UNIVERSITY OF SOUTH FLORIDA

A PREEMINENT RESEARCH UNIVERSITY

Understanding Stigma to Promote Inclusion and Recovery in Behavioral Health and Criminal Justice Settings

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Florida Mental Health Institute

What is stigma?

Whence comes mental illness stigma?

We see it in headlines…

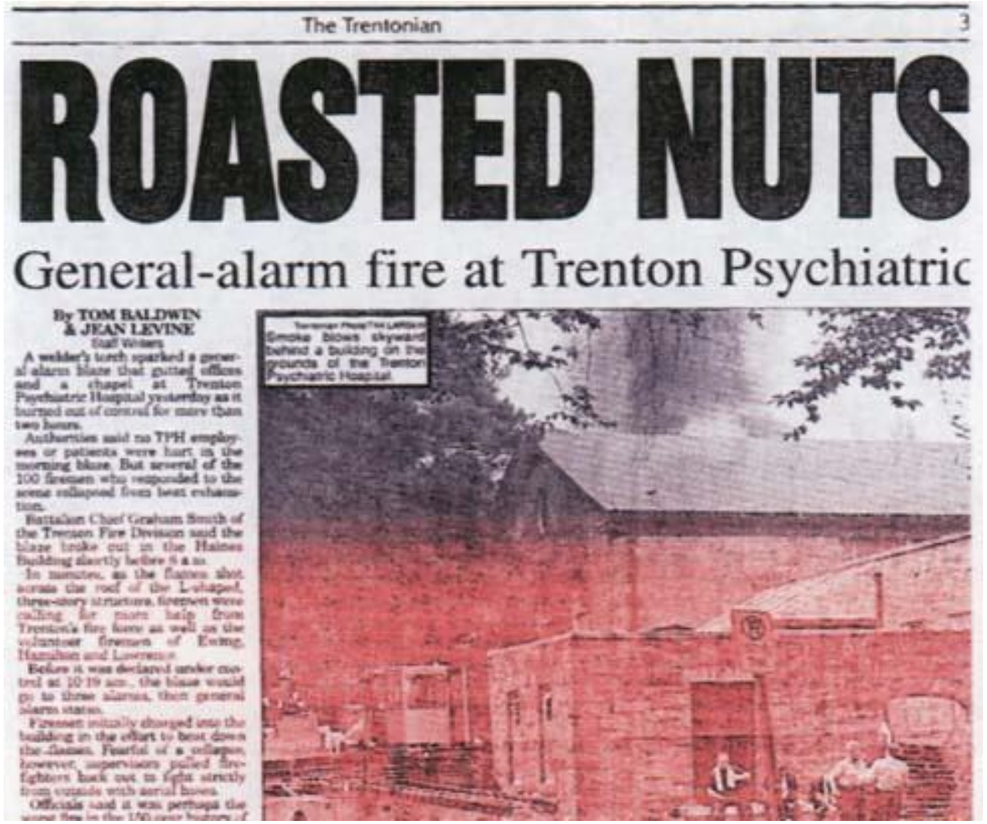
We see it in headlines…

July 10, 2002

Trenton State Hospital has fire.

What was the Trentonian's headline the next day?

What was the Trentonian's headline the next day?



The Trentonian 3

ROASTED NUTS

General-alarm fire at Trenton Psychiatric

By TOM BALDWIN & JEAN LEVINE
Staff Writers

A welder's torch sparked a general alarm blaze that gutted offices and a chapel at Trenton Psychiatric Hospital yesterday as it burned out of control for more than two hours.

Authorities said no TPH employees or patients were hurt in the morning blaze. But several of the 100 firemen who responded to the scene collapsed from heat exhaustion.

Battalion Chief Graham Smith of the Trenton Fire Division said the blaze broke out in the Haines Building shortly before 6 a.m.

In minutes, as the flames shot across the roof of the L-shaped, three-story structure, firegrams were calling for more help from Trenton's fire force as well as the volunteer firemen of Ewing, Hamilton and Lawrence.

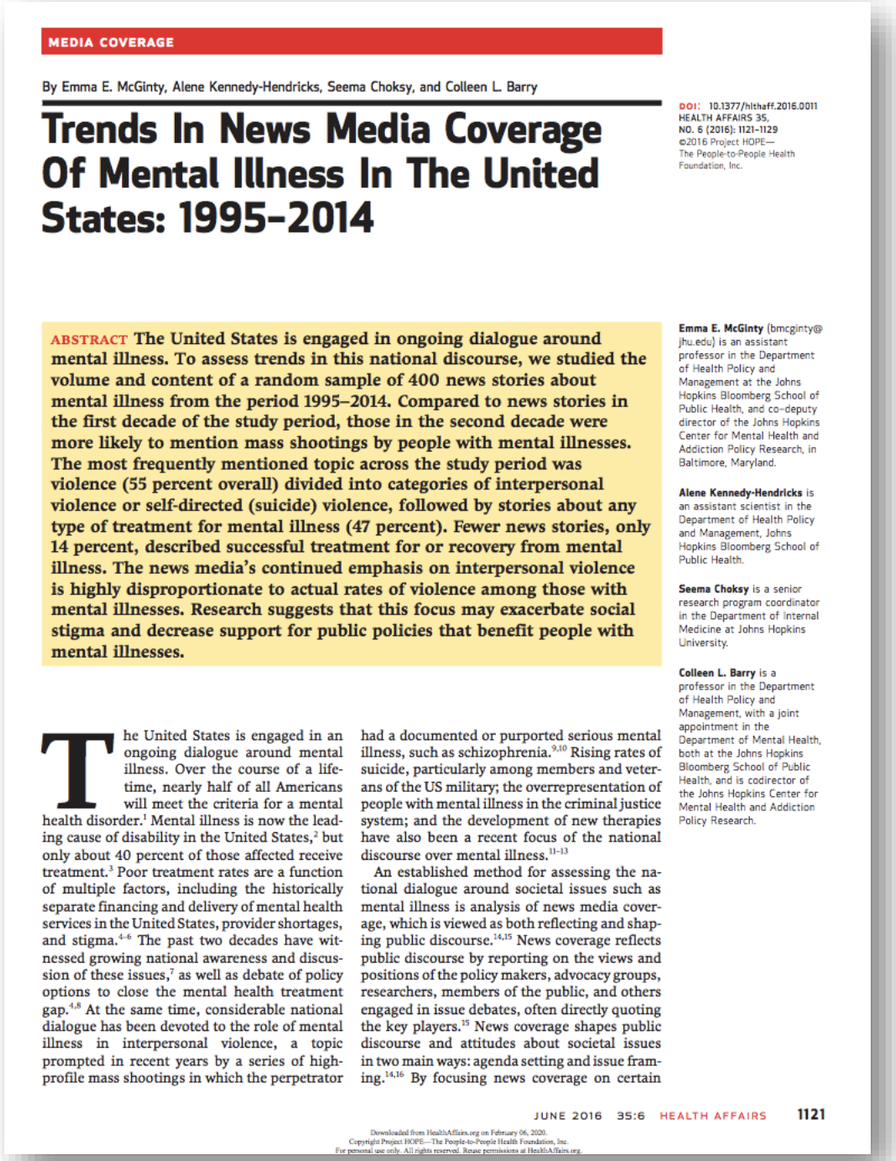
Before it was declared under control at 10:19 a.m., the blaze would go to three alarms, then general alarm status.

Firemen initially charged into the building in the effort to beat down the flames. Fearful of a collapse, however, supervisors pulled firefighters back out to fight directly from outside with aerial hoses.

Officials said it was perhaps the worst fire in the 150-year history of

Smoke blows skyward behind a building on the grounds of the Trenton Psychiatric Hospital.

News Media Coverage of Mental Illness Across Time



MEDIA COVERAGE

By Emma E. McGinty, Alene Kennedy-Hendricks, Seema Choksy, and Colleen L. Barry

Trends In News Media Coverage Of Mental Illness In The United States: 1995–2014

DOI: 10.1377/hlthaff.2016.0011
HEALTH AFFAIRS 35,
NO. 6 (2016): 1121–1129

ABSTRACT **The United States is engaged in ongoing dialogue around mental illness. To assess trends in this national discourse, we studied the volume and content of a random sample of 400 news stories about mental illness from the period 1995–2014. Compared to news stories in the first decade of the study period, those in the second decade were more likely to mention mass shootings by people with mental illnesses. The most frequently mentioned topic across the study period was violence (55 percent overall) divided into categories of interpersonal violence or self-directed (suicide) violence, followed by stories about any type of treatment for mental illness (47 percent). Fewer news stories, only 14 percent, described successful treatment for or recovery from mental illness. The news media's continued emphasis on interpersonal violence is highly disproportionate to actual rates of violence among those with mental illnesses. Research suggests that this focus may exacerbate social stigma and decrease support for public policies that benefit people with mental illnesses.**

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Alene Kennedy-Hendricks is an assistant scientist in the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health.

Seema Choksy is a senior research program coordinator in the Department of Internal Medicine at Johns Hopkins University.

Colleen L. Barry is a professor in the Department of Health Policy and Management, with a joint appointment in the Department of Mental Health, both at the Johns Hopkins Bloomberg School of Public Health, and is codirector of the Johns Hopkins Center for Mental Health and Addiction Policy Research.

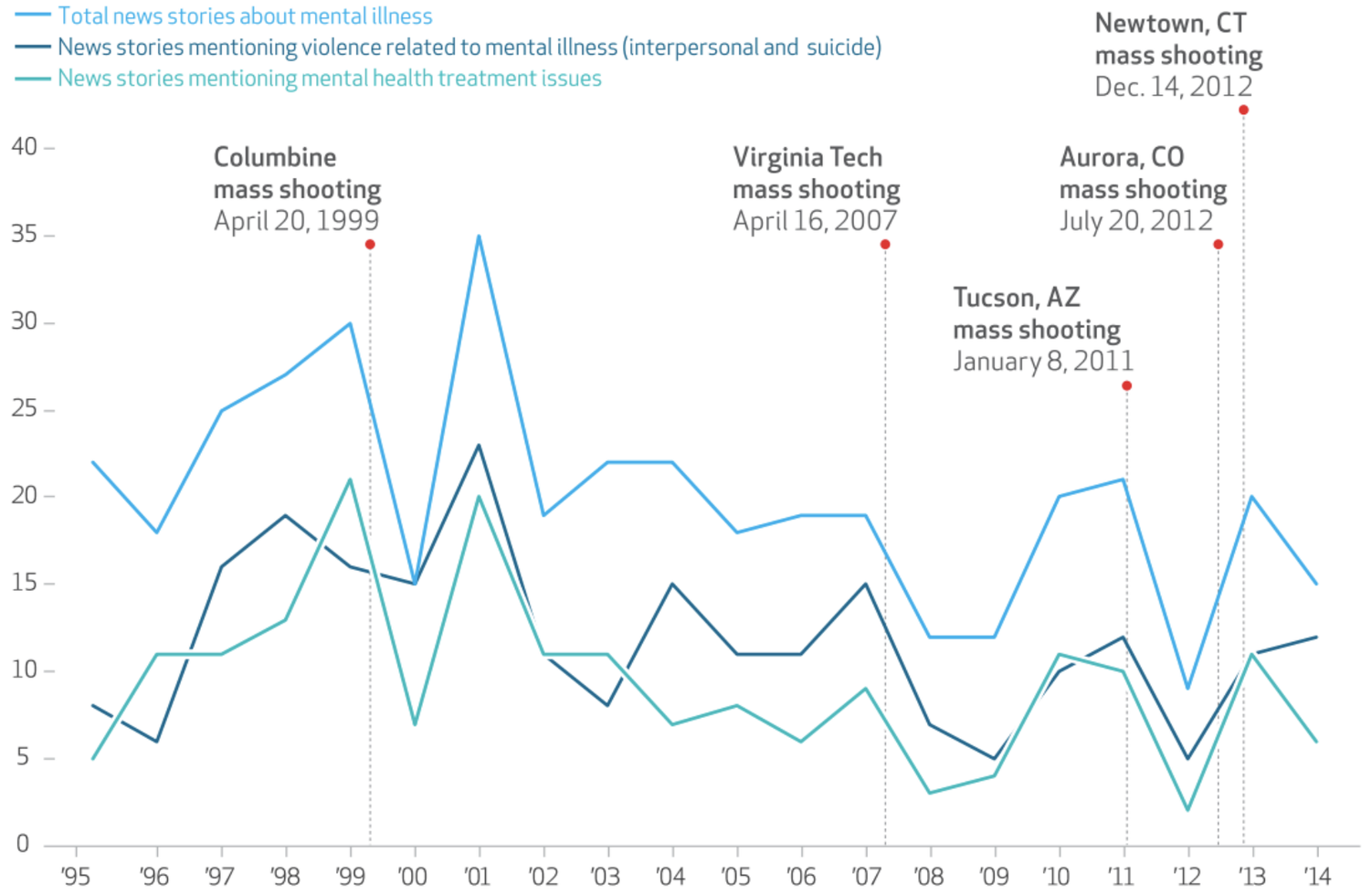
The United States is engaged in an ongoing dialogue around mental illness. Over the course of a lifetime, nearly half of all Americans will meet the criteria for a mental health disorder.[1] Mental illness is now the leading cause of disability in the United States,[2] but only about 40 percent of those affected receive treatment.[3] Poor treatment rates are a function of multiple factors, including the historically separate financing and delivery of mental health services in the United States, provider shortages, and stigma.[4–6] The past two decades have witnessed growing national awareness and discussion of these issues,[7] as well as debate of policy options to close the mental health treatment gap.[4,8] At the same time, considerable national dialogue has been devoted to the role of mental illness in interpersonal violence, a topic prompted in recent years by a series of high-profile mass shootings in which the perpetrator had a documented or purported serious mental illness, such as schizophrenia.[9,10] Rising rates of suicide, particularly among members and veterans of the US military; the overrepresentation of people with mental illness in the criminal justice system; and the development of new therapies have also been a recent focus of the national discourse over mental illness.[11–13]

An established method for assessing the national dialogue around societal issues such as mental illness is analysis of news media coverage, which is viewed as both reflecting and shaping public discourse.[14,15] News coverage reflects public discourse by reporting on the views and positions of the policy makers, advocacy groups, researchers, members of the public, and others engaged in issue debates, often directly quoting the key players.[15] News coverage shapes public discourse and attitudes about societal issues in two main ways: agenda setting and issue framing.[14,16] By focusing news coverage on certain

News Media Coverage of Mental Illness Across Time

EXHIBIT 1

Volume of US news coverage focused on mental illnesses overall, by mention of violence, and by mention of treatment



News Media Coverage of Mental Illness Across Time

EXHIBIT 3

Content and type of news stories about mental illness and interpersonal violence, 1995–2014

	1995–2014 (*N* = 152)		1995–2004 (*n* = 92)		2005–14 (*n* = 60)	
	No.	%	No.	%	No.	%
NEWS STORY MENTIONED:						
Depiction of specific violent event committed by a person with mental illness	113	74	68	74	45	75
Gun violence event	41	27	22	24	19	32
Mass shooting event	21	14	8	9	13	22**
School shooting event	13	9	6	7	7	12
Family violence event	22	14	12	13	10	17
STATEMENTS ABOUT MENTAL ILLNESSES AND INTERPERSONAL VIOLENCE						
Mental illness increases the risk of interpersonal violence	57	38	34	37	23	38
Most people with mental illnesses are not violent toward others	12	8	9	10	3	5
It is difficult to predict interpersonal violence in people with mental illnesses	2	1	1	1	1	2
SPECIFIC DIAGNOSES MENTIONED IN THE CONTEXT OF INTERPERSONAL VIOLENCE						
Schizophrenia	26	17	14	15	12	20
Depression	16	11	12	13	4	7
Bipolar disorder	4	3	2	2	2	3
Post-traumatic stress disorder	2	1	0	0	2	3
Psychotic symptoms mentioned in the context of interpersonal violence	25	17	17	18	8	13
RISK FACTORS FOR VIOLENCE						
Drug use	8	5	6	7	2	3
Stressful life event precipitating violence	8	5	5	5	3	5
Alcohol use	5	3	4	4	1	2
Abuse or trauma	1	1	1	1	0	0
TYPE OF NEWS STORY						
Print news	129	85	77	84	52	87
Front page	12	8	1	1	11	18****
Print opinion	8	5	5	5	3	5
Television news	18	12	13	14	5	8

SOURCE Authors' analysis of news media data, 1995–2014. **NOTE** Significance was determined by the use of chi-square tests to compare the proportion of news stories mentioning a given measure in the first decade of the study period (1995–2004) versus the second decade (2005–14). $^{**}p < 0.05$ $^{****}p < 0.001$

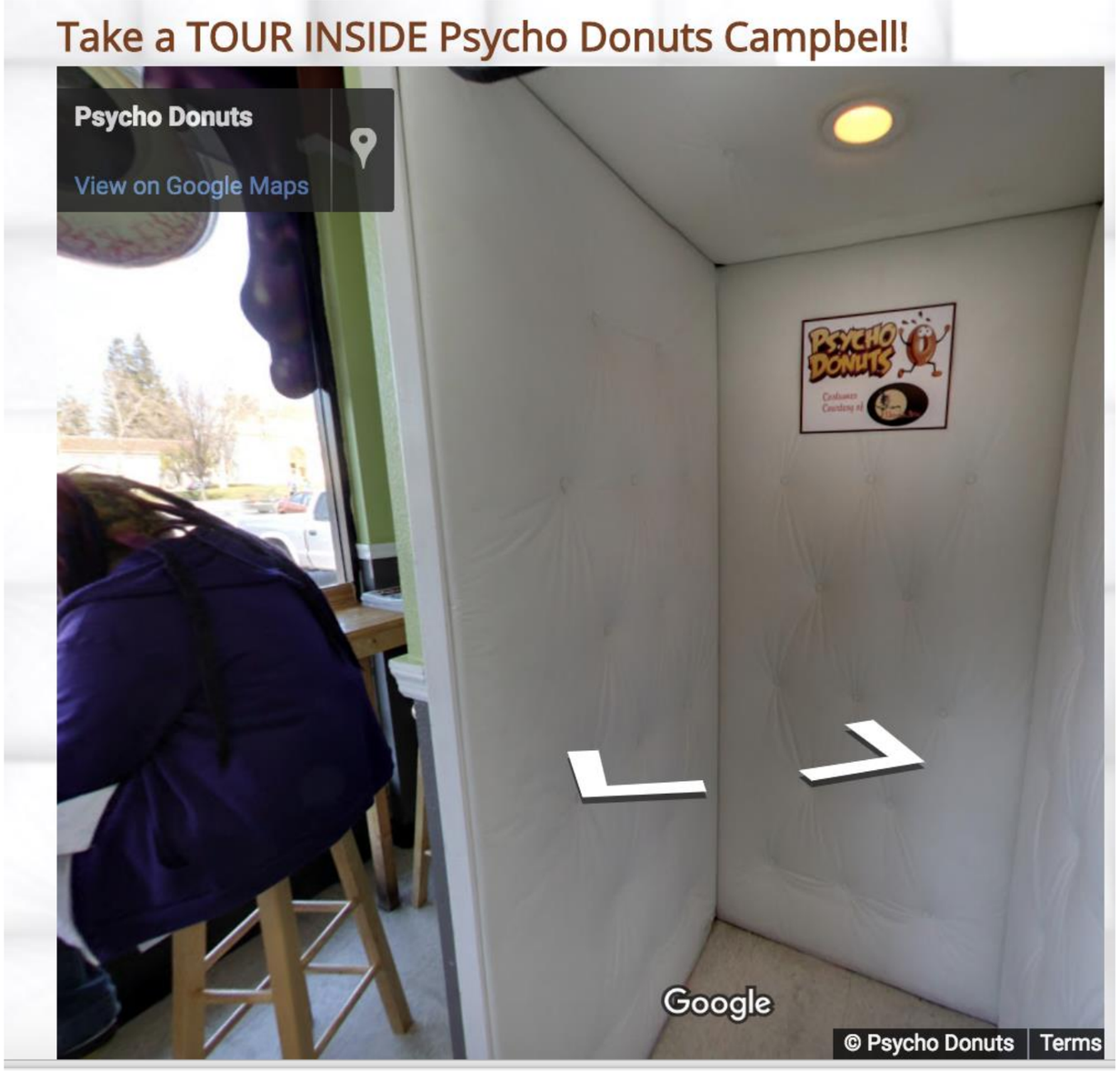
We see it in advertising…


PSYCHO DONUTS®
Crazy Good!

A trip to Psycho Donuts is a sensory experience, designed to bring out the crazy in all of us. Psycho nurses are on hand to provide bubblewrap therapy to minimize your selection anxiety. Psycho Donuts doubles as a quirky, offbeat art gallery, offering inexpensive original artwork from local artists. Take a picture in The Psycho Padded Cell; and 'donut' miss our collection of eclectic merchandise.


4:20 - ???
PSYCHO DONUTS
BATES MOTEL
VACANCY

Take a TOUR INSIDE Psycho Donuts Campbell!



Defining Mental Illness Stigma: Types x Constructs

Types

Constructs

	Public stigma	Self-Stigma	Label avoidance	Structural Stigma
Stereotype (Cognition/Belief)				
Prejudice (Emotional Reaction)				
Discrimination (Behavior)				

Adapted from Corrigan and Kosyluk (2014)

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Defining Mental Illness Stigma: Types x Constructs

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	Public stigma	Self-Stigma	Label avoidance	Structural Stigma
Stereotype (Cognition/Belief)	"People with MI are dangerous."			
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Prejudice (Emotional Reaction) ↓	"I am afraid of people with MI."			
Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."			

Adapted from Corrigan and Kosyluk (2014)

Defining Mental Illness Stigma: Types x Constructs

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Stereotype (Cognition/Belief) ↓	"People with MI are dangerous."	"People with MI are incompetent."		
Prejudice (Emotional Reaction) ↓	"I am afraid of people with MI."			
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Adapted from Corrigan and Kosyluk (2014)

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Stereotype (Cognition/Belief) ↓	"People with MI are dangerous."	"People with MI are incompetent."		
Prejudice (Emotional Reaction) ↓	"I am afraid of people with MI."	"All people with MI are worthless employees- I have a MI therefore I'd make a bad employee."		
Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."			

Adapted from Corrigan and Kosyluk (2014)

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	Public stigma	Self-Stigma	Label avoidance	Structural Stigma
Stereotype (Cognition/Belief) ↓	"People with MI are dangerous."	"People with MI are incompetent." AWARE		
Prejudice (Emotional Reaction) ↓	"I am afraid of people with MI."	"All people with MI are worthless employees- I have a MI therefore I'd make a bad employee."		
Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."	"Why try seeking a job, I wouldn't be able to succeed at it anyway."		

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Prejudice (Emotional Reaction) ↓	"I am afraid of people with MI."	"All people with MI are worthless employees- I have a MI therefore I'd make a bad employee." AGREE		
Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."	"Why try seeking a job, I wouldn't be able to succeed at it anyway."		

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Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."	"Why try seeking a job, I wouldn't be able to succeed at it anyway."		

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AWARE

AGREE

APPLY

RESULT

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Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."	"Why try seeking a job, I wouldn't be able to succeed at it anyway."	"I am not going to be seen walking into that mental health clinic, that way no one will think I'm 'crazy'."	

AWARE

AGREE

APPLY

RESULT

Adapted from Corrigan and Kosyluk (2014)

Defining Mental Illness Stigma: Types x Constructs

Types

Constructs	Public stigma	Self-Stigma	Label avoidance	Structural Stigma
Stereotype (Cognition/Belief) ↓	"People with MI are dangerous."	"People with MI are incompetent."	"People with MI are 'crazy.'"	"People with MI have control over their illness, whereas people with breast cancer do not.."
Prejudice (Emotional Reaction) ↓	"I am afraid of people with MI."	"All people with MI are worthless employees- I have a MI therefore I'd make a bad employee."	"All people with MI are crazy- I am afraid to be labeled as 'crazy.'"	
Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."	"Why try seeking a job, I wouldn't be able to succeed at it anyway."	"I am not going to be seen walking into that mental health clinic, that way no one will think I'm 'crazy'."	

AWARE

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Prejudice (Emotional Reaction) ↓	"I am afraid of people with MI."	"All people with MI are worthless employees- I have a MI therefore I'd make a bad employee."	"All people with MI are crazy- I am afraid to be labeled as 'crazy.'"	"People with mental illness are to blame for their mental illness and don't deserve the same coverage as people with cancer.."
Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."	"Why try seeking a job, I wouldn't be able to succeed at it anyway."	"I am not going to be seen walking into that mental health clinic, that way no one will think I'm 'crazy'."	

AWARE

AGREE

APPLY

RESULT

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Discrimination (Behavior)	"I will not hire people with MI- I need to look out for my safety and that of my other employees."	"Why try seeking a job, I wouldn't be able to succeed at it anyway."	"I am not going to be seen walking into that mental health clinic, that way no one will think I'm 'crazy'."	Lack of Mental Health Parity

AWARE

AGREE

APPLY

RESULT

Adapted from Corrigan and Kosyluk (2014)

Common Stereotypes

- Dangerousness
  - Unpredictable
  - Violent
- Responsibility
  - Blame and Shame
  - Onset Responsibility
  - Offset Responsibility
- Incompetence

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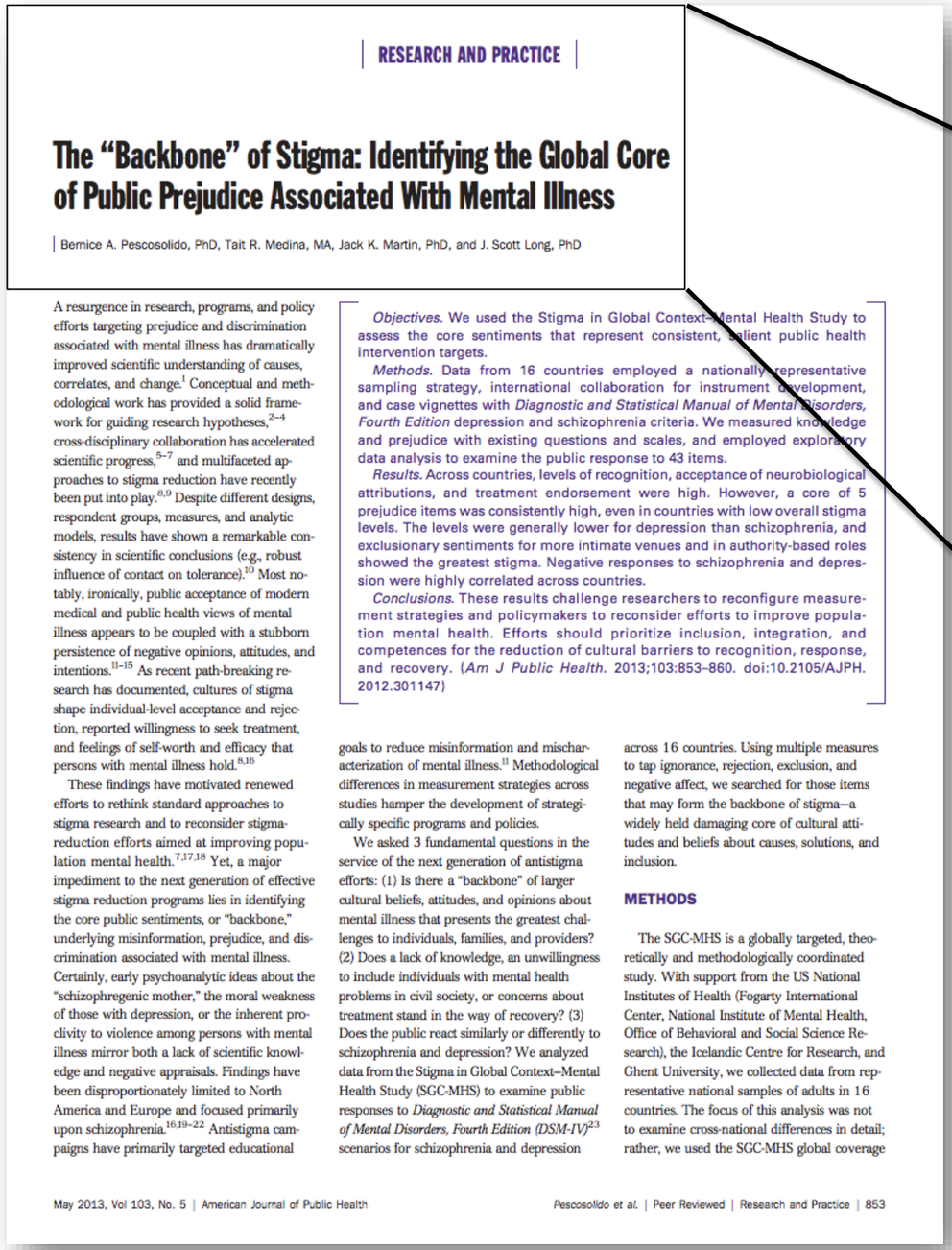
  - Offset Responsibility
- Incompetence

Corresponding Prejudice

- Fear
- Anger
- Pity



RESEARCH AND PRACTICE

The "Backbone" of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness

Bernice A. Pescosolido, PhD, Tait R. Medina, MA, Jack K. Martin, PhD, and J. Scott Long, PhD

Objectives. We used the Stigma in Global Context–Mental Health Study to assess the core sentiments that represent consistent, salient public health intervention targets.

Methods. Data from 16 countries employed a nationally representative sampling strategy, international collaboration for instrument development, and case vignettes with *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* depression and schizophrenia criteria. We measured knowledge and prejudice with existing questions and scales, and employed exploratory data analysis to examine the public response to 43 items.

Results. Across countries, levels of recognition, acceptance of neurobiological attributions, and treatment endorsement were high. However, a core of 5 prejudice items was consistently high, even in countries with low overall stigma levels. The levels were generally lower for depression than schizophrenia, and exclusionary sentiments for more intimate venues and in authority-based roles showed the greatest stigma. Negative responses to schizophrenia and depression were highly correlated across countries.

Conclusions. These results challenge researchers to reconfigure measurement strategies and policymakers to reconsider efforts to improve population mental health. Efforts should prioritize inclusion, integration, and competences for the reduction of cultural barriers to recognition, response, and recovery. (*Am J Public Health.* 2013;103:853–860. doi:10.2105/AJPH.2012.301147)

A resurgence in research, programs, and policy efforts targeting prejudice and discrimination associated with mental illness has dramatically improved scientific understanding of causes, correlates, and change.[1] Conceptual and methodological work has provided a solid framework for guiding research hypotheses,[2–4] cross-disciplinary collaboration has accelerated scientific progress,[5–7] and multifaceted approaches to stigma reduction have recently been put into play.[8,9] Despite different designs, respondent groups, measures, and analytic models, results have shown a remarkable consistency in scientific conclusions (e.g., robust influence of contact on tolerance).[10] Most notably, ironically, public acceptance of modern medical and public health views of mental illness appears to be coupled with a stubborn persistence of negative opinions, attitudes, and intentions.[11–15] As recent path-breaking research has documented, cultures of stigma shape individual-level acceptance and rejection, reported willingness to seek treatment, and feelings of self-worth and efficacy that persons with mental illness hold.[8,16]

These findings have motivated renewed efforts to rethink standard approaches to stigma research and to reconsider stigma-reduction efforts aimed at improving population mental health.[7,17,18] Yet, a major impediment to the next generation of effective stigma reduction programs lies in identifying the core public sentiments, or "backbone," underlying misinformation, prejudice, and discrimination associated with mental illness. Certainly, early psychoanalytic ideas about the "schizophregenic mother," the moral weakness of those with depression, or the inherent proclivity to violence among persons with mental illness mirror both a lack of scientific knowledge and negative appraisals. Findings have been disproportionately limited to North America and Europe and focused primarily upon schizophrenia.[16,19–22] Antistigma campaigns have primarily targeted educational goals to reduce misinformation and mischaracterization of mental illness.[11] Methodological differences in measurement strategies across studies hamper the development of strategically specific programs and policies.

We asked 3 fundamental questions in the service of the next generation of antistigma efforts: (1) Is there a "backbone" of larger cultural beliefs, attitudes, and opinions about mental illness that presents the greatest challenges to individuals, families, and providers? (2) Does a lack of knowledge, an unwillingness to include individuals with mental health problems in civil society, or concerns about treatment stand in the way of recovery? (3) Does the public react similarly or differently to schizophrenia and depression? We analyzed data from the Stigma in Global Context–Mental Health Study (SGC-MHS) to examine public responses to *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*[23] scenarios for schizophrenia and depression across 16 countries. Using multiple measures to tap ignorance, rejection, exclusion, and negative affect, we searched for those items that may form the backbone of stigma—a widely held damaging core of cultural attitudes and beliefs about causes, solutions, and inclusion.

METHODS

The SGC-MHS is a globally targeted, theoretically and methodologically coordinated study. With support from the US National Institutes of Health (Fogarty International Center, National Institute of Mental Health, Office of Behavioral and Social Science Research), the Icelandic Centre for Research, and Ghent University, we collected data from representative national samples of adults in 16 countries. The focus of this analysis was not to examine cross-national differences in detail; rather, we used the SGC-MHS global coverage

RESEARCH AND PRACTICE

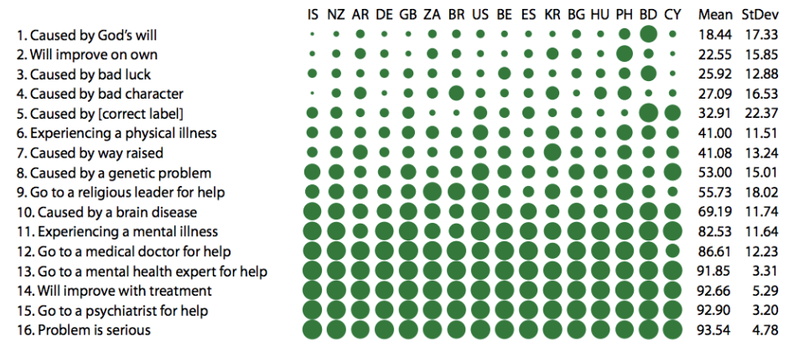
The "Backbone" of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness

Bernice A. Pescosolido, PhD, Tait R. Medina, MA, Jack K. Martin, PhD, and J. Scott Long, PhD

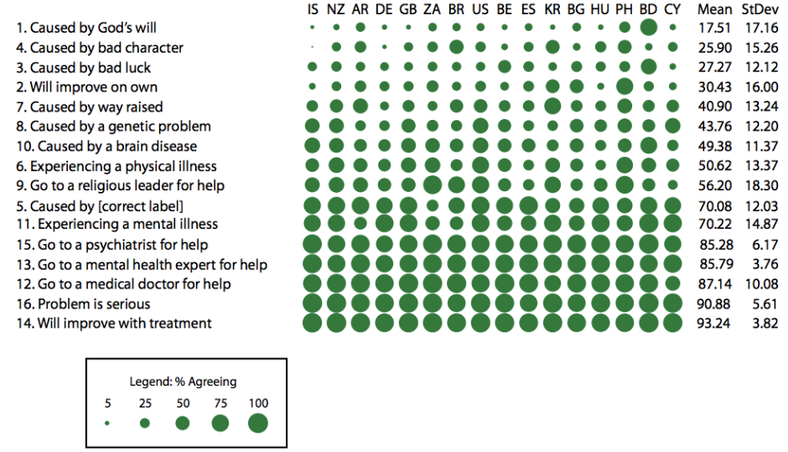
(Pescosolido, Medina, & Long, 2013)

Public Response to Mental Health Knowledge, Beliefs, and Treatment Endorsements

a



b

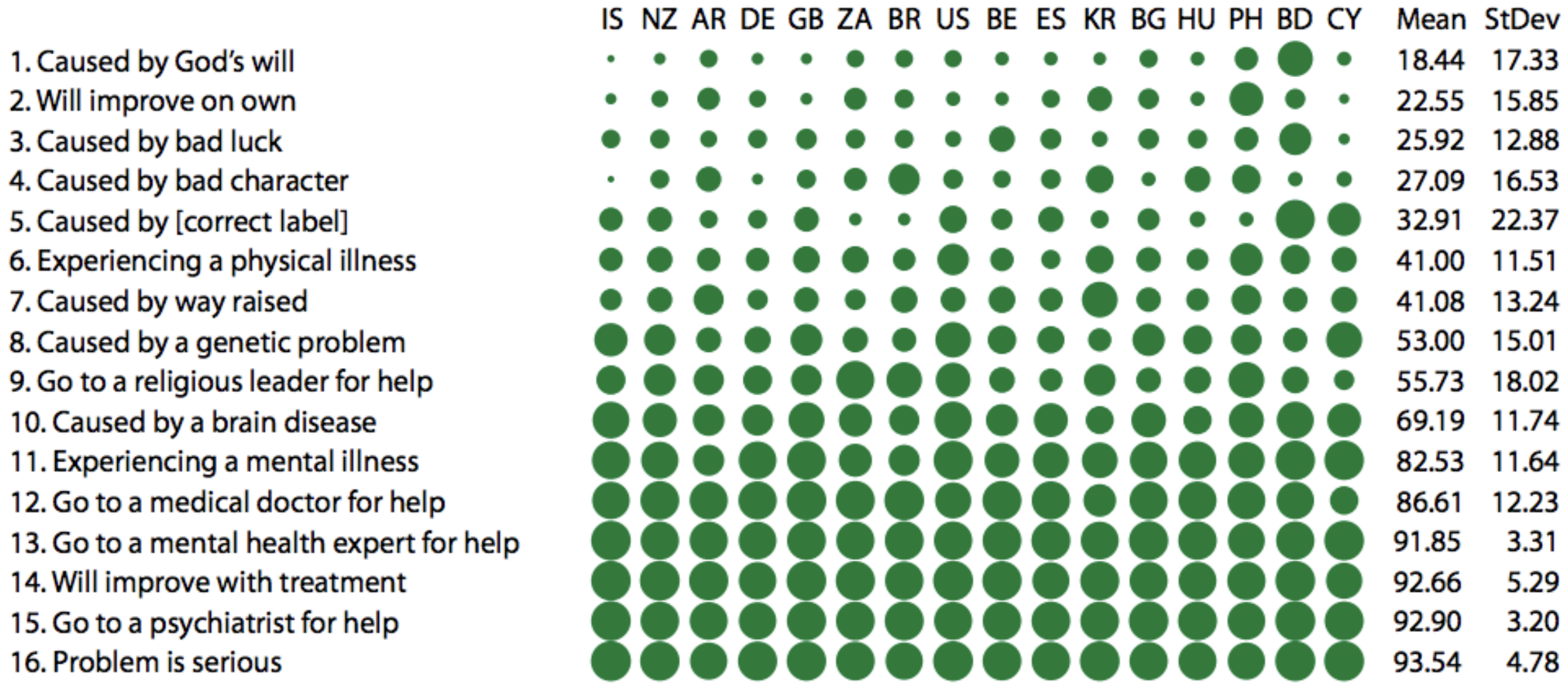


Note. AR = Argentina (South America; n = 1420); BD = Bangladesh (Asia; n = 1501); BE = Belgium (Europe; n = 1166); BG = Bulgaria (Europe n = 1121); BR = Brazil (South America; n = 1522); CY = Cyprus (Europe; n = 804); DE = Germany (Europe; n = 1255); ES = Spain (Europe; n = 1206); GB = Great Britain (Europe; n = 1030); HU = Hungary (Europe; n = 1252); IS = Iceland (Europe; n = 1033); KO = South Korea (Asia; n = 1003); NZ = New Zealand (Australia; n = 1020); PH = Philippines (Asia; n = 1200); US = United States (North America; n = 1425); ZA = South Africa (Africa; n = 1550). Area of circle corresponds to percentage agreeing on each item in each country. Items are ordered from low to high according to across-country mean percentage agreeing (second-to-last column) and countries are ordered from low to high according to across-item mean percentage stigmatizing. The sample sizes were n = 6542 for schizophrenia and n = 6539 for depression.

FIGURE 1—Public response on mental health knowledge, beliefs, and treatment endorsements for (a) schizophrenia and (b) depression: Stigma in Global Context–Mental Health Study, 2004–2012.

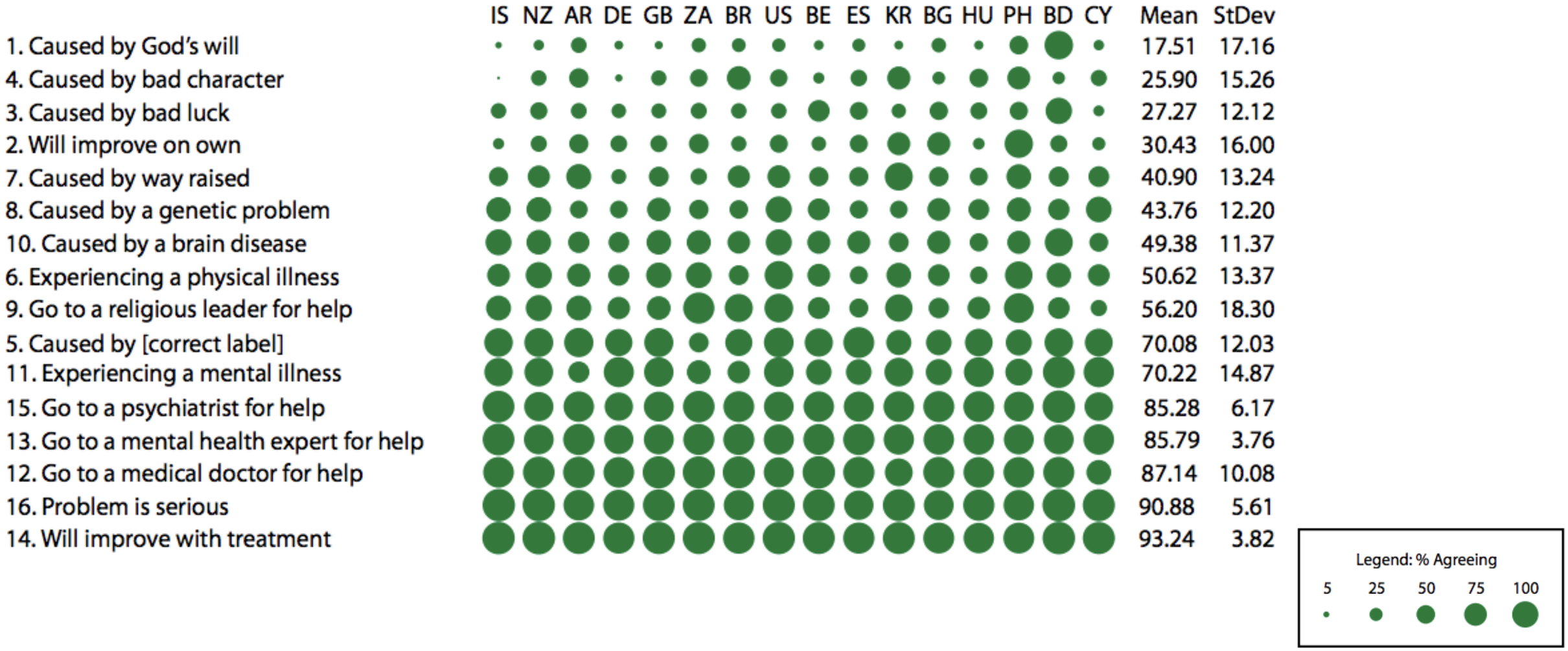
Public Response to Mental Health Knowledge, Beliefs, and Treatment Endorsements: Schizophrenia

a

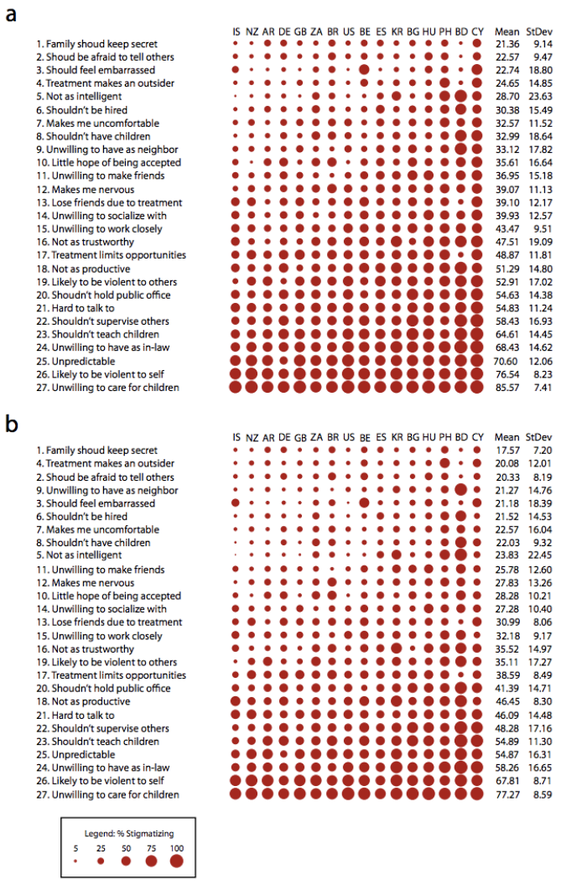


Public Response to Mental Health Knowledge, Beliefs, and Treatment Endorsements: Depression

b



Public Response to Stigma Items

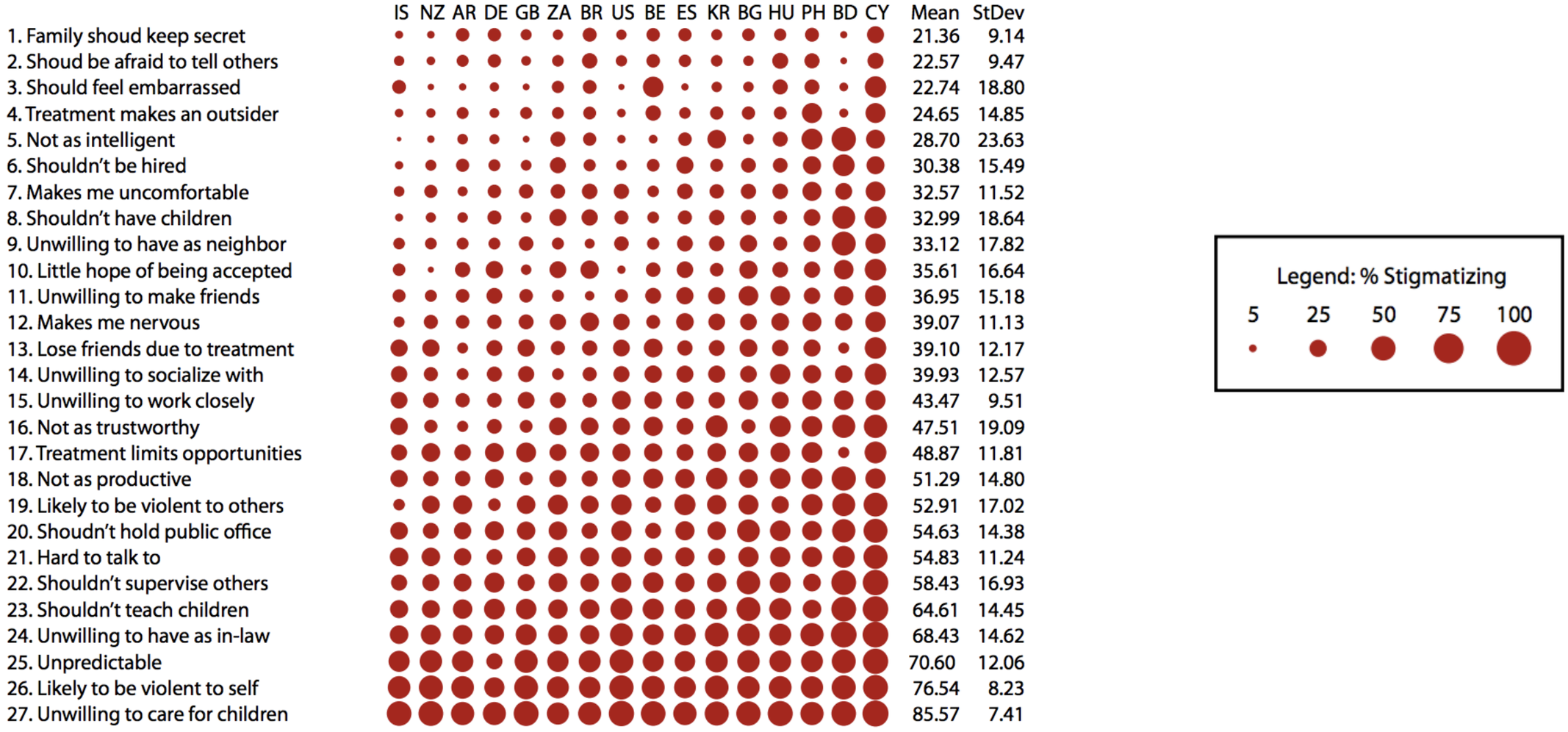


Note. AR = Argentina (South America; n = 1420); BD = Bangladesh (Asia; n = 1501); BE = Belgium (Europe; n = 1166); BG = Bulgaria (Europe n = 1121); BR = Brazil (South America; n = 1522); CY = Cyprus (Europe; n = 804); DE = Germany (Europe; n = 1255); ES = Spain (Europe; n = 1206); GB = Great Britain (Europe; n = 1030); HU = Hungary (Europe; n = 1252); IS = Iceland (Europe; n = 1033); KO = South Korea (Asia; n = 1003); NZ = New Zealand (Australia; n = 1020); PH = Philippines (Asia; n = 1200); US = United States (North America; n = 1425); ZA = South Africa (Africa; n = 1550). Area of circle corresponds to percentage stigmatizing on each item in each country. The sample sizes were n = 6542 for schizophrenia and n = 6539 for depression.

FIGURE 2—Public response to stigma items for (a) schizophrenia and (b) depression: Stigma in Global Context–Mental Health Study, 2004–2012.

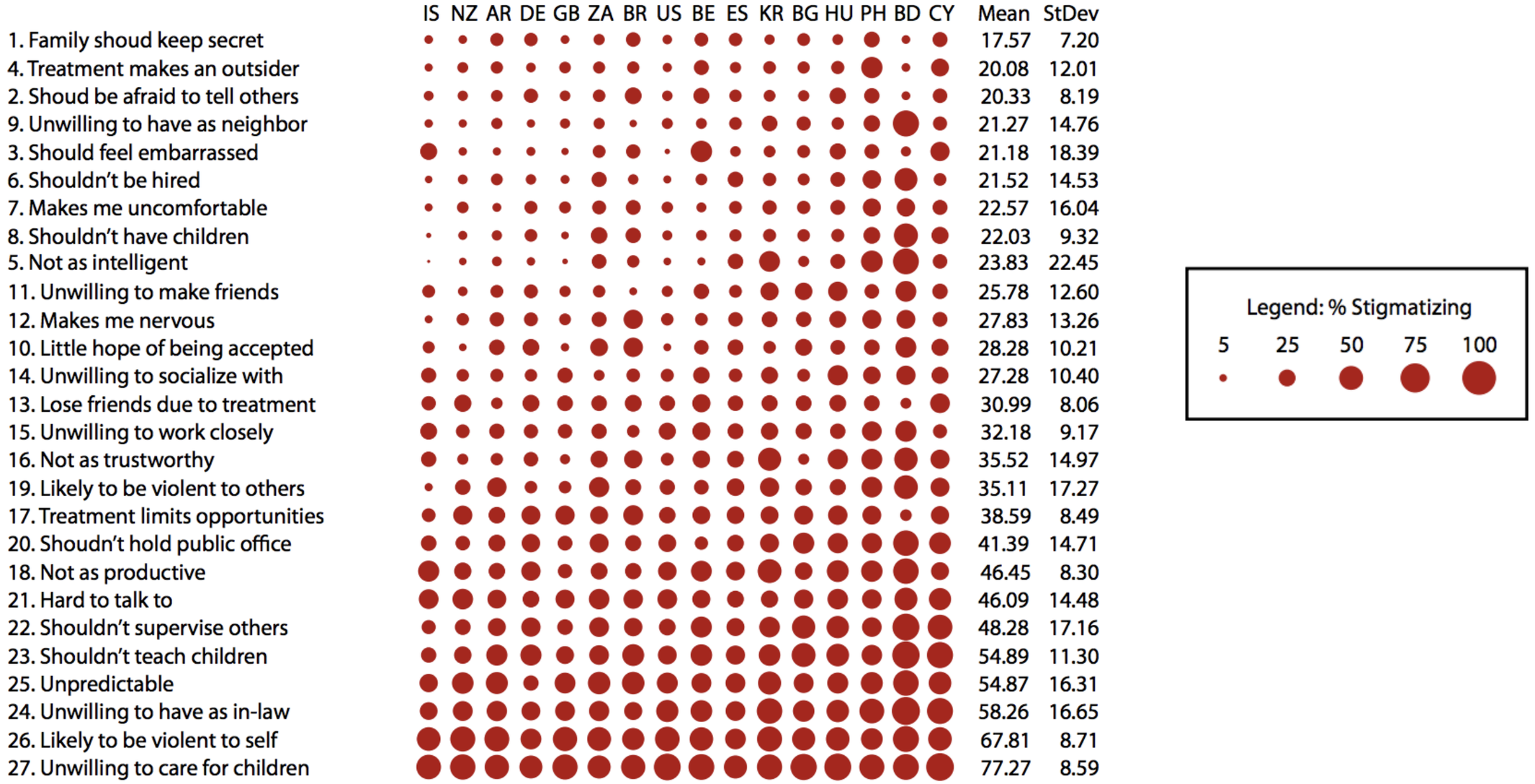
Public Response to Stigma Items: Schizophrenia

a



Public Response to Stigma Items: Depression

b



Consequences of Stigma *DISCRIMINATION*

- Stigma is one of the greatest barriers individuals with mental illness face in achieving life goals (Corrigan, Larson, & Rusch, 2009)
  - Employment (Corrigan & Penn, 1999; Stuart, 2006)
    - Refusal to hire (Thompson v. Selective Personnel, 2009).
    - Lower level jobs with fewer opportunities for advancement (Stuart, 2007).
  - Participation in Postsecondary Education (Breslau, Lane, Sampson, & Kessler, 2008; Salzer, 2012)
  - Social Isolation (Corrigan & Penn, 1999)

Consequences of Stigma *DISCRIMINATION*

- Mental Health Treatment Participation/Service Utilization (Corrigan, 2004; Corrigan, Druss, & Perlick, 2014; Henderson, Evans-Lacko, & Thornicroft, 2013)
- Barrier to Healthcare (Corrigan et al., 2014; Knaak, Mantler, & Szeto, 2017)
- May prolong course of illness (Surgeon Generals Report, 1999)

DISCRIMINATION
in Treatment Settings

- “People with mental illnesses and their families routinely report that the attitudes and [behaviors] of health and mental health professionals exacerbate their experiences with stigma” (Livingston, 2013).

DISCRIMINATION
in Treatment Settings

- Physical ailments ignored or rejected.
- Failure to educate people on their illness and/or medication side effects.
- Using legal leverage and coercion to gain treatment compliance.
- Tolerating routine application of dehumanizing practices.
- Excluding people with mental illness from the treatment process/ adopting paternalistic stance.

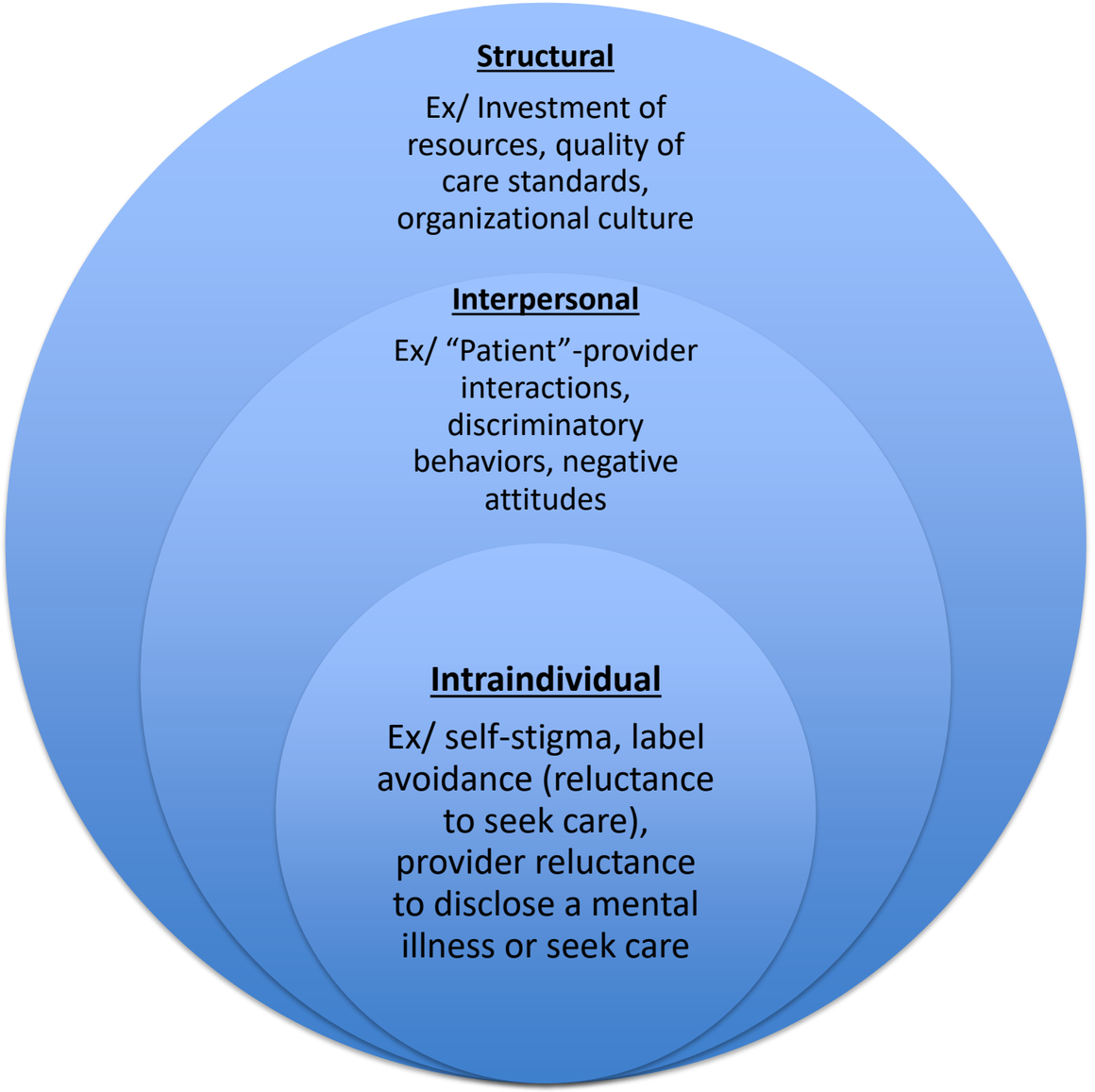
DISCRIMINATION
in Criminal Justice Settings

- People with mental illness grossly over-represented in the criminal justice system (Fazel & Danesh, 2002).
- Factors that influence mental health are generally the same as those that influence crime (ex/ poverty, unemployment, lack of education, poor living conditions, inequitable access to wealth, power, and resources) (Dumont, Brockmann, Dickman, Alexander, & Rich, 2013; Lurigio, 2011).

DISCRIMINATION
in Criminal Justice Settings

- Structural stigma that materializes in other domains (i.e. employment, housing) can put people at risk for conflict with the law (Livingston, 2013)
- Some evidence suggests that criminal justice professionals (i.e. police, judges, and correctional officers; Black & Downie, 2010) routinely endorse stereotypes about mental illnesses, which then effect policy and practice.
  - People with mental illness on probation tend to be subjected to supervision th at is more intensive.
  - Presence of mental illness appears to lower probation officers' threshold for br eaching people under their supervision (Eno Louden, & Skeem, 2012).

Discrimination is a Multilevel Phenomenon



Livingston (2013)

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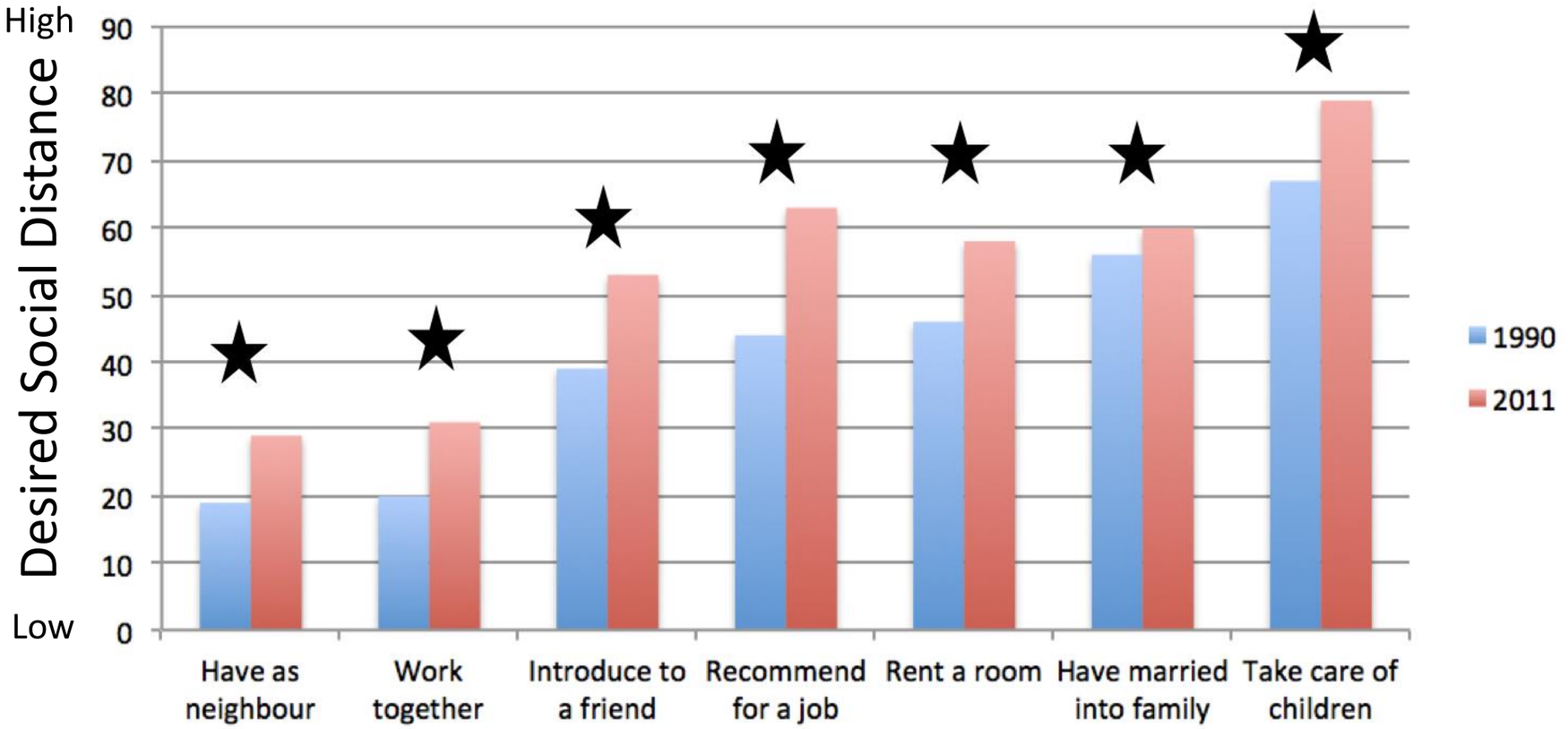
Desired Social Distance and Schizophrenia



(Angermeyer, Matschinger, & Schomerus, 2013)

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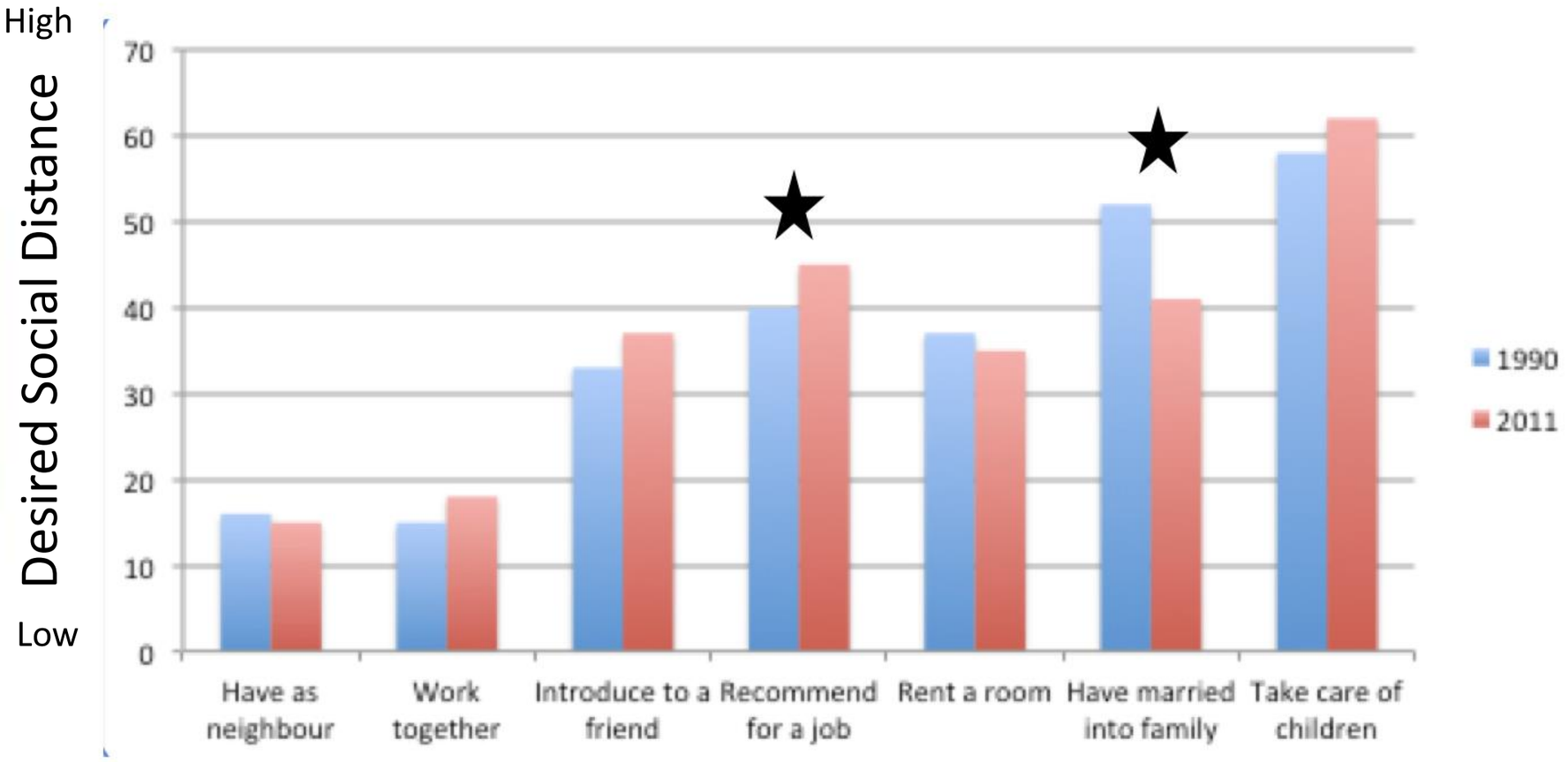
Desired Social Distance and Depression



(Angermeyer, Matschinger, & Schomerus, 2013)

PUBLIC OPINION

By Bernice A. Pescosolido, Bianca Manago, and John Monahan

Evolving Public Views On The Likelihood Of Violence From People With Mental Illness: Stigma And Its Consequences

DOI: 10.1377/hlthaff.2019.00702
HEALTH AFFAIRS 38,
NO. 10 (2019): 1735–1743

ABSTRACT **Highly publicized acts of violence routinely spark reactions that place blame on the perpetrator's presumed mental illness. Despite solid evidence that people with mental illness are unlikely to be dangerous, such prejudice can lead to support for inappropriately using legal means to force people into treatment. We examined trends in public perceptions of violence and support for coerced treatment across a twenty-two-year period using data from three National Stigma Studies. The studies gave respondents one of three vignettes describing people who met clinical criteria for mental disorders or one describing a person with nonclinical "daily troubles." Perceptions regarding potential violence and support for coercion generally rose over time—significantly so for schizophrenia. By 2018 over 60 percent of respondents saw people who met criteria for schizophrenia as dangerous to others, and 44–59 percent supported coercive treatment. Sixty-eight percent saw people with alcohol dependence as dangerous to others, and 26–38 percent supported coercion. Lower but substantial percentages were reported for people with depression and, remarkably, for those with nonclinical "daily troubles," who were viewed as dangerous. These findings reflect political discourse, not scientific data, and could lead to policies that would be ineffective and misdirect the search for the underlying roots of violence while unnecessarily increasing stigma toward people with mental illness.**

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John Monahan is the John S. Shannon Distinguished Professor of Law at the University of Virginia School of Law, in Charlottesville.

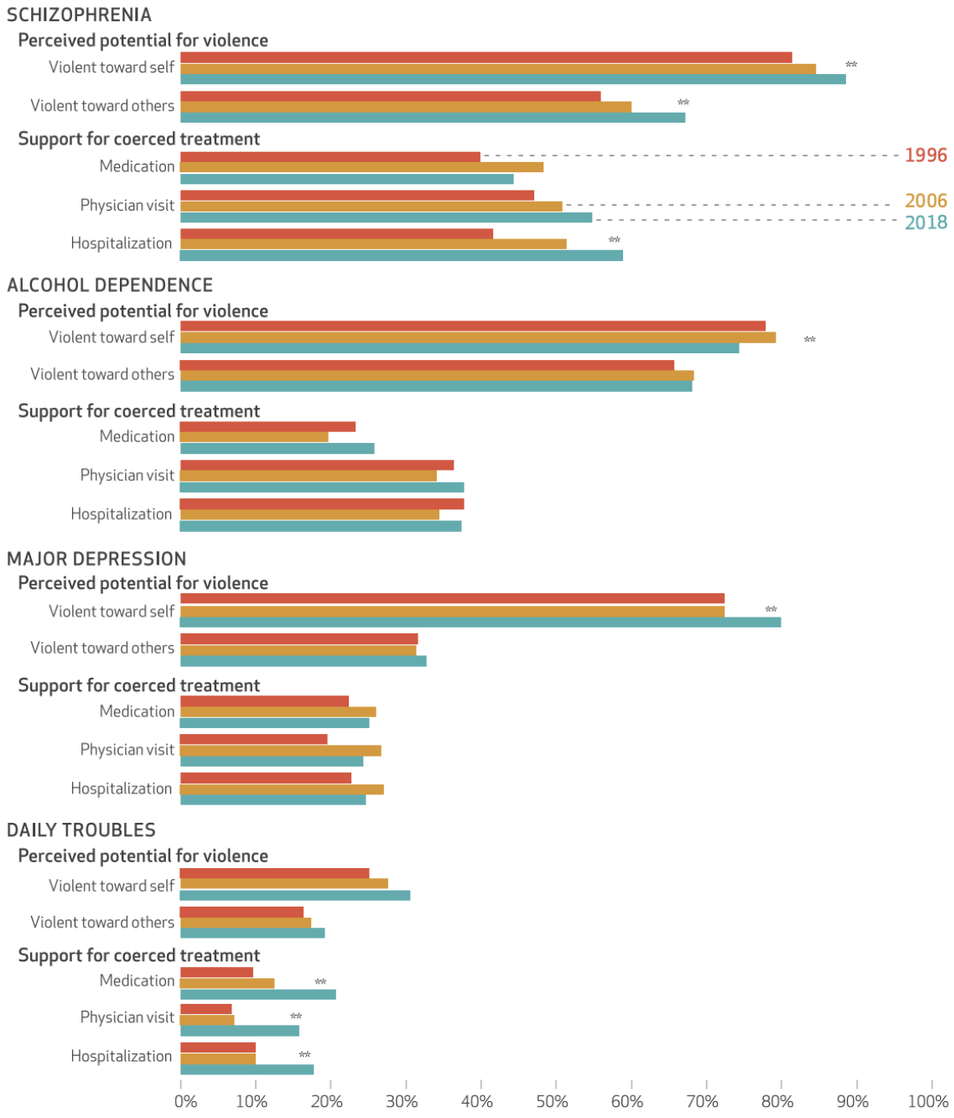
Issues of violence and danger are front and center in the minds of the American public. Just under half of the population fears random mass shootings (41.5 percent) and terrorist attacks (43.8 percent).[1] As witnessed in political debates, including presidential ones, public responses to these concerns have become routine.[2] Public health advocates focus on gun control as a policy solution, while others—most notably the National Rifle Association—point to the dangerousness of people with mental illness and the need for a national database of such people and greater treatment availability.[2] The tenor of these debates remains the same even though the link between violence and mental illness has been scientifically documented to be weak, at best, for at least three decades.[3,4] A recent review concluded, "Even if we had a cure for serious mental illnesses that completely eliminated active psychotic and mood disorders, the problem of interpersonal violence in the population would be reduced only by an estimated 4%, while 96% of violent acts would still occur."[5(p368)]

As a result, mental health advocates face a "painful dilemma":[2] How can they counter the dangerousness stereotype while fostering public policy discussions about much-needed resources for public mental health services? Ironically, this dilemma harks back to a long-held contention by

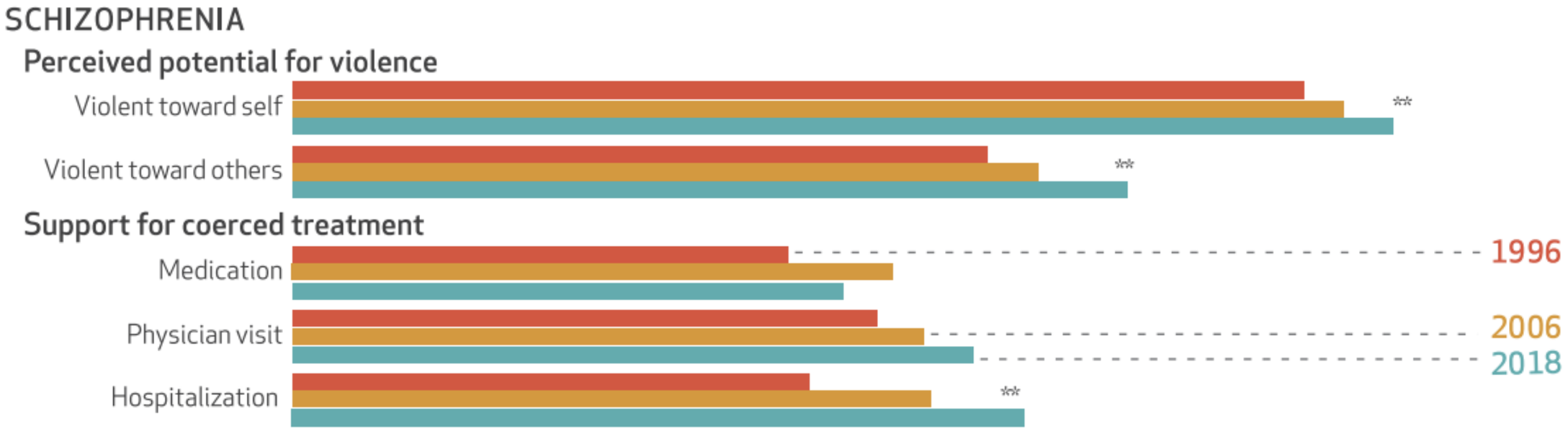
(Pescosolido, Manago, & Monahan, 2019)

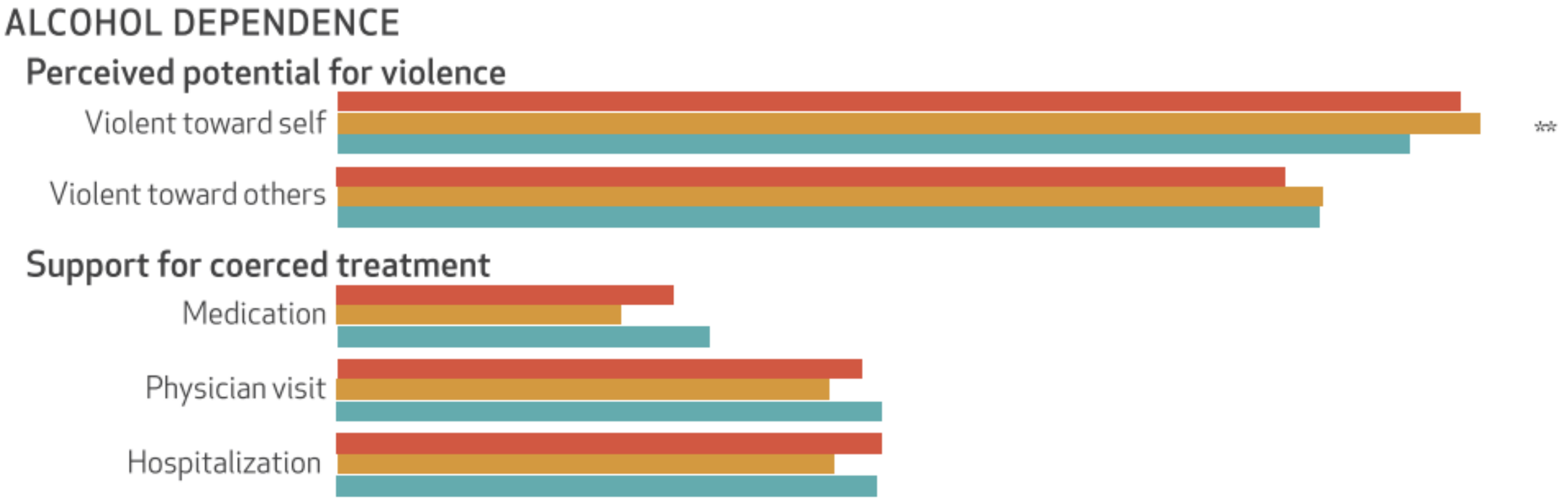
EXHIBIT 1

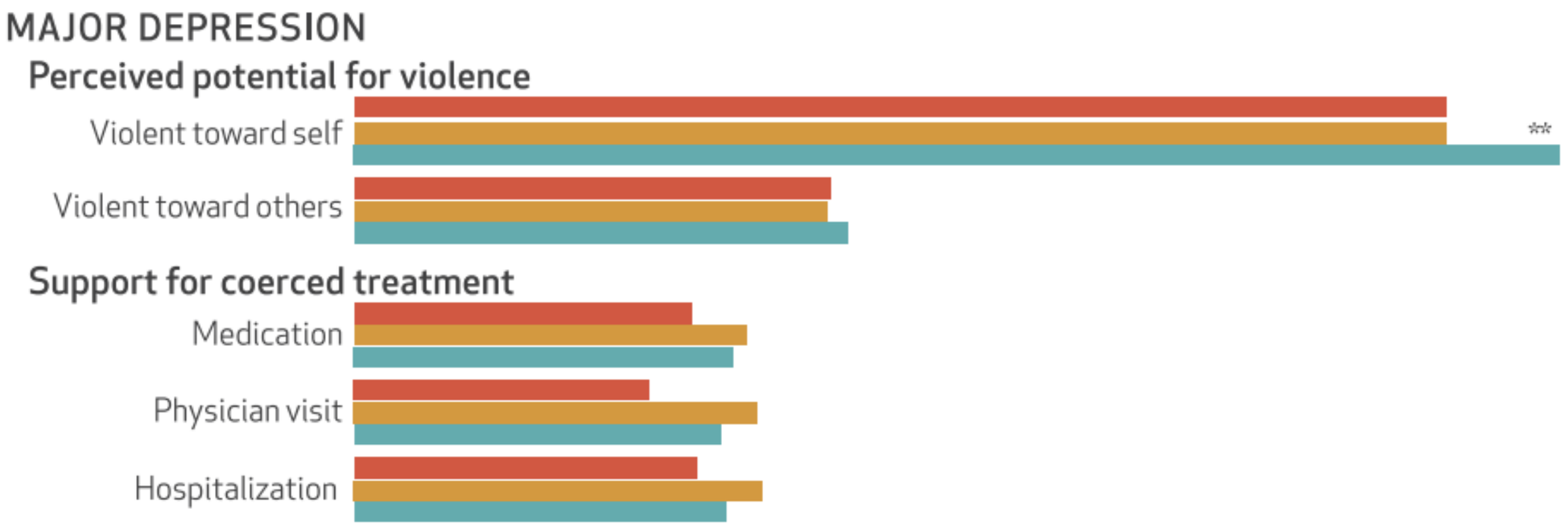
Unadjusted percent of respondents to the 1996, 2006, and 2018 National Stigma Studies who rated the potential for violence of, and their support for coerced treatment for, people with mental illness in study vignettes



SOURCE Authors' analysis of data from the 1996, 2006, and 2018 National Stigma Studies. **NOTE** Homicides include deaths related to legal intervention (for example, police-involved shootings).


SCHIZOPHRENIA
Perceived potential for violence
Violent toward self
**
Violent toward others
**
Support for coerced treatment
Medication
Physician visit
Hospitalization
**
1996
2006
2018


ALCOHOL DEPENDENCE
Perceived potential for violence
Violent toward self
**
Violent toward others
Support for coerced treatment
Medication
Physician visit
Hospitalization


MAJOR DEPRESSION
Perceived potential for violence
Violent toward self
**
Violent toward others
Support for coerced treatment
Medication
Physician visit
Hospitalization

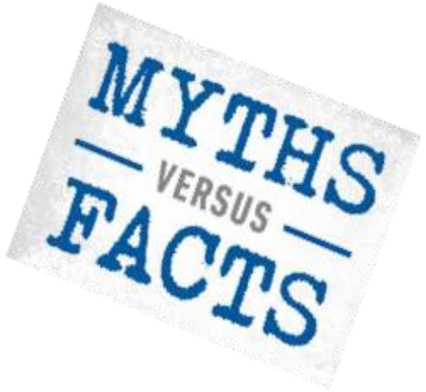
DAILY TROUBLES

Perceived potential for violence

Support for coerced treatment

Common Public Stigma Change Strategies

- Protest
- Education
- Contact



Common Public Stigma Change Strategies

- Protest
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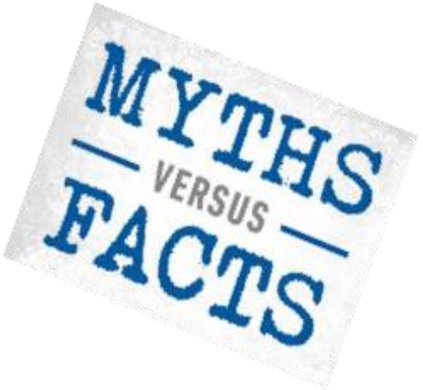

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How to address stigma in your setting?

- Invest in contact-based strategies and seek out credible people to deliver the message.
  - Examples: NAMI Peer-to-Peer, This Is My Brave
  - Relatedly: Employ and value the unique contributions of peer providers.
- Invest in evidence-based education strategies.
  - Examples: Crisis Intervention Team Training for Law Enforcement, Mental Health First Aid
- Use person first language.
  - Person with schizophrenia NOT “schizophrenic.”
- Examine everything through the lens of a person with a behavioral health condition and their loved ones.

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