Findings were based on a sample of 250 adults recruited through various adverts. The study showed that attitudes were not significantly better than in a group of the UK general public previously recruited for scale validation.

We are undertaking the overall evaluation of the campaign. Our evaluation design is based on a conceptual framework which describes stigma as problems of knowledge (ignorance/misinformation), attitudes (prejudice), and behaviour (discrimination). Therefore, in addition to measuring prompted campaign awareness, our evaluation included measures of mental health-related knowledge (measured by the Mental Health Knowledge Schedule), attitudes (measured by the Community Attitudes towards Mental Illness scale) and behaviour (measured by the Reported and Intended Behaviour Scale).[2] To address the multifaceted nature of the campaign, we use several levels of evaluation, including assessments of: the overall programme at a national level, specific target groups (e.g. medical students, trainee teachers) and regional and local interventions.[3]

Our initial evaluation of the campaign in Cambridge used a pre/post-evaluation design among the campaign target population. These findings suggested modest but significant changes in this group. An important finding was that although campaign awareness was not sustained following the first phase of activity, significant and sustained shifts occurred for knowledge items 2 weeks following the campaign. There was a 24% ($P<0.001$) increase in the number of persons agreeing with the statement 'If a friend had a mental health problem, I know what advice to give them to get professional help', and a 10% ($P=0.05$) rise in the number of people agreeing with the statement 'Medication can be an effective treatment for people with mental health problems'. Over this short-term activity, changes were not evident for attitudinal or behaviour-related questions.

Another difference between our evaluation and that of Abraham *et al* is that we found familiarity with mental illness to be associated with less stigmatising responses. Therefore, our findings suggest the possibility of significant further progress via more openness, disclosure and social contact. It is clear from these studies that further investigation is needed to address the most effective dissemination and communication of anti-stigma messages.[4] Additionally, evaluation of the maintenance of changes over time and the additive effect of subsequent bursts of campaign activity will help us understand more about the effectiveness of this campaign in the long term. We are currently analysing data collected over the first year of the campaign.

Abraham *et al* also cite our paper comparing public attitudes in England and Scotland,[5] and state: 'Unfortunately, there have been reports that national anti-stigma campaigns are not particularly effective'. In fact, this paper shows the opposite, namely that 'the results are consistent with early positive effects for the See Me anti-stigma campaign in Scotland'.

Declaration of interest

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Role players' experience of psychiatric examinations

Professional role players are increasingly being employed in psychiatric training. There have been several studies of their experience. A Dutch study showed an 'unexpectedly high' rate of reported mild stress in those playing psychiatric roles.[1] An American study found that role playing mania and depression could be exhausting and that being more than 40 minutes in role with more than three or four repetitions was stressful.[2]

We were interested in the experience of UK professional role players. We conducted semi-structured interviews with ten professional role players, six women and four men, followed by two focus groups with the same individuals. They were taking part in local mock Objective Structured Clinical Examinations (OSCEs) and had between 5 and 10 years' experience of simulating patients with psychiatric disorders several times a year. They were recruited and trained by a professional trainer with a background in psychiatry.

Generally, the role players we interviewed felt appreciated and well looked-after at psychiatric OSCEs. They emphasised the value of seeing the full scenarios beforehand, including the instructions to candidates and examiners as well as examiners' score sheets. These inform their training sessions. Guided, collective training is crucial; they prefer not to rely on their imaginations to work out how a particular patient would behave. Role players' instructions should include directions on how to act the role; they felt that portraying the appropriate affect is important. Too long a history can make them anxious lest they forget bits; this detracts from their capacity to think and feel themselves into role.

Thinking and feeling oneself into role is a key aspect of method acting. The researchers in the Dutch study thought that method acting may have contributed to their role players' reported stress. They played 'emotionally and psychologically complex roles' only occasionally. Another study reported that role players find it difficult to 'turn off characterisation'.[3]

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However, an experienced UK role player has argued strongly in favour of method acting in order to give convincing performances. She considers these simulations appropriate even for amateur actors so long as they have a sense of humour and the capacity to 'switch off' afterwards.[4]

In keeping with American professional role players,[4] ours liked their work and felt it had allowed them to develop greater empathy towards people with mental illness. They said they had come to appreciate the human exchange that seemed to them central to a psychiatric consultation and felt more able to deal with psychiatric problems experienced by friends and family. They felt that psychiatric role playing can be physically demanding, much of the simulation being non-verbal. They found some very intense scenarios distressing, disturbing and draining, but they did not find the work disturbing overall; they felt they could shrug their roles off afterwards. They regarded psychiatric role playing as interesting and satisfying. Although they reported no continuing stress or adverse consequences from their work, they agreed collectively that only experienced role players should undertake psychiatric roles. So whether a role player is stressed or distressed by simulating may reflect his or her experience. The individual's emotional stability and buoyancy may also be important. Their trainer writes that 'an individual with baggage from personal experience may need more support when de-roling and, in our experience, may be unsuitable'.[5]

Ours is the first study of the experience of UK role players. Its main limitation is that it draws on a small number of role players from only one programme and may therefore not be representative of the UK as a whole. Also, OSCEs have now been replaced by Clinical Assessment of Skills and Competencies (CASCs) in the Royal College of Psychiatrists examinations. Nonetheless, there are sufficient similarities between OSCEs and CASCs to render our study still relevant.

Declaration of interest

S.M. has 6 years' experience delivering mock OSCEs and CASCs, working with role players from RolePlay North.

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Staff attitudes to recovery

We read the paper by Gudjonsson *et al*[1] with interest. We wish to highlight the findings of our study in Ireland, which examined the knowledge and attitudes of mental health professionals (*n* = 153, nurses, doctors, social workers, occupational therapists and psychologists) to the concept of recovery in mental health across both in-patient and community settings.[2] We used the Recovery Knowledge Inventory (RKI),[3] an instrument developed in the USA but which we found useful for an Irish population, and which has also been found to be of use in European and Australian populations.[4] The RKI was developed to gauge recovery-oriented practices among providers. It assesses four domains of understanding: roles and responsibilities in recovery; non-linearity of the recovery process; roles of self-definition and peers in recovery; and expectations regarding recovery. It comprises 20 items, each of which is rated on a 5-point Likert scale.

Our study findings concurred with Gudjonsson *et al* in finding that respondents viewed recovery positively as a philosophy of care for delivering mental health services. Participants in our study indicated their positive approach to recovery and expressed a need for more training, acknowledging the need for interprofessional learning as a team and the need for a multidisciplinary team approach to care. Respondents were less comfortable with encouraging healthy risk-taking.

However, whereas Gudjonsson *et al* report that experience of working in forensic services was not significant to total scores, in our study less experienced staff scored higher in having more positive attitudes and knowledge regarding recovery. Also of interest was that females and non-nursing professionals scored higher than nursing professionals in our study. We found no significant difference between in-patient or community-based staff; 22% of our staff had received training in recovery, compared with 37% in Gudjonsson *et al*'s study. We did not compare results of those with training and those without, sharing the concern that those who had received training may have been positive about recovery before training.

Both studies discuss decision-making and its challenges around choice and control, and both are in strong agreement regarding hope and optimism being central to the process. Finally, both studies support the idea that irrespective of the specialty (or indeed country), the delivery of a recovery approach to care can be implemented, and knowledge and attitudes of mental health professionals are key in this process.

We look forward to the findings of the prospective study on the recovery approach currently under investigation by Gudjonsson and colleagues, and further discussion on this important topic.

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