new conceptualisations to address mental health issues not adequately addressed by current treatment methods. In addition, aiming to improve mental health services at the policy and funding levels will improve resources and service availability, thus reducing occupational pressure and limitations for our own practice.

Other community members may benefit strongly by becoming more involved in active participation and promotion of strategies consistent with their own ideals and values. We have had promising results among a large sample of introductory psychology students on a measurement scale designed to reflect the cooperative community ideology. We found that aspiring to a cooperative community was an excellent predictor of positive attitudes and behavioural and action intentions (Gee, 2005). If we can boost this we may have an interaction that works well for community members, professionals and consumers alike.

Given the advantages of the cooperative community arrangement described, and the initial research indicating that aspiration to this community is an important construct for measuring and producing change, a few notes on the implementation of group-based interaction to bring about this community are warranted. We are continuing to investigate the effectiveness (and limitations) of the group-based interaction intervention in order to can assess the prospect of change towards a cooperative community. We have begun research to examine the effects of group-based interaction specifically in strengthening cooperative community aspirations in the three target groups (community, professionals and consumers). As each sub-group would benefit from producing meaningful and positive change in the fight against stigma, all should come together in this arrangement as mutually respected partners with shared aspirations, and each individual acts as a leader to outline their contribution to improving attitudes and achieving change. As the positive aspiration for change spreads, more people become involved and the result is a group of experts working together to directly challenge stigma at many levels. Our research will continue to investigate the program and aim to better understand the context and conditions required for the program to produce positive and meaningful change in a range of applications.

Conclusion

The group-based interaction intervention is an effective and valuable method because it increases commitment to and identification with mental health advocacy in the community and requires participants to demonstrate commitment to this group by articulating methods to achieve the group identity aims. As we better understand the context and conditions required to achieve maximal effectiveness of the program, so too can we better understand the program's potential for future directions. Increasing commitment to the aims of mental health advocacy in members of the general community can lead to a situation whereby community members and people with mental disorders are working together for the same vision. Thus, increasing support, recognition and participation of mental health advocacy at the community level is vital in aiming to reduce stigma and improve outcomes for people with mental disorders. This structure also provides greater recognition of people with mental disorders in engaging with the community and conducting important advocacy work to fight for improved care and support by their community. This can have important consequences for both people with mental disorders and the mental health providers that are in contact with them.

On a final note, although we accept and argue strongly that stigma is an important issue because of the potential consequences of negative views from the community and mental health professionals, we feel we must also highlight that there are many who do have positive attitudes including, we suspect, many of the readers of this paper. It is through acknowledging and recognising the power of the positive view that enormous opportunities for promoting change emerge.

References

Alexander, L. A., & Link, B. G. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. Journal of Mental Health, 12, 271-289.

Angermeyer, M. C., Schulze, B., & Dietrich, S. (2003). Courtesy stigma: A focus group study of relatives of schizophrenia patients. Social Psychiatry & Psychiatric Epidemiology, 38, 593-602.

Baxter, H., Singh, S. P., Standen, P., & Duggan, C. (2001). The attitudes of 'tomorrow's doctors' towards mental illness and psychiatry: changes during the final undergraduate year. Medical Education, 35, 381-383.

Bliuc, A.-M., McGarty, C., Reynolds, K., & Muntele, D. (in press). Opinion-based group membership as a predictor of commitment to political action. European Journal of Social Psychology.

Brockington, I. F., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. British Journal of Psychiatry, 162(1), 93-99.

Caldwell, T. M., & Jorm, A. F. (2001). Mental health nurses' beliefs about likely outcomes for people with schizophrenia or depression: A comparison with the public and other healthcare professionals. Australian & New Zealand Journal of Public Health, 10, 42-54.

Callaghan, P., Shan, C. S., Yu, L. S., Ching, L. W., & Kwan, T. L. (1997). Attitudes towards mental illness: testing the contact hypothesis among Chinese student nurses in Hong Kong. Journal of Advanced Nursing, 26, 33-40.

Camp, D. L., Finlay, W. M. L., & Lyons, E. (2002). Is low self-esteem an inevitable consequence of stigma? An example from women with chronic mental health problems. Social Science & Medicine, 55, 823-834.

Corker, E. (2001) Stigma and discrimination: the silent disease. International Journal of Clinical Practice, 55, 138-140.

Corrigan, P. W. (1998). The impact of stigma on severe mental illness. Cognitive & Behavioral Practice, 5, 201-222.

Corrigan, P. W., Edwards, A. B., Green, A., Diwan, S. L., & Penn, D. L. (2001). Prejudice, social distance, and familiarity with mental illness. Schizophrenia Bulletin, 27, 219-225.

Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. Psychiatric Services, 52, 953-958.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. American Psychologist, 54, 765-776.

Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., et al. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. Schizophrenia Bulletin, 28, 293-309.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. Clinical Psychology: Science & Practice, 9, 35:53.

Couture, S. M., & Penn, D. L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. Journal of Mental Health, 12, 291-305.

Frese, F.J., & Davis, W.W. (1997) The consumer-survivor movement, recovery, and consumer professionals. Professional Psychology - Research and Practice, 28, 243-245.

Gee, A. (2004). How effective is group-based interaction in changing attitudes about mental disorder? Unpublished manuscript, Australian National University: Canberra, Australia.

Gee, A. (2005). Group-based interaction in an educational setting and the aspiration to a cooperative community ideology. Unpublished manuscript, Australian National University; Canberra, Australia.

Green, G., Hayes, C., Dickinson, D., Whittaker, A., & Gilheany, B. (2003). A mental health service users perspective to stigmatization. Journal of Mental Health, 12, 223-234.

Happell, B., & Roper, C. (2003). The role of the mental health consumer in the education of postgraduate psychiatric nursing students: the students' evaluation. Journal of Psychiatric and Mental Health Nursing, 10, 343-350.

Haslam, N., & Ernst, D. (2002). Essentialist beliefs about mental disorders. Journal of Social and Clinical Psychology, 21, 628.

Hocking, B. (2003). Reducing mental illness stigma and discrimination - everybody's business. Medical Journal of Australia, 178, 47-48.

Holmes, P. E., Corrigan, P. W., Williams, P., Canar, J., & Kubiak, M. A. (1999). Changing attitudes about schizophrenia. Schizophrenia Bulletin, 25, 447-456.

Hugo, C. J., Boshoff, D. E. L., Traut, A., Zungu-Dirwayi, N., & Stein, D. J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. Social Psychiatry & Psychiatric Epidemiology, 38, 715-719.

Jorm, A.F. (2000) Mental health literacy: public knowledge and beliefs about mental disorders. British Journal of Psychiatry, 77, 396-401.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals. Australian and New Zealand Journal of Psychiatry, 33, 77-83.

Kaufmann, C.L. (1999). An introduction to the mental health consumer movement. In A.V. Horwitz and T.L. Scheid (Eds), A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems (pp. 493 - 507). Cambridge; Cambridge University Press.

Khalaf, A. (2002). An Effective Stereotype Change Program for Mental Disorders. Unpublished manuscript, Canberra, ACT.

Levine, M., Toro, P.A., & Perkins, D.V. (1993) Social and community interventions. Annual Review of Psychology, 44, 525-558.

Link, B. G. (2001). Stigma: Many mechanisms require multifaceted responses. Epidemiologia e Psichiatria Sociale, 10, 8-11.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual Review of Sociology, 27, 363-385.

Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. Journal of Health and Social Behavior, 39, 335-347.

McKay, D. (2000). Stigmatizing pharmaceutical advertisements. British Journal of Psychiatry, 177, 467-468.

Mental Health Council of Australia. (2000). Enhancing Relationships Between Health Professionals and Consumers and Carers - Final Report. Available: http://www.mhca.org.au/Publications/documents/ERreport.pdf

Mino, Y., Yasuda, N., Tsuda, T., & Shimodera, S. (2001). Effects of a one-hour educational program on medical students' attitudes to mental illness. Psychiatry & Clinical Neurosciences, 55, 501-507.

Sartorius, N. (2002) Iatrogenic stigma of mental illness. British Medical Journal, 324, 1470-1471.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. Social Science & Medicine, 56, 299-312.

Singh, S. P., Baxter, H., Standen, P., & Duggan, C. (1998). Changing the attitudes of 'tomorrow's doctors' towards mental illness and psychiatry: a comparison of two teaching methods. Medical Education, 32, 115-120.

Stone, K. (2004). Accounting for Prejudice Reduction in Opinion-Based Group Interventions: A Social Identity Analysis. Honours Thesis, Australian National University, Canberra, ACT.

Turner, J.C., Hogg, M.A., Oakes, P.J., Reicher, S.D., & Wetherell, M.S. (1987) Rediscovering the Social Group: A Self-Categorization Theory. Oxford: Blackwell.

Wahl, O. F. (1999). Mental health consumers' experience of stigma. Schizophrenia Bulletin, 25, 457-478.

Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996). Community attitudes to mental illness. British Journal of Psychiatry, 168, 183-190.

APPENDIX B: SUPPLEMENTARY MATERIALS FOR STUDIES 1, 2 AND 3 (CHAPTER 4)

Information Provided to Participants (Khalaf, 2002)

One in five people in Australia will suffer from a mental health problem serious enough to significantly influence their daily lives. These problems can range from long-term and severe disorders to short-term stress related disorders. People with these mental health problems face isolation and discrimination just because they have a disorder. Mental disorder is surrounded by community fear and stigma. This stigma has a detrimental effect on people's ability to lead a normal life.

Mental disorder affects people of all ages, races, nationalities, life-styles and socio-economic levels. People suffering from a mental disorder are a very diverse group: many are employed, married, raising children or pursuing education. Prejudice and community misunderstanding remain among the most significant barriers to people with a mental disorder being able to actively participate in the community. Therefore, the biggest hurdle for people trying to get well is confronting the attitudes that we, their neighbours, employers, friends and family, hold towards them because of their disorder.

There are many commonly held misconceptions about the nature and treatment of mental disorder. One such misunderstanding involves the idea of mental disorder as an extreme, incapacitating disability requiring hospitalisation and long-term care. Most mental disorders are troubling but not incapacitating, do not require hospitalisation, and can be treated effectively with medication, psychological therapy or lifestyle changes.

People often fear individuals with a mental disorder because they believe that the disorder is linked to unpredictable and violent behaviour. This false idea is maintained by the media which usually depicts people with mental disorders as dangerous. However, research has concluded that there is only a weak association between major psychiatric disorders and violence in the community. Further, recent research has demonstrated that individuals who abuse drugs and alcohol are actually more prone to violence than individuals with schizophrenia. In fact, there is less violence committed by people with mental disorders than is found in the community generally. People with mental disorders are rarely dangerous; instead they tend to be more anxious or fearful. A minority of people may occasionally become aggressive because of their fears. However, this aggression is rarely targeted at strangers.

People often don't realise that there are support networks and other organizations set up and run by people with mental disorders for others diagnosed with a mental disorder, much like cancer support groups and agencies. People with mental disorders, despite their difficulties, aim to help themselves and each other through these groups, providing a supportive community environment, information and knowledge and some practical help to members. These support networks are made up of sufferers, families and friends and other people in the community who are concerned about mental health issues. For example, in the Canberra community there are several agencies set up to provide support for people with a mental disorder and promote true integration within the wider community. These agencies may have several functions. Some such agencies provide a supportive network to people with a mental disorder, for example support groups run by Mental Health Foundation ACT and by GROW. Other agencies provide help for people with a mental disorder to gain and maintain employment, for example Café Pazzini, a Canberra Schizophrenia Fellowship program providing information and vocational rehabilitation for people living with serious mental disorders. Others encourage active participation in social and community activities, such as the Leisure Program ACT which offers discounted community activities. Still other agencies are targeted towards improving attitudes in the wider community and improving policies and funding for mental health services (advocacy groups).

Advocacy groups are run by consumers of mental health services (people with mental disorders), by family and friends of consumers and other community members. They aim to fight discrimination against people with mental disorders, promote the needs of mental health consumers, empower consumers to take control over their mental health, influence policies, improve mental health services and encourage participation and influence within the community. For example, the ACT Mental Health Consumer Network is a nationwide network run by consumers. As well as assisting people with mental disorders, this network provides briefing to parliament on health policies, information seminars at hospitals for staff and the public and also is involved in teaching programs for medical students. Overall this network is effective, highly valued and provides a sense of community and worth for people with mental disorders. Anybody who works to help improve the situation for people with mental disorders, even by starting discussion to consider their difficulties, can be seen as part of this network.

Mental health advocacy is a movement that aims to

1. Promote well-being of people diagnosed with mental disorders through improving available services.
2. Promote knowledge and understanding in the community to reduce discrimination and stigma associated with mental disorder.
3. Uphold the rights of people diagnosed with mental disorders.
4. Promote an integrative community of people diagnosed with mental disorders and other community members.

Mental health advocacy relies on the combined efforts of people diagnosed with mental disorders and other community members to work effectively together towards achieving the above aims.

Tick which of the following applies to you

I am a supporter of the aims of mental health advocacy

I am not a supporter of the aims of mental health advocacy

Aspirations for a Cooperative Community Scale

Currently in Australian society people with mental disorders are often marginalized and excluded. To what extent do you favour the following changes in Australian society:

1. The burden of stigma and of the mental health problems experienced by people with mental disorders is more widely recognised.
2. People with mental disorders, community citizens and health professionals work together to combat negative attitudes and improve mental health resources.
3. The expertise and experience of all members (i.e., people with mental disorders, health professionals and community citizens) is respected and their contributions valued.

4. The input of all members is used to inform efforts to combat stigma and improve conditions for people with mental disorders.
5. Members make sure that all members of the community have the opportunity to have a say about the issues affecting people with mental disorders.

To what extent do you believe that these changes will:

6. Break down the divide that exists to differentiate people with mental disorders from other members of the community.
7. Increase the degree of knowledge and understanding of mental health problems in the community.
8. Provide better services for people with mental health problems.

To what extent do you agree or disagree with the following statements:

9. The changes to Australian society described above represent a vision that will never be achieved.
10. The changes to Australian society described above represent a vision that I, personally, am strongly committed to.

Paragraph Outlining the Characteristics of a Cooperative Community (Study 3)

One way to help combat the stigma of mental illness is with the development of a cooperative community to achieve positive change. A cooperative community relies on its members fulfilling important roles whether they are people with mental illness, professionals or part of the wider community. Members of a cooperative community rely on each other and value all contributions equally.

In this way, the cooperative community draws on the unique skills, experience and knowledge brought by each member to achieve its aim, which may involve for example, correcting friends or family when they express derogatory views or misconceptions about mental illness, holding public social events to increase awareness, or lobbying political groups for structural change.

In a cooperative community, there is strength in unity and interdependence and through this, meaningful and effective change can occur.

APPENDIX C: OUTLINE OF THE CODING PROCESS FOR DOCUMENT ANALYSIS FOR STUDY 4 (CHAPTER 6)

This appendix provides a description of how document content was coded to identify the reported goals, actions and values of the consumer-run organization (Chapter 7).

General Coding Strategy

Coding of document content was driven by the pre-defined categories of goals, activities and values. Content could be words, sentences or paragraphs and some initial coding grouped similar ideas or sentiments together. As this initial coding progressed, the common themes became more clear and specific goals, activities and values could then be identified. Once this coding structure had emerged, the documents were analysed a second time to ensure this structure fit with the content of the documents and to ensure consistency in the coding approach.

Coding: Goals <u>or</u> Activities <u>and</u> Values

Content was coded as either a goal or an activity and was coded onto only one specific goal or activity within those categories. Values (also with content coded onto only one) could emerge from material that had also been coded as a goal or an activity. Consider the following examples:

- "Goal 1 – Build and utilise consumer knowledge" was coded as a goal to develop consumer knowledge (that is, coded as only one goal) **and** coded as a value to recognise consumer knowledge and experience (also only one value)
- "Goal 2 – Express the consumer voice" was coded as material reflecting a goal to provide a voice for consumers **as well as** the value of recognising consumer knowledge and experience.

As a result of this double-coding, the counted number of references could add up to more than 100% of coded material.

Goals

The goals that emerged from the document analysis were identified in statements that reflected aims for the organization, or what the organization wanted to achieve. These were variously referred to in the documents as aims, goals, objectives, vision or strategies.

Activities

The organization's activities identified from the documents included those that were:

- future oriented and presented as planned activities in the documents
- currently underway, in which case the documents provided updates on these
- completed.

Values

Values were most often identified in content that described goals and activities, although were also present in narratives and other communications (such as quotes from advocates and reports in newsletters).

APPENDIX D: OUTLINE OF THE CODING PROCESS FOR DOCUMENT ANALYSIS FOR STUDY 5 (CHAPTER 7)

Rationale for the Choice of Documents

As this research project began in early 2009, documents included in this analysis were key communication documents from the period 2007-2008. The newsletter content came from sections of the umbrella organization's newsletters that were specific to the group. This material provided evidence of the way the group represented itself to its auspice organization and affiliates.

Note that the newsletters included in this analysis were distributed during 2007. Only one of the four newsletters from 2008 mentioned the group and this content was written by staff from the umbrella organization. As the researchers were interested in documents that reflected the group's own direct communication, this content was not included in the analysis. Having ruled out availability of newsletters from 2008, newsletters from 2007 were then considered. The group was mentioned in all 7 newsletters for 2007. Two of those mentioned the group to report changes in staffing only and thus were not included in this analysis. The remaining 5 newsletters for 2007 included a small report (an average of 385 words) from the group's Executive Officer and these 5 newsletters were included in the analysis.

General Coding Strategy

Coding of document content was driven by the pre-defined categories of goals, activities and values. Content could be words, sentences or paragraphs and some initial coding grouped similar ideas or sentiments together. As this initial coding progressed, the common themes became more clear and specific goals, activities and values could then be identified. Once this coding structure had emerged, the documents were analysed a second time to ensure this structure fit with the content of the documents and to ensure consistency in the coding approach.

Coding: Goals <u>or</u> Activities <u>and</u> Values

Content was coded as either a goal or an activity and was only coded onto one specific goal or activity within those categories. Values (also with content coded onto only one) could emerge from material that had also been coded as a goal or an activity. Consider the following examples:

- "to strengthen and raise the profile of the national consumer and carer voice" was coded as a goal to provide voice and recognition to consumers and carers (that is, coded as only one goal) **and** coded as the valuing input and genuine participation (only one value)
- the strategy of "members to hold meetings with state/territory mental health services and key consumer and carer organizations to seek information about relevant initiatives" was coded as material reflecting the activity of collaboration **as well as** the value of partnerships.

As a result of this double-coding, the counted number of references could add up to more than 100% of coded material.

Goals

Goals of the group were identified in statements that reflected aims for the group, or what they wanted to achieve. These could be broad or specific and were variously referred to in the documents as goals, purpose, aims, Terms of Reference, or strategy. In general, goals appeared in the documents under headings or preambles stating they were goals or aims, however content relating to goals also appeared independently of this. The following example is from the Operating Guidelines document (p. 4) and reveals three goals in one sentence describing the work of the group:

> [The group] provides a mechanism for mental health consumers and carers to come together to foster partnerships [*coded as a goal to foster partnerships*] and to ensure the input of consumers and carers into the activities of the mental health sector [*a goal to increase participation*] including the reform of mental health policy and service delivery in Australia [*a goal to influence reform*].

Actions

Content identified as actions undertaken by the group included those that:

- could be specific (e.g., "members in each state/territory to develop a plan to meet with members of parliament in that state/territory and to discuss the Briefing Paper with them and to seek their response"), or general (e.g., "[Roles:] Lobbying of key decision makers, including in particular at different levels in the health and human service sectors")

- were outlined in documents as roles for the group
- were described as "actions and tasks"
- appeared in updates of the group's work, such as in newsletters
- had been completed, were planned or were currently underway.

Values

Values were most often identified in content that described goals and activities, although were also present in narratives and other communications (such as reports in newsletters).

Barriers

In addition to the pre-defined categories described above, content from documents outlined barriers facing members of the group and to seeing changes in mental health reform. Document material that referred to barriers appeared only in newsletters.