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Stigma and discrimination in mental illness: Time to Change

On Jan 21, 2009, the largest ever programme in England to reduce stigma and discrimination against people with mental health disorders was launched, called Time to Change.¹ The initiative is funded with £18 million from the Big Lottery Fund and Comic Relief to run until September, 2011, and is being run by three charities: Mental Health Media, MIND, and Rethink. The evaluation partner is the UK's Institute of Psychiatry at King's College London. Here we describe this programme and how it is being evaluated.

Time to Change uses coordinated action at national and local levels to engage individuals, communities, and stakeholder organisations—such as statutory health services and professional membership groups—to take part. For example, mass physical exercise events held annually during Mental Health Awareness Week (called Get Moving!) facilitate social contact between people with and without experience of mental health disorders.

The national campaign uses bursts of mass-media advertising and public relations exercises. Its key messages are: (1) mental illnesses are common and people with such disorders can lead meaningful lives; (2) mental illness is our last taboo, such that the accompanying discrimination and exclusion can affect people in a way that many describe as worse than the illness itself; and (3) we can all do something to help people with mental illness. This call to action encourages people to support those they know with mental illness—eg, by maintaining social contact.

Two types of projects for people with mental health disorders are ongoing. 28 local schemes promote mental and physical wellbeing, and 32 antidiscrimination initiatives (Open Up) aim to empower people through consciousness raising groups and antidiscrimination projects.

For targeted groups (medical students, trainee teachers, trainee head teachers, social inclusion officers), Education

not Discrimination uses social contact to educate, change attitudes, and reduce discrimination.^{2–7} Time to Challenge aims to augment employers' knowledge of discrimination related to mental health with respect to employment and will help people take legal action against organisations that have discriminated.

Our evaluation of Time to Change is based on a conceptual framework that describes stigma as consisting of difficulties of knowledge (ignorance or misinformation), attitudes (prejudice), and behaviour (discrimination).⁸ The figure, adapted from the final report of the Foresight mental capital and wellbeing project,⁹ outlines a systemic model of these relations to show how Time to Change components will work against factors that contribute to stigma and discrimination, and how our evaluation will measure the programme's success.

The right side of the figure shows sources of discrimination. Here, we see that without specific knowledge of mental illness (ignorance), cultural stereotypes and myths can lead to misinformation that—combined with general beliefs about people different to oneself—could create prejudicial attitudes. These attitudes can lead to social mistreatment or material discrimination.

To the left of the figure we see targets of discrimination. These show the effect of discrimination and social mistreatment on physical and mental health. Negative emotional responses to discrimination are also indicated; loss of confidence and self-esteem are made worse by behavioural responses to the anticipation of further discrimination, such as avoidance.

Every year from 2009 to 2011, we will assess knowledge, attitudes, and behaviour, using the UK's Department of Health's national public attitudes to mental illness survey.¹⁰ In collaboration with SHiFT,¹¹ which commissioned this survey on attitudes, we have developed and added the mental health knowledge

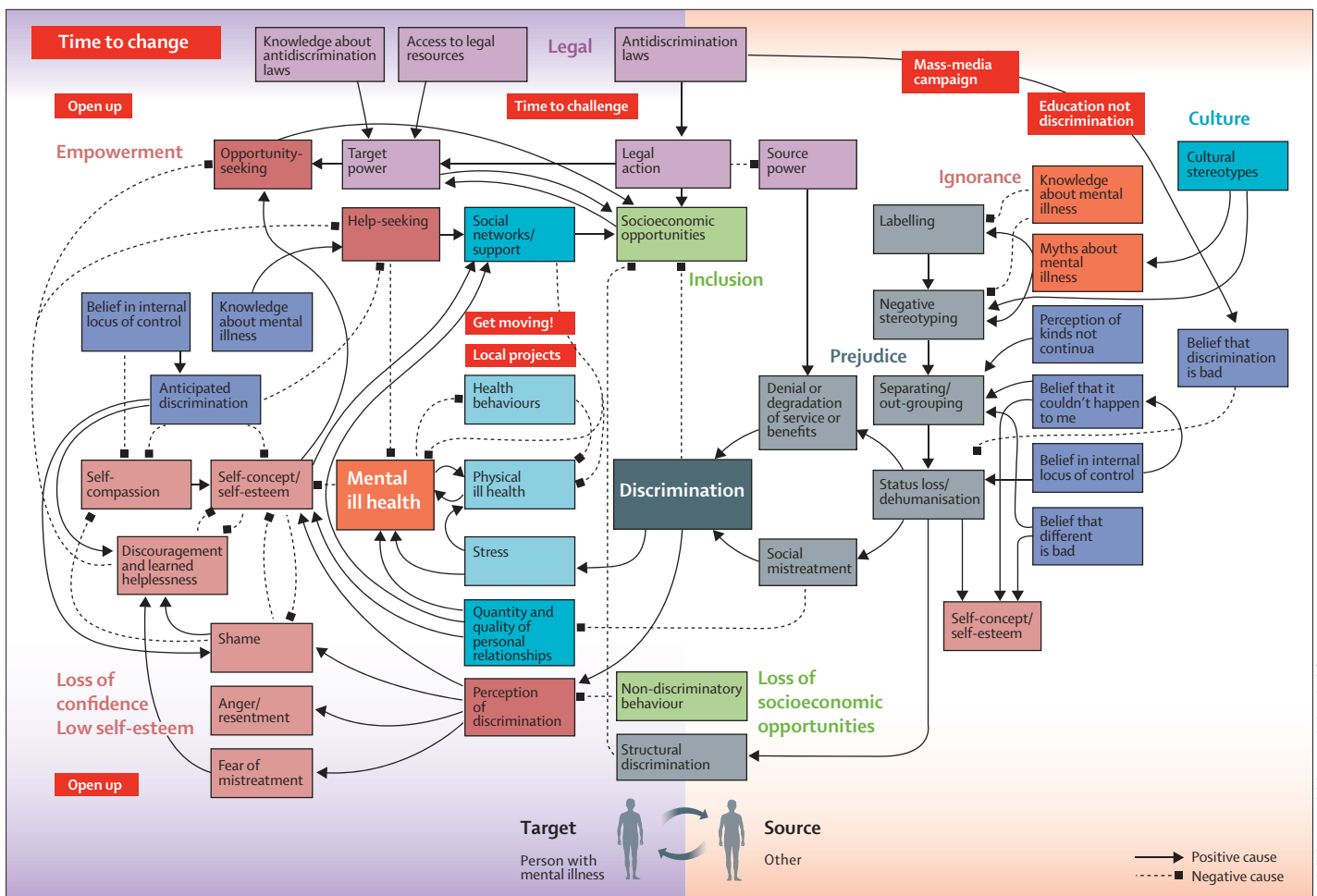


Figure: Systemic model of contributing factors to stigma and discrimination. Red boxes=Time to Change components. Adapted from reference 9.

schedule and the reported and intended behaviour scale to pre-existing attitude questions. Selected knowledge, attitudes, and behaviour questions from the Department of Health survey will also be used to evaluate the effect of interventions for specific target groups.

To assess the effect of the Time to Change programme on people with mental health disorders, the Viewpoint survey (a component of the Time to Change evaluation, commissioned by SHiFT) will use the discrimination and stigma scale¹² annually to assess individuals' experiences of discrimination within the previous 12 months. We will also analyse press coverage of topics related to mental health over the course of the programme.

Stigma and discrimination about mental illness are worldwide issues.^{12,13} We aim to make our results informative to organisations elsewhere that are considering anti-stigma programmes. Showing that measurable

change is possible would bring hope to people whose aspirations are frustrated by discrimination.

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Recent developments in hyperthyroidism

Since the Seminar in *The Lancet* on hyperthyroidism in 2003,¹ several reports have enhanced our understanding of the end-organ manifestations of subclinical and overt hyperthyroidism, provided data that help refine therapeutic decision making, and suggested novel approaches to the treatment of Graves' disease.

In mild (ie, subclinical) hyperthyroidism, patients' serum levels of free thyroxine and tri-iodothyroxine or free tri-iodothyroxine are within the broad range of normal, but the serum concentration of thyroid-stimulating hormone (TSH) is subnormal, often less than 0.1 mU/L. Studies over the past 1–2 decades have shown that subclinical hyperthyroidism causes atrial fibrillation in people over age 60 years, as well as bone loss in postmenopausal women. In a prospective cohort of individuals over age 65 years, even serum TSH between 0.1 and 0.5 mU/L (ie, very mild thyroid overactivity), was associated with atrial fibrillation.² In a meta-analysis, subclinical hyperthyroidism was associated with a 41% increase in all-cause mortality, and mathematical modelling suggested that the increased risk depended on the age at diagnosis, with a significant increase beginning at the age of 60 years, especially in men (figure).³ These findings have clinical implications, and suggest that very mild thyroid hyperfunction should be treated, even in asymptomatic older patients.

Previous studies have suggested that bone loss in subclinical hyperthyroidism occurred only in postmenopausal women. However, even premenopausal women could potentially be at risk for bone loss,

although not to the degree seen in postmenopausal women.⁴ Further studies in premenopausal women are necessary to see if this finding can be replicated. In-vitro studies as well as animal and preliminary human data have suggested that TSH itself may have a positive role in maintaining bone health, via a direct inhibitory effect on osteoclast function, independent of its regulation of thyroid function.⁵

Several clinical studies have examined the symptoms of hyperthyroidism. In one report, untreated patients with Graves' disease who had high levels of anxiety due to their illness had increased glucose metabolism in specific brain regions on FDG-PET scanning, particularly in the limbic system, an area known for its role in emotional activity.⁶ In a second study, up to 50% of adult men with hyperthyroidism had sexual dysfunction,⁷ which improved with treatment. In a third report, thyroid myopathy improved when hyperthyroidism was treated, and recovery of muscle function could be enhanced by medical therapy plus resistance training.⁸

The three treatments for Graves' disease remain antithyroid drugs, radioiodine, and surgery. Anti-thyroid drug therapy is the preferred first-line treatment outside the USA and methimazole or carbimazole are favoured over propylthiouracil due to their simple once-a-day dosing and higher adherence.¹ In a randomised trial of initial therapy for Graves' disease, 369 patients received 12 weeks' therapy with propylthiouracil 300 mg, methimazole 30 mg, or