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BRIEF REPORT

Key Ingredients to Contact-Based Stigma Change: A Cross-Validation

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Objective: Contact-based antistigma programs seemingly have a larger and more sustained impact than educational strategies. Previous qualitative research of advocates with lived experiences yielded 32 key ingredients of contact-based programs comprising 5 categories. This study sought an independent sample's feedback of the 32 ingredients. ***Methods:*** One hundred advocates with lived experience of mental health conditions who have led, coordinated, and/or delivered antistigma presentations completed an online survey to rank importance of key ingredients. ***Results:*** Analysis of rank distributions showed most important ingredients in program categories: (a) design: face-to-face presentations, audience discussion; (b) target: specific group identified (e.g., employers), assessment completed with targets to derive stigma change goals relevant to needs; (c) staff: presenters are people with lived experience; (d) message: message includes on the-way-up stories; and (e) evaluation/follow-up: post-presentation follow-up actions discussed with targets. ***Conclusions and Implications for Practice:*** Future research hopes to yield a fidelity measure for contact-based programs.

Keywords: antistigma programs, community-based participatory research, fidelity measure, mental health advocacy, public stigma

Policymakers and advocates have made elimination of stigma a public health priority. A recent meta-analysis summarized research on antistigma strategies, sorting approaches into education (challenging myths with facts about mental health conditions) and contact (planned exchanges between people with lived experience and the "public"; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Results showed effect sizes for contact programs were significantly larger than education, sometimes by threefold or more. These findings call for more contact-based interventions, which begs the question: what are the defining characteristics of contact-based antistigma programs? If, for example, these programs were to be designated an evidence-based practice (EBP), what must people leading them do to demonstrate effective practice?

To answer these questions, we completed a qualitative study using community-based participatory research (CBPR) to identify these key ingredients (Corrigan et al., 2013). Results yielded 32 key ingredients sorted into five Program Categories: (1) *Design*, logistics and operational concerns necessary to implement the program; (2) *Target*, identifiable and discrete groups for whom individual presentations are crafted; for example, landlords, employers, and educators; (3) *Staff*, those who develop, present, and sustain the program; (4) *Message*, the content of presenter stories; and (5) *Evaluation/follow-up*, subsequent efforts meant to assess stigma change and cement antistigma progress. The study presented here sought feedback on key ingredients from an independent sample of people with lived experience who have expertise in delivering contact-based, antistigma programs. Participants ranked importance of key ingredients for changing public stigma.

Method

One hundred participants were recruited from e-mail listservs and directed to an online survey where they were fully informed and consented about the study. The sample had a mean age of 45.5 years ($SD = 11.2$) and was 67% female. In terms of ethnicity, 11% reported themselves as African/African American, 3% Native American, 4% Asian/Asian American, 76% European/European

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American, and 11% other. Nine percent identified themselves as Latino or Hispanic. In terms of educational attainment, 4% reported earning a high school diploma, 34% an AA/AS or some college, 21% a BA/BS, 7% some graduate school, and 34% a graduate degree. Research participants were presented key ingredients and told to rank the top three most important to address public stigma. Rankings were coded as 3 (*most important*), 2 (*important*), or 1 (*less important*).

Data Analysis

The unit of analysis to prioritize key ingredients was the individual item from the list and not research participant; hence, data transformation was required. First, importance rankings of key ingredients were determined by specifying total number of participants who ranked the ingredient among the most important; note only three of the items under each program category might be ranked among the top most important by an individual participant. The mean of those importance rankings was then determined (a score between 3 and 1).

Results

Table 1 lists sums of ranking for key ingredients by Program Category. Cutoffs for the top and bottom third of the distribution of key ingredients are provided per Program Category. Items were

Table 1
Sum of Importance Rankings for Key Ingredients

Key ingredient	Importance	
	# Endorsed	*M* (*SD*)
Design		
1. Presenters present program face-to-face.	87	2.48 (.67)
2. Presenters travel to targets' setting.	45	2.19 (.71)
3. Presenters matched with and reflective of the target audience.	67	2.30 (.66)
4. Presentation includes written materials for more information.	47	1.57 (.71)
5. Target group size on average is optimal.	50	1.54 (.59)
6. Presentation provides Web address for more information.	19	1.66 (.58)
7. e-media for interactive discussion/exchange.	38	1.84 (.75)
8. Structured training for program presenters.	55	2.05 (.73)
9. Facilitated audience discussion.	86	1.73 (.61)
10. SDR program presenters compensated for work.	41	1.72 (.81)
Top third	80	2.28
Bottom third	28	1.70
Target		
11. Specific group identified.	87	2.43 (.69)
12. Affirming goal corresponds with group.	89	2.08 (.60)
13. Needs assessment completed with targets.	90	2.11 (.63)
14. SDR develop partnered plan with target representatives.	87	1.75 (.60)
15. Partners with target leadership to publicly support SDR efforts.	85	1.55 (.65)
Top third	87	2.32
Bottom third	85	1.60
Staff		
16. Program presenter is person with lived experience.	97	2.62 (.58)
17. Program coordinator is person with lived experience.	57	2.18 (.67)
18. Program led by steering committee of people with lived experience.	68	1.82 (.70)
19. Program has mutual support.	48	1.55 (.58)
20. Presenters reflect diversity: ethnicity, language, and/or faith.	80	1.65 (.47)
21. Presenters reflect diversity: gender, age, and or sexual orientation.	76	1.60 (.73)
Top third	84	2.15
Bottom third	52	1.62
Message		
22. Message includes struggles with lived experience.	82	2.51 (.66)
23. Message includes on-the-way-up story.	87	2.16 (.62)
24. Message includes empowered person who attains goals.	85	2.02 (.65)
25. Message includes affirming goal statement.	75	1.64 (.63)
26. Message respectful of and relevant to target group.	68	1.55 (.58)
27. Presenters emphasize program's core values.	37	1.29 (.49)
Top third	85	2.22
Bottom third	53	1.40
Follow-up/Evaluation		
28. Post presentation follow-up actions discussed with targets.	86	2.44 (.62)
29. Post presentation follow-up contact with targets conducted.	81	2.07 (.62)
30. Post-presentation evaluation of goal attainment.	84	1.88 (.62)
31. Program debriefing/quality improvement discussion with presenters.	87	1.95 (.68)
32. At least 1-month follow-up evaluation conducted.	69	1.43 (.59)
Top third	85	2.20
Bottom third	74	1.54

identified as important ingredients if both number endorsed and mean importance ranking were equal to or above the top third cutoff. They include the following:

- Design: face-to-face presentations and audience discussion;
- Targets: specific group identified and assessment completed to derive stigma change goals;
- Staff: presenters are people with lived experience;
- Message: message includes on-the-way-up story;
- Evaluation/Follow-up: post presentation follow-up actions discussed with targets.

The bottom thirds represented ingredients viewed as least important:

- Design: Web address;
- Targets: partner with target leadership;
- Staff: mutual support program for presenters;
- Message: emphasize core values;
- Evaluation/Follow-up: 1-month follow-ups.

Discussion

This study sought to cross-validate and prioritize key ingredients of contact-based antistigma programs that were identified in a previous qualitative study of advocates with lived experience (Corrigan et al., 2013). Key ingredients ranked important included face-to-face presentations, identifying specific target groups, presenters being people with lived experience, messages including on-the-way-up stories, and post-presentation follow-up discussion. Least important ingredients included Web addresses for more information, mutual support programs for presenters, and emphasizing program core values.

A significant limitation of the study was that data did not represent a sample of the population. Yet the population-of-interest here is the relatively narrow collection of self-identified advocates already working in antistigma programs with lived experience. We were able to recruit 100 people in this category from the United States with good ethnic and other demographic diversity. Future research needs to validate these findings in other, larger samples examining effects for demographics. Studies should also examine other factors that might be relevant here: for example, concerns about cultural relevance, importance of disclosing one's mental health conditions, and personal history in advocacy efforts.

If further substantiated, these findings imply the most important ingredients of contact-based antistigma programs. In turn, these data lead to developing a fidelity measure for future program implementation.

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