THE (GLOBAL) RISE OF ANTI-STIGMA CAMPAIGNS

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Introduction

Within the global mental health assemblage (a diverse network of actors, organisations, technologies, policies and ideas that aim to scale up access to mental health services globally) stigma is a key point of focus. In this assemblage, mental distress is understood as illness and as universal, meaning that stigmatisation of “mental illness” is also thought to be universal, to be “worsening”, and to be “the greatest obstacle to the improvement of the lives of people with mental illness and their families” (Kadri and Sartorius, 2005: 0597). As a response to this, there has been a rise and intensification of anti-stigma and mental illness awareness campaigns both nationally and internationally. Anti-stigma campaigns have increasingly become a feature of everyday public health initiatives around the world. By and large these campaigns aim to improve attitudes towards mental illness and end mental health discrimination by educating the public that mental distress is best understood and acted upon through biomedical and psychological explanations and interventions.

The focus of this chapter is the leading anti-stigma campaign in the UK – *Time to Change* (TTC), which launched in 2007, aiming to “change the way we all think and act about mental health problems” (TTC, n.d.). *Time to Change* is now part of a Global Anti-Stigma Alliance (GASA) which aims to “eliminate mental health stigma and discrimination around the world” (TTC, 2019).

In this chapter we draw upon scholarship from Mad Studies, survivor research and user-controlled research (and the necessary intersections between these diverse areas of scholarship) (Faulkner, 2017a; Sweeney, 2016), and including the scholarship of Mad people of colour, to provide an anti-sanist and intersectional analysis of the ways in which conceptualisations of stigma, and resultant anti-stigma campaigns, are constituted by and reproduce sanism. Sanism is understood here as a “system of discrimination and oppression” deeply embedded in western thinking and that underpins epistemic injustice and marginalises Mad ways of knowing (Leblanc and Kinsella, 2016: 61; Poole and Jivraj, 2015). Sanism is closely entwined with psychocentrism – the location of difference and transformation inside bodies and minds, instead of within socioeconomic and political structures (Rimke and Brock, 2012). In contrast, Mad studies “produces knowledge where the meaning-making of mad people is centred”, against the societal debasement of mad people’s knowledge (within and outside of academia).
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Leblanc and Kinsella, 2016). Yet sanism is not experienced in the same way by all Mad folks as it intersects with other forms of oppression, including racism and white supremacy (Gorman, et al, 2013; Meerai et al, 2016). McWade (2019) uses a Mad Studies analysis of anti-stigma campaigns that construct mental distress as illness to show how these representations are themselves productive of stigmatising psy-discourse – where stigma is understood as a form of power. This chapter makes the point that as anti-stigma gets done globally, it is important both to draw upon Mad knowledge to understand the potentially sanist practices of anti-stigma campaigns but also grapple with and challenge the whiteness of some Mad Studies scholarship. The chapter proceeds as follows: First, we provide a reflection on our positionality within the discipline of Mad Studies. Second, we sketch briefly the recent history of anti-stigma campaigns before introducing England’s Time to Change campaign and the associated global anti-stigma alliance (GASA). We will contextualise the significance of these campaigns through observations of the way TTC is performed at key events (attended by one of the authors of this chapter), before exploring the assumptions about the workings of stigma made by TTC.

Who we are

Positionality is also part of anti-sanist praxis. As authors we want to avoid the temptation of succumbing to confessing our subject positions and then breathing a sigh of relief and carrying on as ‘normal’. Yet it does matter who we are, and from where we write this chapter. It matters that we are two white, European women who have different relationships with distress and madness, but who do not identify as ‘mad’ or as ‘survivors’ (although our lives have been touched by both psychiatry and psychopharmaceuticals). It matters that our relationship is shaped by unequal power relations of student and academic ‘supervisor’. It also matters that we write from locations within both the colonial University and UK University marketplace where book chapters such as this are seen to ‘count’ for nothing in the numerical ranking of research outputs. The western University is a site through which colonialism as a global project, and specifically colonial knowledge and hierarchies, is “produced, consecrated, institutionalised, and naturalised” (Bhambra et al, 2018: 5). This is significant because it highlights the potential limitations of critiques generated from colonial spaces, including some Mad Studies scholarship (discussed later).

Potted history of anti-stigma campaigns in the UK

This section introduces the development of anti-stigma campaigns in the United Kingdom through a discussion of the three principal mental illness awareness campaigns since the 1990s: Defeat Depression (1992–96), Changing Minds (1998–2003) and Time to Change (2007–2019/present). An exploration of the historical context and power dynamics in which these initiatives operate aids in illustrating how current campaigns have emerged to correspond with neoliberal and globalising logics of stigma and mental health.

The Royal College of Psychiatrists’ (RCP) 4-year Defeat Depression (1992–96) campaign was a response to research that identified considerable reluctance and embarrassment (interpreted as due to stigma) in people to seek professional help when they feel depressed (Priest et al, 1995). The principal messages devised to address this perceived stigma were to show that depression is a common disorder amongst the population, and that professional help is easily accessible in the form of anti-depressants and psychiatric counselling (IJHCQA, 1995). Within the timeframe of this campaign, attitudes towards people with depression only shifted marginally in response,
while the prescription of antidepressants increased by over 50% (Paykel et al, 1998). Defeat Depression was followed two years later by another RCP campaign on a larger scale: Changing Minds (1998–2003) was an attempt to educate the public (including GPs and the media) about the nature of mental illness as there was a perceived lack of understanding of the common occurrence of mental disorders, supposedly leading to stigma against those diagnosed. While people experiencing issues with substance-use were viewed as the most stigmatised, those suffering from depression or schizophrenia were generally depicted by the media as “violent, erratic and dangerous” (Luty et al, 2007: 327). Through ‘factsheets’, advertising campaigns and education packages sent out to newspapers, Changing Minds attempted to improve attitudes to mental disorders. The logic that followed this campaign was that – if mental illnesses are put on the same level as physical illnesses, not viewed as an individual’s fault, and addressed through medication and correct treatment, then attitudes towards those experiencing mental distress would improve. While follow-up studies (e.g. Abraham et al, 2010; Sampogna et al, 2017) found little evidence that Changing Minds brought about significant positive changes in public attitudes, the campaign laid the groundwork for England’s current Time to Change (TTC) campaign.

**Time to Change (TTC) and the Global Anti-Stigma Alliance (GASA)**

Time to Change was launched in 2007 and is jointly managed by the UK-based charities Mind and Rethink Mental Illness, both of which receive funding from the UK government. According to their website, mental health charity Mind (2018) received £1.9m funding from the government in 2018 alone to run Time to Change. This, and the fact that the government’s current mental health strategy (Department of Health and Social Care, 2016) stresses the importance of combating stigma, suggests a long-term policy interest in constructing and responding to the rising diagnoses of mental illness in the UK as a public health issue. Moreover, the UK government continues to pledge increased funding in support of Time to Change.

In 2012, the Director of Time to Change – Sue Baker – became one of the co-founders of the Global Anti-Stigma Alliance (GASA). Currently combining the efforts of 17 countries, GASA was created with the aim to share learning, methodologies, best practice, materials, and the latest evidence in order to achieve better outcomes for people facing stigma and discrimination related to mental health issues.

*(Time to Change, 2017: 2)*

Its secretariat and coordination lies with England’s Time to Change campaign, and even though, at first glance, the Alliance appears to be a loose network of mental health anti-stigma campaigns around the globe, it has established itself as an arm-length body of Time to Change England through a strong presence on social media. In 2018 GASA released a short video “Time to Change Global – It’s time to talk about mental health” which features mental health stories from around the world, including celebrity stories by Nadiya Hussain, a popular British TV chef and presenter, and Glenn Close, an American award-winning actress. Negative consequences of stigma are identified as creating barriers to employment and adequate psychiatric treatment, while stigma is described as “knowing no boundaries”, affecting “all ages, all income groups and all cultures” and as deeply ingrained in all societies and that these must be transformed to
put mental health on the same level as physical health. In the film, transformation is imagined through encouraging people to talk about their experience and diagnosis, which is presented as therapeutic.

Similarly to TTC, GASA puts a strong emphasis on the use of stories of lived experiences (so called ‘leaders of change’) and evidence-based programmes to eliminate mental health stigma and discrimination (TTC, 2019: 3). Despite GASA’s insistence that approaches to tackle mental health discrimination “vary from country to country and are tailored according to need and culture as, as such, are not identical” (TTC, 2019: 2) the messages about mental illness that are communicated via GASA’s social media presence mirror those which are used in the national context of England. For example, the idea that “1 in 4” is affected by a mental illness and that a ‘social movement’ which encourages talking about mental health issues is a key driver of change against mental health discrimination. GASA presents an interesting window into the emerging global politics of mental health as its narrative merges psychiatric knowledge with the idea of a ‘social movement’. Despite the current lack of dedicated funding for the organisation (TTC, 2019), it has stressed that

eliminating mental health stigma and discrimination is the work of generation and therefore requires long term and sustained activity and investment.

(TTC, 2019: 3)

Tweeting anti-stigma

*Time to Change*, as the leading anti-stigma campaign in the UK, relies heavily on the use of social media to distribute its message, reach, and interaction with the public. In the case of GASA, the most up-to-date information about the campaign can often be found in its social media feeds, particularly Twitter. In the following, we will illustrate, through an engagement with tweets by the *Time to Change Global* twitter account, how ‘stigma’ is conceptualised within the global agenda of mental health discourse. The notion of ‘mental health stigma’ as an obstacle to be overcome by countries is invoked through several different narratives that run through *Time to Change*’s online discourse. The key two ‘stories’ told about mental health by *Time to Change* are summarised in the following two tweets from the *Time to Change Global* Twitter account:

Mental health problems know no boundaries – it affects all ages, all income groups, and all cultures.

(Twitter; 10 Oct 2018)

Every country in the world can be considered as a developing country when it comes to #mentalhealth.

(TTC Global Twitter; Vikram Patel; 10 Oct 2018)

The first tweet mobilises a common statistic (“1 in 4”) employed by mental health campaigns in the UK to draw attention to the prevalence and commonality of mental health problems. This idea is now extended to discuss the global phenomenon of rising diagnoses of mental illnesses. Two things are missed in this first tweet. Firstly, mental distress does not affect everyone equally. For example, in the UK, people from Black and minority ethnic backgrounds as well as those living under austerity or harsh economic conditions are much more likely to experience mental distress, to be diagnosed with a mental health condition, and to experience the
hard end of mental health services (including force and coercion) (Legraien, 2018; Longhurst, 2017). Moreover, the assertion that “mental health knows no boundaries” seems to suggest that mental illnesses can be diagnosed in any global setting using the same diagnostic logics by which a mind is judged to be ‘healthy’ or ‘unhealthy’. Thereby, the “1 in 4” mentality also aids in the process of ‘othering’ those who are diagnosed with a mental disorder. Put simply, the idea that mental distress operates without borders puts forward a globalising narrative of mental illness that does not consider the fact that not everyone is affected equally by experiences of mental distress nor, that Western psychiatry may be rejected outside (or even within) its geographical context.

The second tweet exemplifies the problematic narrative of Time to Change in two related ways. Firstly, it suggests that there is a relationship between mental health and a country’s level of ‘development’. This is problematic not only because it leaves unquestioned notions that development is necessary and of who gets to define what counts as development, but also because it posits mental health as an obstacle to development processes (Mills, 2018a). Secondly, since ‘every country’ is in need of development, it implies that more ‘scaling-up’ is to be done in terms of tackling mental health stigma. This developmentalist narrative that places ‘stigma’ at the forefront of mental health issues worldwide forms part of a much broader emerging global mental health assemblage, including calls to ‘scale up’ access to mental health services worldwide, increase access to the WHO’s essential medicines (some of which are psychopharmaceuticals), redistribution of previous clinical tasks to non-specialists through task-sharing, and use of technology to extend reach of mental health services (see Mills and Hilberg, 2018 for a discussion of these processes in India).

Measuring (time to) change

In the last 12 years, a variety of studies and reports have attempted to determine the success of TTC. The results have been mixed. While Sampogna et al (2017) found that active participation with TTC, particularly by mental health service users, can lead to an increased willingness to challenge stigma, the study is limited by the fact that its conceptualisation of ‘stigma’ corresponds with that of TTC, leading to a one-sided engagement with discrimination. In another study, Henderson and Thornicroft concluded that, while there was an overall reduction of experienced discrimination between 2008–11 there was also a negative shift in public attitudes to some aspects of mental health (2013: 46). Henderson and Thornicroft end their evaluation with a paragraph suggesting that “stigma and discrimination against people with mental illness are global challenges” (2013: 47), which reflects an emergent narrative of scholars concerned with stigma and mental health. An early study of Time to Change (Abraham et al, 2010) found that its logo inspired very little recognition and that its name could be confused with a political message, especially around times of election. A more recent and longer-term investigation into the campaign and attitudes towards mental illness in Britain (Evans-Lacko et al, 2013) concluded that the launch of the Time to Change campaign was successful in offsetting some negative attitudes towards mental illness, but that long-term involvement with the campaign would be needed to bring about more significant change. Despite the diversity in opinion and lack of clarity regarding the evidence of a decrease in population-wide stigma, TTC continues to approach mental health discrimination through stigma in a way that prioritises biomedical understandings of mental illness and places the source of stigma firmly in the individual subject, rather than acknowledging
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the possibility of systemic causes, or the need for legal redress (the legal ramifications invoked through discrimination do not apply to stigma). This is where mental health anti-stigma campaigns could learn from moves within Disability Studies to work beyond stigma, focusing on discrimination and oppression (Hunt, 1996).

Moreover, the campaign continues to receive millions of pounds in funding annually from the government, which has also made the positioning of the UK as a ‘world leader’ on mental health a priority.

As will be seen in the following sections, TTC still follows similar logics (educating the public through psychiatric discourse with a specific focus on how prevalent mental illnesses are) to its predecessor campaigns. Although these campaigns only brought about small changes in perceptions of mental illness at a population level, they seem to be treated as a success. While TTC engages the public on a much more direct (and global) level through social media, its basic framework regarding discourses around psychiatric diagnoses and treatment is similar to those followed by campaigns in the 90s and early 2000s. Yet there are some differences. The most interesting shift in narrative has happened on the level of everyday experiences of mental health. There is less of a focus now (certainly in the context of austerity Britain, where mental health services are experiencing drastic cuts in government funding) in increasing access to psychiatric services, and instead more impetus on how to manage one’s mental health on an everyday basis that allows one to continue participating in the labour market. Whilst a shift away from traditional psychiatric treatments (e.g. pharmaceutical solutions or therapy) might be welcomed as a challenge to existing psychiatric hegemony, psychiatric logics continue to underpin the concept of ‘everyday functioning’. Moreover, a move away from interventionist medical solutions suggests that mental distress becomes normalised as an aspect of everyday life, where treatment takes the form of self-management.

Stories: Performing anti-stigma

Mental health and stigma are ‘done’ globally in multiple overlapping ways: from campaign materials, and policy documents, to social media presence, and events and performances. Anti-stigma campaigns like TTC rely on the use of personal stories by people diagnosed with a mental illness to communicate a simple message about, for example, the commonality of mental health problems. It is now commonplace for personal stories from service users and/or people who have experienced distress to be used to educate the public and change public attitudes (often through emphasising prevalence and recovery); to raise funds and build brand; and to elicit political support (Costa et al, 2012). Writing about TTC, Crepaz-Keay and Kalathil show how these recovery-oriented developmental narratives follow

a linear path from illness to wellness where both illness and recovery are re-articulated in terms of bio-medical and social constructions of normality.

(2013: 13)

Sharing stories by those who identify as mental health users/survivors, or as psychosocially disabled, “has been central to the history of organizing for change in and outside of the psychiatric system” (Costa et al, 2012: 85) and to questioning unequal power structures and “the medical/psychiatric establishment’s role in perpetuating these structures” (Crepaz-Keay and Kalathil, 2013: 4). Yet these stories are now used by organisations and academia to promote
personal recovery or individual attitude change rather than as a tool for societal (including, economic and political) transformation. Here personal narratives are reduced to another set of data to be analysed and interpreted using existing hierarchical values and criteria or as commodities for marketing institutional or organisational agendas. (Crepaz-Keay and Kalathil, 2013: 13)

Russo has critiqued the academic “re-telling and packaging of individual and collective survivor stories” as highly damaging (Russo, 2012: 28), something which equally applies to organisational re-telling of personal narratives.

Creating spaces to tell stories about mental health and recovery at high-level ‘global’ events is a key part of how TTC is performed globally. In October 2017, the ninth meeting of the Mental Health Gap Action Programme (mhGAP) Forum took place at the World Health Organization (WHO) in Geneva. The meeting, attended by approx. 225 people (including one of the authors), provides an opportunity for people to network, and to feedback to the WHO about their global mental health products (Mills and Hilberg, 2019). Anti-stigma work played a key part throughout the two-day event. The spaces outside the main plenary session, where people congregate to drink coffee, were festooned with posters (translated into a number of languages) from the WHO’s “Let’s talk” anti-stigma campaign focused on depression. The Forum fell on World Mental Health day, with a well-attended lunchtime seminar on “Mental health in the workplace”, which included presentations from Sue Baker announcing that TTC would be going global, and Adam Spreadbury (co-chair of the Mental Health Network at the Bank of England). The Bank of England signed up to the TTC pledge to tackle mental health in the workplace, in 2013.¹

A year later, Sue Baker also made an appearance at the Global Ministerial Mental Health Summit, hosted by the UK Government, in 2018. This event aimed to “place a spotlight on mental health at a global level”, and build momentum in tackling stigma. TTC had a strong presence at the event, from branded products to hosting a panel about their global work. Speaking about the event, Sue Baker said that

many of us hope that this first ever global mental health summit will be a tipping point that prioritises more action on mental health. We’ve made major progress on mental health stigma in England and hope the summit acts as a springboard for change across all countries and cultures, so that there is no shame attached to mental health anywhere in the world.

However, this event and TTC’s presence at it didn’t pass without critique. Coalitions of mental health activists, psychiatric survivors, and service-users organized open letters detailing their concerns with the global summit and with the Lancet Commission on Global Mental Health and Sustainable Development (Patel et al, 2018), which was launched at the event (Beresford, 2018; NSUN, 2018; TCI Asia Pacific, 2018). One open letter led by the UK’s National Survivor and User Network (NSUN) stated that

[t]he Summit is set to announce the global launch of the anti-stigma programme, Time to Change, with programmes planned in India, Ghana, Nigeria, Uganda and Kenya. Millions of pounds have already been spent on this campaign which claims to

¹ See video at https://www.youtube.com/watch?v=AQUJ3m_N7e0
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have made a positive impact on mental health stigma, while evidence also shows that there has been no improvement in knowledge or behaviour among the general public, nor in user reports of discrimination by mental health professionals.  
(National Survivor User Network, 2018)

The letter goes on to raise concerns that while the UK Government funds the TTC programme, it continues to engage in mass stigmatisation of disabled people who claim welfare. NSUN point out that it is objectionable that the UK government continues to fund a programme that aims to address stigma while carrying on with the most stigmatising and discriminatory policies that affect persons with psycho-social disabilities.  
(National Survivor User Network, 2018)

The letter references the work of Alison Faulkner and her critique of anti-stigma campaigns based on social contact and behaviour change. For Faulkner (2017b) the main reason that anti-stigma campaigns have largely failed to have much impact is that they rarely address intersectional and structural discrimination, including the crafting of stigmatisation of certain groups by government. Furthermore, such campaigns largely aim to encourage help-seeking but are not always realistic about what help is actually available to people (Faulkner, 2017b), especially in contexts of austerity, cuts to services, inequality and poverty.

Stigma and anti-stigma and Mad Studies

When thinking about anti-stigma going global, it is worth engaging with how stigma itself is understood in the literature. In literature and practice, stigma tends to be understood as “problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination)” (Thornicroft et al, 2008) that are seen to act as barriers to treatment and to mental health gaining policy traction (Mackenzie, 2014). Public health approaches to stigma have largely relied on public education about illness as prevalent but treatable (Corrigan et al, 2005). In the 2018 Lancet Commission (Patel et al, 2018), reduction of stigma – mentioned alongside discrimination – is explicitly linked to “increasing timely help-seeking” (2018: 1578), and to addressing “demand-side constraints for mental health care caused by stigma and discrimination” (2018: 1553). This approach is modelled on understanding of HIV/AIDS anti-stigma (Patel et al, 2006) where anti-stigma work largely involves educating people about biomedical understanding of disease (Howell et al, 2017).

However, the concept of stigma and the practice of anti-stigma within mental health has been widely critiqued. The majority of research into stigma is individually focused, and based on an interpersonal understanding of one person doing something to another (Hatzenbuehler and Link, 2014). This approach does not acknowledge that models and interventions that conceptualize distress as ‘illness’ may themselves be stigmatising. This is despite research consistently demonstrating that disease-based and biological explanations for mental distress are more stigmatizing and more likely to increase public desire for distance from those experiencing distress than psychosocial explanations, which have been found to increase empathy and reduce stigma (Corrigan, 2007; Longdon and Read, 2017; Read et al, 2006). A 2012 meta-analysis of data from eight countries over 16 years found that as public belief about the genetics of mental illness at population level increased, stigma also increased (Schomerus et al, 2012). This research suggests that interventions to change public attitudes can actually intensify stigma
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(Schomerus et al, 2012), and inhibit collective anti-stigma work (Hatzenbuehler and Link, 2014). Furthermore, anti-stigma campaigns often fail to acknowledge that stigmatization is a structural process shaped by social, political and economic determinants, and that interventions to reduce stigma can also be structural and not only educational (Hansen et al, 2014; and see special issue on structural stigma in Social Science and Medicine, 2014).

Instead of assuming stigma is largely in the realm of public attitudes, research shows how structural stigma can be written into state legislation (Corrigan et al, 2005), and that Governments may actively craft stigmatisation of particular groups. For example, since 2008, the UK Government has engaged in the state sanctioned stigmatization of disabled, including psychosocially disabled, people who claim welfare benefits, in order to garner public consent for punitive welfare reform (such as, cuts to public services, welfare conditionality, use of sanctions, and mandatory workfare) (Tyler and Slater, 2018: 727). These policies have been linked to an increase in suicides, worsening mental health, and increases in prescriptions of anti-depressants (Barr et al, 2015; Mills, 2018b). At the same time the UK Government positions itself as a world leader in mental health, exemplified in its recent hosting of the Global Ministerial Mental Health Summit, an event which saw both the launch of the Lancet Commission (Patel et al, 2018), and the launch of GASA.

The sanism and whiteness of anti-stigma campaigns and also of Mad Studies

As anti-stigma work is articulated as global, and as campaigns travel globally, it is important both to draw upon Mad knowledge to understand the potentially sanist practices of anti-stigma campaigns but also grapple with and challenge the whiteness of some Mad Studies scholarship. This chapter brought to bear scholarship from Mad Studies, survivor research and user-controlled research onto a specific anti-stigma campaign in England, and its recent attempts to ‘go global’. Using diverse Mad knowledges to rethink stigma and anti-stigma makes visible the ways that anti-stigma work is often constituted by and reproductive of sanism. Furthermore, sanist models of stigma and the anti-stigma campaigns that result from them are being exported globally, while sanism is deeply embedded within and productive of older forms of colonialism and modernity, and continued (settler) coloniality in many parts of the world.

Mad Studies taps into and is a space for the production of ways of knowing that can be used to interrogate “the adultist, disableist, saneist, colonial and racist logics that often underpin the conventional academic imaginary” (Mills and LeFrancois, 2018: 506) and it is thus sometimes described as in/disciplinary in that it disrupts Eurocentric models of knowledge carved into ‘disciplines’ (Gorman and LeFrançois, 2017; LeFrançois et al, 2013; Russo and Sweeney, 2016). Yet Mad Studies also emerges from a landscape made possible by (settler) colonialism, ableism, racism and more, and has been critiqued for reproducing hierarchies of differentiation which shape all of our lives albeit in very different ways. Like White Disability Studies, Mad Studies also reproduces whiteness, and thus requires an intersectional approach to madness constantly committed to dismantling ableism and sanism (Miles et al, 2017). Crepaz-Keay and Kalathil (2013) illustrate that much can be learned from projects that centre experiences of distressed and/or mad identified people of colour (for example in the UK context) (Atkinsons et al, 2008; Kalathil et al, 2011). For example, they document multiple projects that narrate and use storytelling in ways that, in contrast to many anti-stigma campaigns, make connections between personal narratives and social structures, power, racism, discrimination, and collective action (and that illustrate how narratives are themselves shaped by social and cultural context).
Conclusion

This chapter has drawn upon Mad Studies to contribute an anti-sanist and intersectional analysis of dominant anti-stigma campaigns, with a focus on *Time to Change* as it takes its anti-stigma work globally. We have chosen to highlight our positionality as white, female scholars writing in equally white western universities early on in this chapter as we believe it is essential to reflect on the kind of voices that are being heard (and published) in Mad Studies scholarship. These unavoidable markers of our privileged positionality open up spaces for critical debate about how knowledge in Mad Studies continues to be produced. We are fully aware that people’s experiences of anti-stigma initiatives around the world are diverse and might not reflect the analysis put forward in this chapter – all the more important it is to engage discussion on the level of where knowledge about mental health is legitimated through academic discourse. Our contribution to the field of Mad Studies emerged through a critical engagement with the processes of knowledge production in Mad Studies alongside critiques of knowledge production about mental health and stigma on a global scale. Key here is our call to investigate further how structural conditions, including those in academic and research environments, shape our understanding of the intersection between stigma and mental distress.

As researchers in-between disciplines – psychology, global public health, international relations – whose literatures do not always speak to one another in productive ways, we suggest that an interdisciplinary approach that centres diverse forms of Mad knowledge production is necessary to start bringing forward a nuanced critique of global anti-stigma campaigns and to enact alternative collective and structural transformation of the conditions that produce stigma and discrimination. At the centre of any research going forward should be an ethos dedicated to appreciating and revealing the multiple facets in which oppression of those deemed ‘mad’ manifests – both in psychiatric and anti-psychiatric knowledge production. Finally, we hope that this chapter forms part of an emerging, diverse conversation about the relationships between psychiatry, stigma, and mental illness, which carves out a space for novel challenges to existing regimes of psy power within global politics.

References


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