beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety[1]

This Information Paper has been developed to provide an in-depth understanding of the stigma and discrimination associated with depression and anxiety. It brings together the latest evidence on different types of stigma and discrimination, the debilitating impact it can have on people's lives, and effective ways to reduce this impact. This Information Paper should be used as a reference document, to inform the development and implementation of stigma and discrimination strategies.

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[1] This information paper relates to the stigma and discrimination associated with depression and anxiety. It is acknowledged that:

- There is significant stigma associated with suicide. Information on this relationship is available in Suicide Prevention Australia's Position Statement: "Overcoming the stigma of suicide".
- Experiencing other forms of discrimination (for example, ethnic, race, sex, gender identity or sexuality-based discrimination) is a risk factor for poor mental health and wellbeing. While reducing this discrimination is an important priority for *beyondblue*, this information paper relates only to the stigma and discrimination that is directly associated with depression and anxiety. More information on the impact of discrimination on mental health is available in the '*beyondblue Position Statement: Depression and anxiety in gay, lesbian, bisexual, trans and intersex populations'* and on the *beyondblue* Stop.Think.Respect (Phase 2) campaign website.

Executive summary

People with depression and anxiety, and their family and friends, experience significant levels of stigma and discrimination. The stigma associated with depression and anxiety is complex – the level, type and experience of stigma and discrimination may be influenced by factors such as the condition itself, the age and gender of the person, culture, and the beliefs and language used to describe and explain mental health conditions. People with depression and anxiety report that the stigma and discrimination they experience may be worse than their mental health condition(s).

The stigma associated with depression and anxiety includes three components – problems of knowledge (ignorance or misinformation), problems of attitude (prejudice), and problems of behaviour (discrimination). Improving one component may not necessarily impact on the other components. A comprehensive response to stigma is therefore needed, to address all three components.

There are **different types of stigma** associated with depression and anxiety. This includes:

- personal stigma - a person's stigmatising attitudes and beliefs about other people *("People with depression should snap out of it.")*
- perceived stigma - a person's beliefs about the negative and stigmatising views that other people hold *("Most people believe that a person with depression should snap out of it.")*
- self-stigma - the stigmatising views that individuals hold about themselves *("I should be able to snap out of my depression.")*
- structural stigma - the policies of private and governmental institutions and cultural norms that restrict the opportunities of people with depression and anxiety *("Mental health services and research don't deserve as much funding as other health problems.")*.

There is some evidence that there are improvements in the stigma associated with depression and anxiety. However, recent *beyondblue* research indicates that it still exists, and it continues to have a significant impact on people's lives - **the greatest impact is on personal relationships and employment**

Research findings suggest that there are two effective approaches to reduce stigma:

- Educational approaches – This includes information resources (for example, books, flyers, movies, websites etc) which challenge inaccurate stereotypes and replace them with factual information.
- Contact approaches – This includes interpersonal contact with people with depression/anxiety.

To achieve real improvements in stigma and discrimination, stigma-reduction strategies need to be developed and implemented in a collaborative, sustainable and multi-sectoral way. These strategies should be led by people with depression and anxiety and their family and friends, and be supported by system-level reform and policies, that influence national attitudes and behaviours.

One of *beyondblue's* goals is to reduce people's experiences of stigma and discrimination. To achieve this, *beyondblue* is implementing a comprehensive suite of stigma-reduction strategies, which target different population groups and settings, and are informed by the evidence base on 'what works'. These strategies will continue to be developed and implemented, in partnership with people with depression and anxiety and their family and friends, to help reduce stigma and discrimination, and improve the lives of people affected by depression and anxiety.

Stigma and discrimination: overview

Stigma marks a person as 'different'[1]. The World Health Organisation (2001) defines stigma as *"a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society."*[2] Scrambler (1998) describes stigma as *"...any attribute, trait, or disorder that marks an individual as being unacceptably different from the 'normal' people with whom he or she interacts, and elicits some form of community sanction."*[3]

The stigma and discrimination associated with depression and anxiety is complex. Most people with depression and anxiety report experiencing stigma relating to their mental health condition.[4] The level, type and experience of stigma and discrimination may be influenced by factors such as the condition itself, the age and gender of the person, and culture.[5] Much of the research has focused on the stigma associated with mental illnesses broadly, depression and schizophrenia.[6] Further research is needed to understand the stigma and discrimination associated with anxiety conditions better, as evidence suggests that it is not appropriate to generalise the stigma associated with depression to anxiety.[7]

Components of stigma

Stigma can be considered an overarching term that includes three components:[8,9,10]

- problems of **knowledge** (ignorance or misinformation – *"People with depression are dangerous."*)
- problems of **attitudes** (prejudice - *"That's right. People with depression are dangerous."*). This can lead to emotional reactions (for example, *"Because they're dangerous, I fear them."*)
- problems of **behaviour** (discrimination – *"Because they're dangerous, I will avoid them."*)

The relationship between knowledge, attitudes and behaviour is complex. Improving one factor, such as knowledge, may not necessarily impact on attitudes and/or behaviour.[11] This has been demonstrated through international research which shows that there have been improvements in knowledge and understanding of mental health, without any changes in attitudes.[12,13] Likewise, it may be possible to decrease discrimination (for example, through increasing awareness of anti-discrimination legislation), without changing individual attitudes.[14] The complexity of the knowledge – attitudes – behaviour relationship underpins the need for comprehensive stigma reduction strategies, which address all three components of stigma.

Types of stigma

There are different types of stigma associated with depression and anxiety. These are:[15,16,17,18,19,20,21,22]

- **personal stigma** (sometimes referred to as **public stigma**) – a person's stigmatising attitudes and beliefs about other people (*"People with depression should snap out of it."*)
- **perceived stigma** – a person's beliefs about the negative and stigmatising views that other people hold (*"Most people believe that a person with depression should snap out of it."*)
- **self-stigma** – the stigmatising views that individuals hold about themselves (*"I should be able to snap out of my depression."*)
- **structural stigma** – the policies of private and governmental institutions and cultural norms that restrict the opportunities, resources and wellbeing of people with depression and anxiety (*"Mental health services and research don't deserve as much funding as other health problems."*). Structural stigma may be either intentional or unintentional.

Additional research is needed to understand the differences in stigma, to ensure that stigma-reduction strategies are effective and have a significant impact on people with depression and anxiety and their family and friends. Australian research suggests that **levels of perceived stigma are considerably higher than levels of personal stigma** (for more information, see Appendix 1).[23] This has a significant negative impact on the lives of people with depression and anxiety:

> *"The stigma doesn't have to be real, only perceived to be dangerous."* Person with a mental health condition

Differences in perceived and personal stigma may be attributable to the social desirability bias (in which people tend to hold back negative attitudes, and behave in a way that is considered to be more socially desirable), and / or people overestimating the levels of stigma in the community.[24]

Elements of stigma

The most common elements of stigma include:[25,26,27,28,29,30]

- **perceptions that a person is 'weak, not sick'** – *"My father and my sister don't believe in mental illness. If you can't cope with something it's a weakness of character, not an actual illness."* Person with depression
- **perceived dangerousness** – *"All mentally ill are tainted by reports of the extremely unusual 'crazy and dangerous'. As if at any time, they could become horrific mass murderers!"* beyondblue blueVoices member
- **beliefs that a person is responsible and can control his/her condition** – *"Most people seem to think depression is...something that is within your character to control."* Person with a mental health condition
- **feelings of guilt, shame and embarrassment** – *"You keep it to yourself because you're ashamed of it."* Person with depression
- **a reluctance to disclose a diagnosis, due to concerns about discrimination and harassment** – *"When he [husband] was looking at applying for jobs, his psychiatrist said, 'I wouldn't mention he's got a mental illness. They don't need to know'."* Carer
- **a desire for social distance** - *"I lost quite a few friends because they were scared of me or didn't know how to treat me."* Person with depression and anxiety

Measuring stigma and discrimination

There are several scales commonly used to measure depression and anxiety stigma and discrimination. These include:

- the Depression Stigma Scale (DSS) – this measures personal and perceived stigma of depression, by using a vignette about a person with depression and asking people about their own or other people's attitudes towards the person.
- The Social Distance Scale (SDS) – this measures intended avoidance behaviour (social distance), by asking people how willing they would be to move next door to, befriend, work with, or have as a relation, a person with a mental health condition depicted in a vignette.[31]
- the Generalised Anxiety Stigma Scale (GASS) – this measures personal and perceived stigma of generalised anxiety, by using a vignette about a person with anxiety and asking people about their own or other people's attitudes towards the person.
- the Self-Stigma of Depression Scale (SSDS) – this assesses the extent to which a person holds stigmatising attitudes towards themselves in relation to having depression.

- the [Discrimination and Stigma Scale (DISC)](#) – this measures experiences of negative and positive discrimination, through asking people in a structured telephone interview about their discrimination experiences across 21 life areas, including family, social life, employment and health services.[32]

The measurement of stigma and discrimination is challenging, and there are significant limitations associated with research in this field. These include:

- oversimplifying complex issues
- assuming that attitudes can be measured quantitatively, and the measures have the same meaning for all people. These assumptions are not always justified, and may limit the usefulness and appropriateness of research findings[33]
- assessing knowledge, attitudes or behavioural intentions, and incorrectly assuming that these align with actual behaviour[34,35]
- using hypothetical, rather than real situations[36]
- the social desirability bias - this effect may be more pronounced in the evaluation of public education campaigns aiming to reduce stigma, due to the messages of the campaign, which reinforce the socially desirable responses. [37,38]

Levels of stigma

beyondblue's Depression and Anxiety Monitor (2014), a community-based survey with 2,000 people aged 18 years and over, assessed levels of personal stigma for both depression and anxiety, using the Depression Stigma Scale and the Generalised Anxiety Stigma Scale. This research suggests that stigma continues to exist, to varying degrees – see Figures 1 and 2. **Levels of personal stigma associated with depression are generally higher than anxiety.**
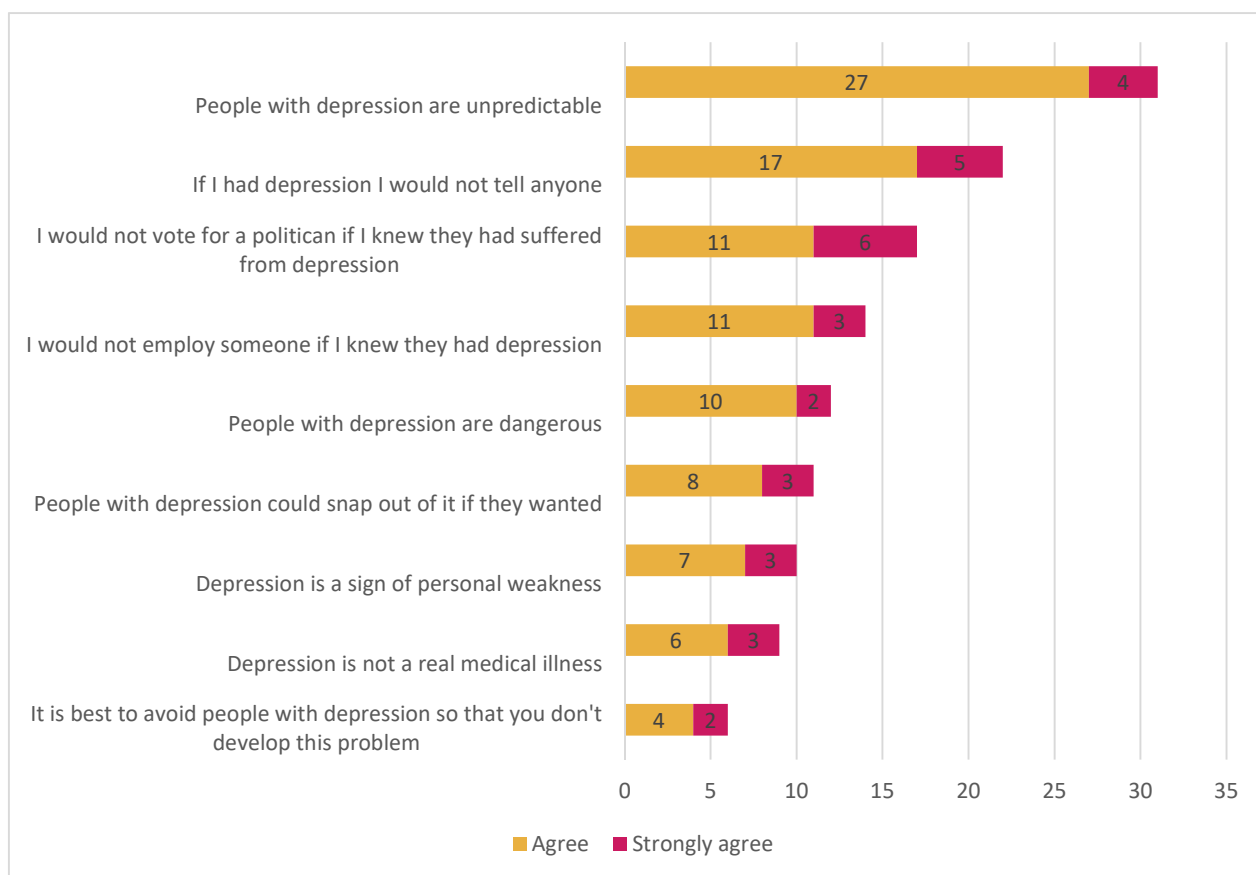

Figure 1: Depression Stigma Scale – proportion of respondents who agreed with the statement (n = 2,000)

Figure showing a horizontal stacked bar chart with Agree (yellow) and Strongly agree (pink) values:

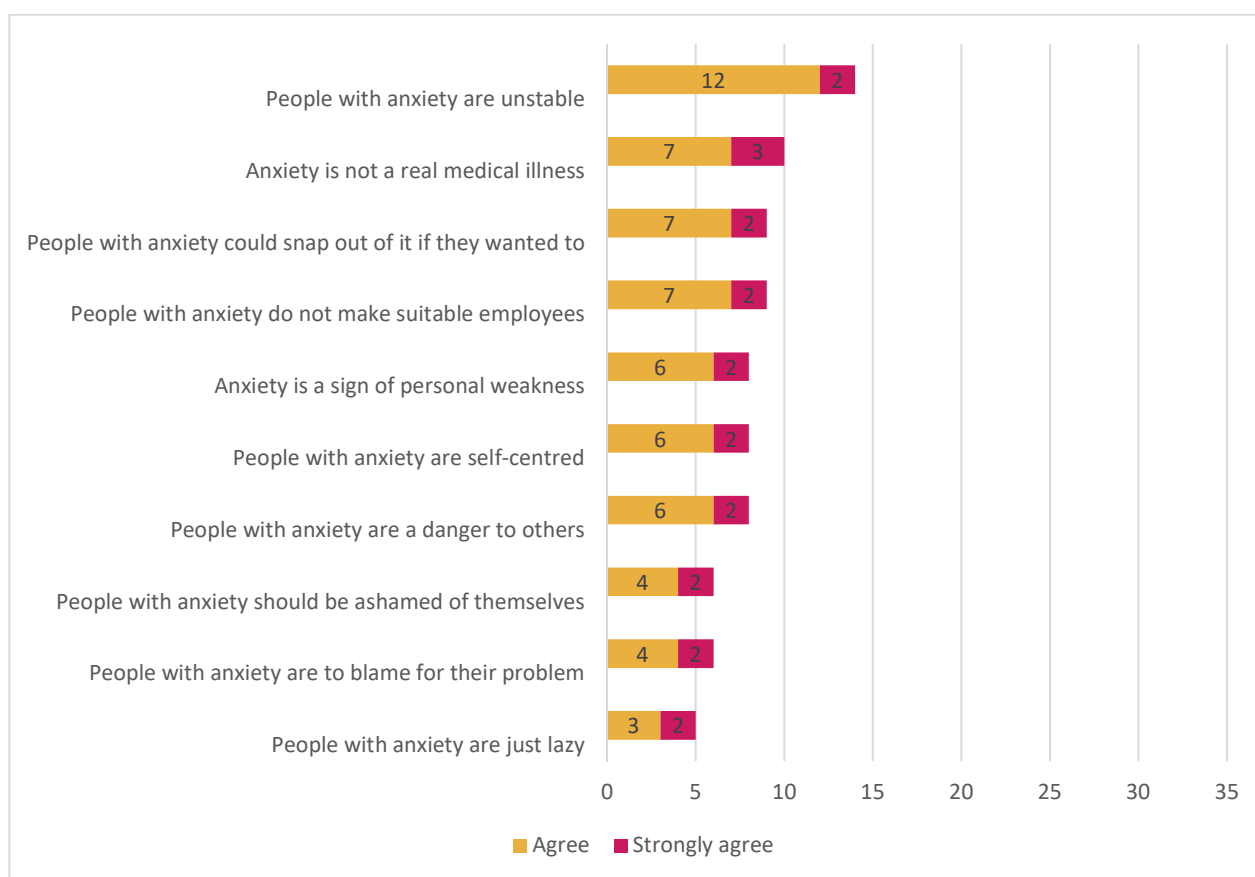| Statement	Agree	Strongly agree
People with anxiety are unstable	12	2
Anxiety is not a real medical illness	7	3
People with anxiety could snap out of it if they wanted to	7	2
People with anxiety do not make suitable employees	7	2
Anxiety is a sign of personal weakness	6	2
People with anxiety are self-centred	6	2
People with anxiety are a danger to others	6	2
People with anxiety should be ashamed of themselves	4	2
People with anxiety are to blame for their problem	4	2
People with anxiety are just lazy	3	2

Figure 2: Generalised Anxiety Stigma Scale – proportion of respondents who agreed with the statement (n = 2,000)

Reavley and Jorm (2012) assessed changes in levels of stigma over eight years (2003/04 – 2011), with a community-based sample of over 6,000 Australians aged 15 years and over. This data suggests that **there are non-significant trends which indicate that levels of stigmatising attitudes may be improving, however the belief that people with depression are dangerous and unpredictable had increased since 2003**.[39]

A **meta-analysis** of 16 studies aggregating data across United States, United Kingdom, Austria, the Netherlands, Poland, Germany, New Zealand and Australia found that **while there had been improved understanding of mental health, there had been no changes in the stigmatising attitudes toward people with mental health conditions more broadly**.[40]

Levels of discrimination

Discrimination relates to the behavioural component of stigma. There is a lack of research assessing discrimination relating to depression and anxiety - most research has measured behavioural *intentions,* rather than *actual* behaviour (for example, through assessing hypothetical rather than real situations), and/or investigated severe mental illness, typically schizophrenia. [41,42,43] However, there are two studies of note:

1. **Lasalvia and colleagues (2013)[44] recently conducted an international cross-sectional survey with more than 1,000 adults attending specialist mental health services across 35 countries**, which has increased our understanding of discrimination related to depression. This research demonstrated that: [45]

o **Discrimination is extremely common** - 79 per cent of people attending specialist mental health services reported experiencing discrimination.

o **Anticipated discrimination is also very common** - between 20 and 37 per cent of survey respondents reported stopping themselves from doing something important (for example, applying for a job, participating in social activities), because of anticipated discrimination. This contributes to people giving up important life goals, known as the 'why-try' effect. While anticipated discrimination appears to have a significant impact on people with depression, it is important to note that it is not necessarily associated with actual experiences of discrimination. Nearly half of participants who anticipated discrimination in employment and personal relationships had not actually experienced discrimination.

o The most **common sources of discrimination are from family members and in employment**.

o **Greater levels of disability** may be associated with an increased likelihood of experiencing discrimination. [46]

It is important to note that this research only included people who had been diagnosed with depression and attended specialist mental health services. The generalizability of the findings to the broader community of people with depression and/or anxiety may therefore be limited.

2. *beyondblue* **assessed experiences of discrimination among a broad community sample of 2,000 Australians, through the** *beyondblue* **Depression and Anxiety Monitor (2014)**. This online survey assessed levels of discrimination, based on the Discrimination and Stigma Scale, among those people who reported having experienced depression or anxiety in the last year (n = 757) – see Table 1. This research demonstrated that, **the situations where respondents felt unfair treatment was most prevalent included finding and keeping a job, in family relationships, in making or keeping friends and in dating or intimate relationships.**

The Depression and Anxiety Monitor data also indicates that **anticipated discrimination is common within the community**. Among those people who had experienced depression and/or anxiety in the last year:

- 51 per cent had concealed or hidden their mental health problem from others – which may relate to a fear of discrimination
- 33 per cent had stopped themselves from having a close personal relationship
- 26 per cent had stopped themselves from applying for work
- 22 per cent had stopped themselves from applying for education or training courses.

	Moderately or a lot (%)	Not at all (%)	Not applicable (%)
In finding or keeping a job	23	43	21
By your family	20	54	5
In making or keeping friends	19	50	7
In dating or intimate relationships	17	42	21
Avoided or shunned by people who know you have a mental health problem	15	48	13

In getting welfare benefits or disability pensions	13	53	25
In housing	12	61	20
In your education	11	54	26
When getting help for physical health problems	11	63	14
By the police	8	55	29
In accessing insurance	8	53	31
By mental health staff	7	62	23

Table 1: Extent to which those with depression or anxiety felt treated unfairly (n = 757)

Stigma and discrimination within different population groups

The level and type of stigmatising attitudes held by different population groups is difficult to determine, due to the complexity of stigma, and the different approaches to measurement.[47,48] Jorm, Reavley and Ross (2012) and Jorm and Oh (2008) suggest that it is important to focus on specific aspects of stigma, that have been measured in consistent ways, to determine whether there are differences within and between population groups.[49,50]

When considering **specific components of stigma**, there are differences in the characteristics of people who may hold more stigmatising views. For example, for the 'belief in dangerousness' component of stigma:[51]

- there is no consistent association between the belief and age or gender
- the belief tends to be lower in better educated people
- there are some cross-national and cross-ethnic differences in the belief.

Comparatively, for the 'desire for social distance' component of stigma, some research suggests that:[52]

- the desire is higher in older than in younger adults
- the desire declines during adolescence
- there are no reliable gender differences
- there is a weak association with low education
- there are some major cross-national differences.

Other factors to consider when reviewing the stigmatising attitudes held within and between population groups, are the differences in self, personal and perceived stigma:

- a review of levels of **self-stigma**, conducted by Livingston and Boyd (2010), suggests that there does not appear to be any consistent or strong correlations between socio-demographic factors and levels of self-stigma.[53]
- for **personal stigma**, *beyondblue's* Depression and Anxiety Monitor (2014) data suggests that males and younger people (18 – 34 years) have higher levels of stigma compared to females and older people
- for **perceived stigma,** those experiencing higher levels of distress appear to hold more stigmatising attitudes, however there are no consistent patterns across other demographic variables. [54]

The research findings suggest that **it is difficult to generalise about population groups and/or characteristics that are associated with higher or lower levels of stigmatising attitudes.**

When considering experiences of discrimination, *beyondblue's* Depression and Anxiety Monitor (2014) suggests that **males and younger people with depression and/or anxiety are more likely to have experienced discrimination in certain settings compared to females and older people**. These settings included educational and work settings, as well as within the community – by police, accessing insurance and by mental health staff.

Other forms of discrimination

It is important to note that **some population groups experience other forms of discrimination**, such as ethnic, race, sex, gender identity or sexuality-based discrimination. **This is a risk factor for poor mental health and wellbeing**. Research has clearly shown that direct discrimination, such as restricting people's participation in public life, and their access to health and housing services, is associated with poorer mental health outcomes.[55,56] The depression and anxiety-related stigma and discrimination experienced by these population groups may also be exacerbated – for example, some ethnic groups may already have difficulties in accessing the health care system, which are then heightened by the stigma and discrimination associated with their mental health condition.[57] This has been demonstrated in Australian research, which has shown that for Aboriginal and Torres Strait Islander people, experiencing racism in health settings is associated with increased psychological distress, beyond what would be expected in other settings. [58]

Experiencing mental health conditions, and the associated stigma, may also contribute to an increased likelihood of being a member of other groups that are also subject to stigma, such as those experiencing homelessness and unemployment.[59] More information on the impact of discrimination on mental health is available in the '*beyondblue Position Statement: Depression and anxiety in gay, lesbian, bisexual, trans and intersex populations*' and on the *beyondblue* Stop.Think.Respect (Phase 2) campaign website.

> *"I believe there still is a stigma with it [mental health issues], but I struggle with my mother because she's also black. I find it hard to weigh up whether certain friends have shied away because she's black and angry, or mentally ill and angry … My mum's been refused a taxi because they thought she was another black lady that hadn't paid her bill. And of course, mum having a mental illness, went off her head. He looked at her as if to say, "well, you're just a typical black woman."* Carer

> *"My long-ago therapist [was]…homophobi[c]…she said I was homosexual because I was attempting to get love from a woman…that I was denied as a child…and to be mentally healthy, I would need to be with a man."* Lesbian woman with a mental health condition

Stigma and beliefs about what causes depression and anxiety

The language used to describe experiences and causes of depression and anxiety can have a significant impact on stigma and discrimination. International research findings suggest that the framing of depression and anxiety as **'mental illnesses', 'brain diseases' or 'illnesses like any other'** can support people to access treatment, as recognising a condition as an illness is often the first step towards seeking help, and it may increase the acceptance that it is a medical problem that has a solution.[60,61] However, this framing and language may contribute towards greater levels of stigma and discrimination, including:[62]

- increasing the desire for social distance
- increasing perceived dangerousness
- increasing self-stigma, if people agree with the negative stereotypes associated with the mental illness label
- increasing anticipated discrimination for those with depression and anxiety.

Corrigan and Fong (2014)[63] suggest that using terms such as 'an illness like any other' highlights a fundamental difference between people with a mental health condition and the rest of the population, and

this 'difference' and 'otherness' underpins and exacerbates stigma. While considering depression and anxiety as 'conditions' rather than 'illnesses' may overcome some components of stigma, it may worsen attitudes towards other conditions perceived to be more serious, such as schizophrenia. Highlighting the differences between 'conditions' and 'illnesses' may negatively impact on self-stigma for those people with more serious conditions.[64] However, further research is needed to better understand the impact of language and framing of depression and anxiety on different conditions.

International researchers have suggested that highlighting the **biogenetic causes** of depression and anxiety may impact on stigma. Biogenetic explanations have been found to reduce the belief that someone is to blame for their condition; however it is also associated with increases in:

- pessimism about treatment and recovery
- the desire for social distance and social exclusion
- beliefs about 'dangerousness'
- the notion of 'otherness'.

While these research findings suggest that biogenetic causes of depression and anxiety should not be highlighted in depression and anxiety information, resources and campaigns, it is important to note that recent Australian research has suggested that biogenetic explanations are generally *not* associated with a belief in dangerousness or a desire for social distance, other than for Post-Traumatic Stress Disorder.[65] Reavley and Jorm's (2014) research suggests that explaining mental health conditions as due to personality characteristics may have a greater impact on stigma than biogenetic explanations, as believing that mental health conditions are caused by a **'weak or nervous personality'** is associated with greater levels of stigma.[66]

The contradictory findings associated with stigma and the framing of depression and anxiety, demonstrates that more research is needed to identify language that accurately describes the causes of these conditions, while also decreasing stigma and anticipated and actual experiences of discrimination, and supports people to get help for these conditions.

The impact of stigma and discrimination

The impact on people with depression and anxiety

> *"I think the reality is...the stigma of mental illness is, in some ways, worse than the illness itself. Unless the stigma can be removed to such a degree that it does not become a barrier to acknowledgement, treatment and hope for the future, the reduction of some mental illnesses will be nothing but a pipe dream."* beyondblue blueVoices member

> *"Stigma affects all areas of my life as a family carer. Family, employment, social life..."* Carer

Stigma and discrimination can have a significant impact on people with depression and anxiety and their family and friends. The greatest impact appears to be related to personal relationships and employment (as described in 'levels of discrimination').[67] The **type and impact of stigma and discrimination experienced varies across different relationships**, due to different expectations, roles and the nature and intimacy of the relationship.[68] For example, Hamilton and colleagues (2014)[69] suggest that in relationships where it is easy to physically distance oneself from someone with depression or anxiety, people will be avoided - for example, friends will not make contact and employers will not hire someone with depression or anxiety. In relationships where this is more difficult, such as families, there may be a tendency to create distance from the condition itself, by denying or dismissing the condition (*"I didn't tell my mother I'd been medicated for depression for quite some years. [When I did], my mother's response was, 'oh what rubbish, you're not depressed'."* Person with depression and anxiety). This demonstrates the need to consider different contexts and relationships when trying to reduce stigma and discrimination.[70]

beyondblue adopts a particular focus on the impact of stigma and discrimination on personal relationships, employment, access to treatment and insurance. These issues are explored further below.

Personal relationships

Stigma may adversely affect personal relationships, with research suggesting that some of the greatest levels of discrimination experienced by people with depression is from family members and friends.[71,72,73] Within families, people with depression and anxiety suggest that experiences of stigma include a **discomfort to talk about mental health issues, a denial of problems, and a dismissal of issues**:[74,75]

- *"Some of my family members are very patronising."* Person with bipolar and post-traumatic stress disorder
- *"My parents played the mute game. They didn't talk about it. I think they were uncomfortable."* Person with anxiety and obsessive compulsive disorder
- *"We spent a lot of years pretending there was something else wrong with [husband]. He knew what was wrong [depression] but he didn't want anybody to know."* Carer
- "They [my husband's family] don't understand that there are times where his behaviour may be different because he is unwell (bipolar / anxiety) – but they consider this as him being rude and weak, they then don't understand he needs to be treated gently, instead they are very tough on him, which makes the situation worse. A lack of understanding is very frustrating." Carer

Feelings of shame, the desire to protect the family name, and being labelled as an 'attention seeker', may contribute to the heightened levels of stigma experienced within families.[76]

Many people with depression and anxiety report losing friends due to their depression and/or anxiety, [77] while stigma can also impact on the development of new relationships:

> *"I am at the point in my treatment (and life) that I feel well enough to want to pursue a romantic relationship…On top of the 'normal' issues faced by a person in my position, I feel the added weight associated with suffering depression. While much of this is self-stigma (She will head for the hills if she knows I have depression; How long do I have to wait before I tell her? How am I going to explain some of the more 'intimate' side effects of the medication? etc.), there are also attitudes I hear in general conversations with acquaintances ('No, steer clear, if he has depression - it is too much hard work' or 'He will only bring you down with him'). beyondblue blueVoices member*

Employment

The stigma and discrimination associated with depression and anxiety is a significant barrier to participating in employment.[78,79,80,81] Stigma may be presented in many different ways within workplaces. This can include depression and anxiety symptoms being construed as **signs of laziness or incompetence, which can contribute to people feeling shameful about their experiences**:[82]

> *"You just get made to feel lazy, like I just couldn't be bothered turning up to work. I ended up having to resign."* Person with depression

> *"…When I was suffering, I was ashamed. I didn't let people know what I was going through. In the workplace, everybody thinks 'oh, everybody's competent, should be in charge'. You think, 'how can I tell somebody I'm anxious?'"* Person with depression and anxiety

> *"There is definite stigma and discrimination…this includes being questioned about my competence due to my mental illness, despite consistently performing well when I was at work… [and] being 'spoken to' on numerous occasions about my need to have time off despite being forthcoming about the fact that I had a mental illness. I felt very stigmatised against, as other colleagues who took time off….were not questioned as I was, and their level of competence was never in doubt as mine was."* beyondblue blueVoices member

People with depression and anxiety may experience discrimination during **recruitment, returning to work, promotional opportunities, and acknowledging workplace-related mental health problems**:[83]

> *"I think employers are reluctant. It's very hard if you have any sort of disability, let alone a mental illness that you're open about, to then be able to get employment."* Person with bipolar and post-traumatic stress disorder

> *"We went through the Comcare system, which is the federal equivalent of Workcover. You've all seen the Workcover 'return to work' ads. That's great if you've broken a leg or hurt your back. We had a workplace that was not interested in re-employing him [husband], that was not looking to find him another job. Our problem was we were going through a system that didn't recognise mental illness."* Carer

> *"Presenting a medical certificate with depression, anxiety or even stress is fraught with danger."* Person with a mental health condition

Stigma also discourages people from disclosing a mental health condition to employers.[84] An Australian study reported that 57 per cent of people with a mental health condition had disclosed their condition to an employer, and of these, 67 per cent reported it being helpful in providing better support, more

understanding, and less stress. The major reasons for not disclosing were embarrassment, fear of discrimination, and concern about how the disclosure would impact on employment opportunities.[85,86]

It is important to note that employment and disclosure is a complex issue, with complete or selective disclosure working well for some people, while not disclosing being better for others. Disclosure can be important when reasonable adjustments can be made to support an individual within the workplace.[87] Considering depression and anxiety as broad 'stress-related conditions' rather than 'psychiatric illnesses' may facilitate disclosure at work, as the conditions may be viewed as more common and transitory in nature.[88]

> *"I suffer from anxiety and mild depression and I have never told anyone other than my wife. The reason being is the stigma and discrimination that still surrounds the illness. I would go as far as saying that my anxiety has played a big part in me not getting a job in my chosen profession."* *beyondblue* blueVoices member

Access to treatment

Stigmatising attitudes impact on access to treatment and mental health services. People with depression and anxiety report experiencing stigmatising attitudes from health professionals, with **people often saying they feel patronised, punished or humiliated in dealing with health professionals**.[89, 90]

> *"I have...found that some of the young GPs who sit in as a locum tend to not take your concerns in regard to chest pains, pain and weakness in the left arm etc. seriously once they read in your notes that you have mental illness...We are not hypochondriacs or attention seekers. We are just a regular person who has a concern in regard to their health."* *beyondblue* blueVoices member

> *"A few years ago I began having small seizures and I went to see a doctor about this. The doctor's immediate assumption was that I was having anxiety attacks and that I should see my psychiatrist. I found this to be very patronising, as I know that these were not anxiety attacks...my psychiatrist...referred me to a neurologist. I have since been diagnosed with partial epilepsy. My concern with this is that if my general practitioner had been the sole health care provider with regards to my depression / anxiety then my epilepsy may not have been diagnosed at all."* Person with a mental health condition

Stigmatising attitudes and behaviours from health professionals may be unintentional, as the health care providers may be unaware that their language and actions can be harmful.[91] Despite this, **there can be significant consequences**. Stigma may contribute to feelings of embarrassment and shame, which may decrease the likelihood of seeking help, increase psychological distress, and reduce treatment adherence.[92,93,94,95] 'Diagnostic overshadowing', in which people with depression and anxiety receive poorer physical healthcare than others, can also be attributed to stigma.[96,97] These negative consequences may contribute to the increased risk of suicide and the higher mortality rates among people with mental health conditions.[98,99]

Research findings also indicate that a concern about others' reactions to seeking help, including reactions from family members, friends and work colleagues, may decrease the likelihood of using mental health services, and seeking help from informal sources. [100,101] This further demonstrates the impact of perceived stigma, and anticipated discrimination, on behaviour.

> *"...I refused the professional help I so desperately needed. The simple reason I didn't get this help was due to the stigma of having a mental illness. I believed it would have cost me my career. The tragic outcome was that I did end up losing my career and my illnesses became far worse...."* *beyondblue* blueVoices member

The level and type of stigma experienced in healthcare settings varies. International research findings suggest that clinical severity is associated with greater levels of discrimination in healthcare settings, and there may be a 'service-specific effect', in which discrimination may be more likely in institutional settings, and less likely in more empowering and recovery-oriented settings.[102] Australian research on the stigma among different health professional groups suggests that General Practitioners may be more likely to hold stigmatising attitudes relating to mental health conditions and to desire social distance, than psychologists and psychiatrists.[103] These stigmatising attitudes may also impact on the mental health and wellbeing of health professionals, and their likelihood of accessing appropriate treatment for their own mental health problems.[104]

Different components of stigma are associated with different attitudes towards help-seeking (see Table 1).[105,106, 107] Some research on the impact of stigma on help seeking is contradictory – for example, the belief that someone with a mental health condition is unpredictable has been associated with both an increased and decreased likelihood of seeking help. This highlights the need for further research to better understand this relationship. Both self and perceived stigma appear to impact help-seeking, with self-stigmatising views being particularly influential.[108]

Components of stigma which may increase the likelihood of seeking help	Components of stigma which may decrease the likelihood of seeking help
Believing that someone with a mental health condition: • is dangerous (Australian and international research) • is unpredictable (Australian research) • will never recover (international research)	*Believing that someone with a mental health condition:* • is 'weak, not sick' (Australian research) • should be avoided (Australian research) • is unpredictable (international research) • is blameworthy (international research)

Table 1: Components of stigma which increase and decrease the likelihood of seeking help. Sourced from Mojtabai (2010)[109] and Wright, Jorm and Mackinnon (2011)[110].

Insurance

> *"...Insurance companies are the worst for it! The stigma of 'Someone has been hospitalised for depression three years ago = don't cover them for income protection because they are unwell'. Lots of things change in three years, including depression which has been effectively managed."* Carer

An example of structural stigma is demonstrated through the substantial difficulties people with depression and anxiety face when seeking different types of insurance products (e.g. life, income protection, travel, health) that are otherwise readily available to people without a history of mental illness.[111] A survey conducted by *beyondblue* and Mental Health Australia in 2010 of experiences of insurance found that over 35 per cent of respondents with depression and/or anxiety strongly agreed that it was difficult for them to obtain any type of insurance due to them having experienced a mental health condition.[112] This almost doubled, increasing to 67 per cent, for life and income protection insurance.[113] Survey respondents reported experiencing significant discrimination when applying for insurance products and making claims against their policies:

• *"My broker said that income protection insurance would be too hard to get because of my history, so don't bother applying and I was advised it would be declined and thus didn't take it further…"* Person with a mental health condition

- *"…I decided not to take up the product for the time being because I felt discriminated against and deeply affected by the stigma and shame the whole process (answering the questions etc.) made me feel."* Person with a mental health condition

The impact on society

In addition to stigma and discrimination impacting on people with depression and anxiety and their family and friends, it also has a significant and negative impact on the broader society.[114,115] There are substantial costs associated with depression and anxiety – for example, it is estimated that untreated mental health conditions cost Australian workplaces approximately $11 billion per year, with the majority of these costs related to absenteeism, presenteeism and compensation claims.[116] **A significant proportion of the cost of depression and anxiety stems not from the conditions themselves, but from the stigma associated with the conditions.**[117] Gelb and Corrigan (2008) suggest that the overall cost of stigma includes lost employee productivity; higher taxes; higher insurance premiums and expenses; legal costs relating to cases of discrimination and depression and anxiety that may be attributable to workplace environments; higher treatment costs due to delays in seeking help; and lower rates of 'purchasing power' and consumption, due to under and/or unemployment.[118] These costs demonstrate the importance of reducing stigma and discrimination, not only to improve the experiences and quality of life for those people experiencing depression and anxiety and their family and friends, but also to benefit the community.[119]

Effective strategies to reduce stigma and discrimination

"I would love to be able one day to discuss my illness openly with all my friends, family and work colleagues without fear of retribution. This can only be done by extensive education of the wider community and associated healthcare professionals. People are always afraid of what they don't understand." beyondblue blueVoices member

"I believe it would be beneficial to share stories on how people have renegotiated their lives and to find new ways of being...It would be so worthwhile to hear stories of people who have recurring depression and/or anxiety who are leading fulfilling lives." beyondblue blueVoices member

Stigma-reduction approaches include: [120]

- **Educational** approaches – This includes information resources (for example, books, flyers, movies, websites etc) which challenge inaccurate stereotypes and replace them with factual information.
- **Contact** approaches – This includes interpersonal contact with people with depression/anxiety.
- **Protest** approaches – This involves highlighting of the injustices of stigma and requesting, or demanding attitudes or behaviours be suppressed. Research suggests that this approach is generally unsuccessful in changing attitudes or behaviours, however there may be a role for combining this approach with contact-based approaches, particularly in social media (for example, in 2013 people with mental health conditions protested against a 'mental health patient' Halloween costume on Twitter, which lead to retailers removing the costume from sale, apologising and donating funding to an anti-stigma campaign).[121]

Educational and contact approaches both significantly reduce stigmatising attitudes. For adolescents, educational approaches may be more effective – this may be because their beliefs are not as firmly developed as adults, and they may therefore be more likely to respond to the messages in educational programs. Educational approaches are also beneficial as they are generally low cost and have broad reach. However, for adults, **contact approaches are the most effective ways to reduce stigma**.[122,123] Integrating education and contact approaches are likely to be the most effective for stigma change.[124,125] Further research is needed to understand how to effectively and efficiently deliver and integrate multiple interventions, which lead to the greatest population-level impact.[126]

Corrigan's (2011) research indicates that there are **five principles that need to be implemented to respond to stigma effectively**:[127]

1. **Contact is fundamental.** This involves *"planned interactions between people with mental illness and key groups",* and to be most effective it should be face-to-face contact. Videotaped contact is also effective, however to a lesser degree than face-to-face. [128]
2. Contact needs to be **targeted.** It should focus on key groups such as employers, landlords and healthcare providers, and aim to change negative behaviours with affirming behaviours (for example, employers hiring more people with depression/anxiety, healthcare providers delivering high-quality and non-stigmatising services).
3. **Local** contact programs are more effective. These may include geographical, political, social, cultural and other diversity factors.

4. Contact must be **credible.** It should be with individuals who are similar in ethnicity and socioeconomic status; it should also be with individuals who are in a similar role; and the contact should be with a person who is in recovery.

5. Contact must be **continuous.** Multiple contacts should occur, and there should be a variety of messages, venues and opportunities.

Corrigan's principles of responding to stigma are supported by **recommendations from people with depression and anxiety on the most effective ways to reduce stigma**:

> *"Being around people (e.g. socialising, formal meetings etc.) who live with mental illness, in my view, can be a real eye-opener for some, as can sitting in an audience where the speaker is talking about their direct experience of mental illness(es). I believe that to be heard and understood, the message about living with mental illness needs to concentrate on the positive possibilities for individuals and communities where there is support and engagement, as opposed to the negatives."* beyondblue blueVoices member

> *"We need to emphasise that normal everyday well-adapted people suffer from mental illness and are capable of leading normal productive lives. I must say, I have made it my mission to disclose my mental illness and be very open about it. I do enjoy it when I get a positive reaction, which is most of the time. It does so much to change public perception. I am a fit, well-groomed, sensible, intelligent woman and I will do as much as I can to remove the stigma attached, even if it means going out on a limb at times."* beyondblue blueVoices member

> *"I try to be casual and open about my illness. It feels much better to be open about it and able to speak freely. I explain the illness, which helps them to understand my behaviour better, and it is reassuring for them to see that I can function normally and still be affected."* beyondblue blueVoices member

> *"Listen to someone who has experience...I think...the experience needs to come from 'like' i.e.: solicitor to solicitor, healthcare to healthcare etc., as I think there still exists an attitude that it doesn't happen to people like me. Follow up required as we all need reminding."* beyondblue blueVoices member

beyondblue (2013) commissioned an **evidence check of community and population-based interventions to reduce stigma associated with depression, anxiety and suicide**.[129] This evidence check confirmed that to successfully address stigmatising attitudes associated with depression and anxiety, a multifaceted approach is needed, that includes different types of interventions targeted to different groups. A summary of the interventions reviewed and the level of evidence to support each intervention is at Appendix 2.

A number of **comprehensive stigma reduction strategies have been implemented and evaluated internationally**. These programs provide further evidence on effective ways to reduce stigma, and should inform Australian programs. A summary of some key findings from the 'Time to Change' program in the United Kingdom, 'Opening Minds' in Canada, and 'Like Minds Like Mine' in New Zealand, are at Appendix 3. An overview of how stigma and discrimination are conceptualised globally, and the impact of this on program designed, is also provided at Appendix 4.

It should be noted that a major limitation of research on effective stigma reduction strategies is the lack of research assessing **how interventions impact on actual behavioural change, and experiences of**

discrimination.[130] The educational and contact-based approaches focus on improving knowledge and attitudes, rather than changing behaviour, and it is therefore not often possible to comment on how effective these strategies are in reducing discrimination, as there is not necessarily a direct relationship between knowledge, attitudes and behaviour.

The Global Anti-Stigma Alliance, of which *beyondblue* is a member, has advised mental health organisations worldwide of the following key approaches for stigma reduction:

- **Lived experience leadership.** People with experiences of mental health conditions are the drivers of social change. Peer support and training can empower social leaders/campaign ambassadors/change champions to challenge stigma and discrimination at individual, community and societal levels. This social leadership should be mirrored within anti-stigma programs themselves. To develop and support change programs can provide peer mentoring, training, support and networking opportunities to empower and build confidence. This can also support recovery and improve social and economic outcomes.

- **Social contact.** Meaningful, effective interaction between people with a mental health condition and people without a mental health condition. This contact, in which people openly discuss their experiences relating to mental health, acts as a mechanism for driving social change as well as empowering people with lived experience. New evidence is emerging (including by *beyondblue* of the impact of virtual social contact).

- **Social marketing.** A mix of marketing activities including paid for advertising, media relations and digital media that target public audiences to secure attitude and behaviour change. Messages and activity need to focus on recovery as messages that undermine dignity work against recovery. Evaluation has shown positive effects when someone who can recall a campaign then meets someone with a mental health condition at a social contact activity. There are two audiences to engage: the public and people with a mental health condition. Population wide messages and activities need to focus on what an audience needs in order to adopt more supportive and non-discriminatory behaviour and for people with a mental health condition to support empowerment and reduce self-stigma.

- **Cultural responsiveness and relevance.** Campaigns and events need to be tailored to and designed by specific audiences. Culturally relevant understanding, values and traditions should be considered and driven by members of those communities. The use of correct language is important. **The use of the word 'stigma' or 'discrimination' should be used with caution**, as it may automatically disconnect an audience which is unintentionally discriminating.

- **A "social movement".** An empowered and confident social movement of individuals, grassroots community groups and organisations from all sectors that are connected and supported by a coordinated campaign. Shared ownership is an important goal, as is the freedom of people to adapt their activity to suit local and organisational needs and cultures.

- **Evaluation and outcome targets.** Evaluation of anti-stigma activities is vital to ensure work is effective in reducing stigma and discrimination and increasing empowerment levels. Reducing stigma and discrimination a generational effort requiring sustained activity and investment. This investment is difficult to attain if previous initiatives have not been appropriately evaluated.

- **Focus at individual, community and societal levels.** People live and work in societies and within multiple communities. A multi-layered approach is required so that anti-stigma initiatives are multi-layered and mutually reinforcing.

The national policy framework

Reducing the stigma and discrimination associated with depression and anxiety is one of the key aims of Australia's national mental health policy and reform agenda. The need to reduce stigma and discrimination is identified in the:

- National Mental Health Policy (2008) – An aim of the Policy is to "reduce the impact of mental health problems and mental illness, including the effects of stigma, on individuals, families and the community."[131]

- Fourth National Mental Health Plan 2009 to 2014 (2009) – The Plan recognises that people with depression and anxiety and their families continue to experience stigmatising attitudes in the media and community, and are at risk of being discriminated against in areas such as employment and housing. The Plan proposes the development and implementation of a sustained and comprehensive national stigma-reduction strategy.[132]

- Ten Year Roadmap for National Mental Health Reform (2012) – Reducing stigma among mental health service and support providers is a strategy included in the Roadmap to improve access to high quality services and supports.[133]

- Mental Health Statement of Rights and Responsibilities (2012) – Non-discrimination and social inclusion is a core domain included in the Statement.[134]

- National Review of Mental Health Programmes and Services (2014) – The review acknowledges that stigma persists, and recommends that evidence, evaluation and incentives are used to reduce stigma.

beyondblue initiatives addressing stigma and discrimination

Reducing people's experiences of stigma and discrimination is one of *beyondblue's* goals in the *beyondblue* Strategic Plan 2015 – 2020. *beyondblue* is implementing a comprehensive stigma-reduction strategy, which includes the following initiatives:

- **National advertising campaigns and supporting resources** – an **educational and contact approach** - Campaigns have been developed to cover a range of conditions (such as depression, anxiety, perinatal depression); life stages (for example, youth, older people); population groups (for example, lesbian, gay, bisexual, trans and intersex people, Aboriginal and Torres Strait Islander people); and settings (for example, rural communities). *beyondblue's* campaigns are based on extensive quantitative and qualitative research with people with depression and anxiety and their family and friends, and provide insights into personal experiences. Campaign messages are disseminated and promoted via print, television, radio, cinema advertising, outdoor billboards, community events and forums and social media. *beyondblue* has also developed a comprehensive suite of free information and resources, including translated materials, which are disseminated to individuals, community groups, health centres, libraries, schools, universities, workplaces and many other settings.

- **Media coverage** – a combined **educational and contact approach** - *beyondblue* has achieved widespread media coverage of depression, anxiety and *beyondblue* programs. Within a two-month period, there are approximately 4,600 news items published or broadcast that mention *beyondblue*, with a cumulative audience/circulation of around 89.5 million people. The increased media coverage of depression and anxiety, and the promotion of personal experiences, leads to greater awareness of mental health, and may contribute to decreasing levels of stigma and discrimination.

- **Social media** – a combined **educational, contact and protest approach** – *beyondblue* utilises its strong social media presence to reduce the stigma of depression and anxiety. Social media is used to:
  - extend campaign reach – for example, in the 2013 *I Am Anxiety* campaign community members used the Twitter hashtag #IamAnxiety to say they had experienced anxiety and there was no reason to hide their experience
  - promote stories of hope and recovery - #SmashTheStigma is used when stories of hope and recovery are posted on Twitter, particularly from high profile individuals. Sharing and retweeting posts through Facebook and Twitter also provides a way for people to promote understanding and share experiences of depression and anxiety
  - increase knowledge of depression and anxiety – *beyondblue's* Facebook, Twitter and Instagram communities are encouraged to share *beyondblue* image and video content which increases knowledge about depression and anxiety (for example, infographics on the prevalence of depression and anxiety)
  - enable conversations about depression and anxiety – through *beyondblue's* online forums, Twitter and Facebook communities, there is a public place for people to share their stories of depression and anxiety and receive advice and support from others.

- ***beyondblue* speakers bureau** – a **contact approach** - *beyondblue* has a pool of speakers who have a personal experience of depression and/or anxiety. The speakers share their stories of recovery and

encourage others to take action and get the support they need, at public events, community forums and to the media.

- **blueVoices** – a **contact approach** – blueVoices is *beyondblue's* reference group of people with personal experiences of depression and/or anxiety and their family and friends. blueVoices members share their personal experiences and perspectives to inform *beyondblue's* work – for example, in campaigns, information resources, project reference and advisory groups, and research projects.

- **Conversations project** – an **educational and contact approach** – a suite of digital resources has been developed to help people have a conversation about anxiety and depression. These resources will increase the confidence and skills of people to talk about depression and anxiety across a range of settings, including among families and friends, workplaces, and with health professionals.

- *beyondblue* **National Roadshow** – an **educational and contact approach** – between February 2014 – May 2015 the *beyondblue* National Roadshow travelled over 50,000 kilometres in a big blue bus across every state and territory in Australia, visiting hundreds of communities and encouraging all Australians to 'Take 1 step' for better mental health. The Roadshow increased community awareness and understanding of depression and anxiety, and aimed to reduce stigma by supporting people to share their stories.

- **The STRIDE project** – an **educational and contact approach** – *beyondblue,* with funding from the Movember Foundation, is commissioning research partnerships to demonstrate the impact of digital interventions to reduce the stigma of anxiety, depression, and/or suicide in Australian men aged 30 to 64 years. The STRIDE project has been informed by *beyondblue's* (2013) evidence check of community and population-based interventions to reduce stigma. [135] Projects commenced in July 2015.

- *beyondblue* **workplace training programs** – an **educational and contact approach** – *beyondblue* has a face-to-face training program and a series of online resources to raise awareness of depression and anxiety in the workplace, and provide practical strategies to support individuals and promote mental health. The training programs and resources include personal stories of depression and anxiety, which aim to increase understanding of these conditions and reduce the stigma and discrimination experienced in workplaces.

- **Discrimination and insurance program** – an **educational and protest approach** - *beyondblue* and Mental Health Australia have been working together for the past ten years to reduce the discrimination experienced by people with depression and anxiety in the insurance industry. While there have been some improvements, such as the development of industry-wide guidelines for insurance sector staff, real change has been slow to happen. *beyondblue* and Mental Health Australia are now building an awareness and advocacy campaign to respond to this discrimination, and are encouraging people to share their stories. Up-to-date information is available at: http://www.beyondblue.org.au/about-us/programs/system-reform-and-access/discrimination-in-insurance

Recommendations to improve the community's response to stigma and discrimination

beyondblue's stigma and discrimination initiatives are an important component of Australia's national response to stigma and discrimination. However, to achieve population-level improvements in stigma and discrimination, it is essential that *beyondblue's* **initiatives are supported through a long-term, collaborative, whole-of-community response to stigma and discrimination**. This national response should include:

- Facilitating **personal contact** with people who have experienced depression and anxiety, in line with recommendations that contact is **targeted, local, credible and continuous.**[136] The role and opportunities to facilitate personal contact through social media should be explored
- Developing and delivering **educational approaches**, which challenge inaccurate stereotypes, and replace them with factual information
- Continuing to work with **media** to promote accurate and positive portrayals of people living with depression and anxiety, with a particular focus on personal stories
- Utilising **social media** to increase understanding of depression and anxiety and sharing personal stories
- Targeting stigma-reduction strategies to **respond to particular types of stigma** – personal, perceived, self and structural
- Delivering stigma- and discrimination-reduction interventions in **multiple settings** – for example, families, workplaces, schools, housing/accommodation services and healthcare centres
- Delivering stigma- and discrimination-reduction interventions across **population groups** with a particular focus on creating cultural and behavioural change
- Developing initiatives that measure and reduce the **structural stigma** associated with depression and anxiety, including both intentional and unintentional stigma
- Improving the **measurement** of stigma and discrimination, with a focus on **actual behavioural changes**, measured longitudinally, to enable regular monitoring of progress
- Implementing both **structural 'top down' programs** that focus on national attitudes and policies impacting on people with depression and anxiety and their family and friends, together with **'bottom up' initiatives that are led by people with depression and anxiety and their family and friends**, health care providers, community groups, schools and workplaces.[137]
- Conducting research to:
  - explore the **interplay between the knowledge, attitude and behavioural components of stigma**, and effective ways to reduce all three components
  - understand **experiences of discrimination**, and effective ways to change behaviour
  - explore the stigma and discrimination associated with **anxiety**
  - determine the best way to deliver and integrate stigma and discrimination initiatives that lead to the **greatest population-level impact**, in a sustainable and ongoing manner
  - understand how to best **optimise resources and create synergies across multiple stigma and discrimination interventions**, delivered both locally and nationally

Appendices

Appendix 1: Personal and perceived stigma

Personal and perceived attitudes – Percentage of respondents who 'agree' or 'strongly agree' with statements about personal and perceived attitudes towards people with depression, social phobia and PTSD[138]

Statement	Depression		Social phobia		PTSD	
	Personal attitude	Perceived attitude	Personal attitude	Perceived attitude	Personal attitude	Perceived attitude
Problem is a sign of personal weakness	13.9	53.0	16.5	55.2	12.1	41.0
Problem is not a real medical illness	13.2	49.5	16.3	58.7	14.9	48.9
Person could snap out of the problem	20.1	53.8	20.5	56.6	19.9	49.0
People with this problem are dangerous	22.0	39.1	15.5	35.1	18.0	36.8
Avoid people with this problem	6.4	36.6	5.2	35.5	2.9	32.6
People with this problem are unpredictable	53.1	69.2	41.7	62.3	49.3	62.3
If I had this problem I wouldn't tell anyone	22.7	70.2	29.5	73.6	17.1	63.9
I would not employ someone with this problem	22.7	70.5	29.5	65.1	17.1	58.1
I would not vote for a politician with this problem	27.0	66.0	26.1	67.4	20.2	61.3

Appendix 2: Evidence of effectiveness of stigma reduction interventions

Evidence of effectiveness of interventions[139]

Intervention	Components of stigma reduced	Level of evidence*	Notes
Psycho-education interventions	Stigmatising attitudes towards depression, including blaming the person, beliefs about dangerousness and the desire for social distance	Sufficient	The number of people that can be targeted remains relatively limited, due to the time-consuming nature of the interventions
School-based interventions	Stigmatising attitudes towards suicidal peers and suicide prevention	Sufficient	
Web-based interventions	Personal stigma to depression	Limited	These interventions may have a valuable role, due to the potential for widespread dissemination
In-person psycho-education (particularly Mental Health First Aid) and web-based interventions	Stigmatising attitudes towards depression in CALD communities, including personal stigma and desire for social distance	Limited	
Interventions targeted to health professionals	Stigma towards depression and suicide (including attitudes to working with people with depression and suicidal ideation or behaviour)	Limited	
Workplace anti-stigma interventions (particularly Mental Health First Aid)	Desire for social distance from someone with depression	Limited	Workplaces are one of the few ways to reach the adult population
National and regional community campaigns	Stigmatising attitudes to depression or anxiety disorders	Inconclusive	Research is limited due to the lack of comparison groups. Barriers to implementation include significant costs, difficulty in targeting hard-to-reach groups, and ensuring that community members

Intervention	Components of stigma reduced	Level of evidence*	Notes
			get an adequate 'dose' to impact on attitudes and behaviours
School-based interventions	Stigmatising attitudes towards depression and anxiety disorders	Inconclusive	
Workplace-based suicide prevention interventions		Inconclusive	
Interventions targeting Aboriginal and Torres Strait Islander communities	Suicide stigma	Inconclusive	
Regional campaigns targeting suicide stigma	Behaviour change (suicidal acts or help seeking)	May be effective	

*In grading the evidence, the following classifications were used:

(1) **Sufficient evidence** from well-designed research

(2) **Limited evidence** from studies of varying quality

(3) **Inconclusive evidence** due to inadequate research or research of insufficient quality

(4) **Likely to be effective** based on low quality studies or parallel evidence and where the results are unlikely to be due to chance

(5) **May be effective** based on low quality studies or parallel evidence and where the results are probably not due to chance.

Appendix 3: International stigma reduction strategies

Opening Minds - Canada

The 'Opening Minds' program was established by the Mental Health Commission of Canada in 2009. It aims to "change Canadians' behaviours and attitudes toward people living with mental illness to ensure they are treated fairly and as full citizens with opportunities to contribute to society like anyone else."[140] The program targets four groups – health care providers, youth, the workforce and the media. An interim evaluation report was published in 2013. Key findings from this report include:[141]

- Focused, **grass-roots approaches** may be more effective, efficient and sustainable compared with social marketing and public awareness campaigns
- There is an important role for the **news media** in creating and maintaining stereotypes associated with people with mental health conditions. These stereotypes can influence society's reactions to people with a mental health condition.
- For **youth-focused programs**, successful program components include:
    o Having ongoing whole-of-school strategies, which are founded on contact-based education. Short one-off interventions are not effective. Booster session and student-led activities are important.
    o Using stories that having a consistent theme of hope and recovery.
    o Selecting storytellers who are engaging and allow for active participation through questions and discussion. Storytellers need to be psychologically ready to share their story, be well supported and provided training.
- For **health professional-focused programs**, successful program components include:
    o Putting the person ahead of the illness / diagnosis
    o Demonstrating recovery and competence
    o Teaching health professionals what to do
    o Finding a passionate anti-stigma champion
    o Using multiple forms of contact-based education (e.g. live personal testimony and video), on an ongoing basis – 'one-off' programs are unlikely to achieve change
    o Including an incentive or expectation for participation (e.g. education credits, position back-filling).
- For **workplace-focused programs**, successful program components include:
    o Having high levels of interaction among group members
    o Using case scenarios specific to one's workplace
    o Using engaging and exciting videos
    o Having endorsement of the initiative from senior executives, rather than more passive approval
    o Expecting and valuing participation

Time to Change – England

Time to Change is England's mental health stigma and discrimination program, developed by Mental Health Media, Mind and Rethink Mental Illness, and launched in 2007. It is being evaluated by the Institute of Psychiatry at King's College. The program aims to improve public attitudes towards people with mental health problems.

An evaluation of the first phase of the program demonstrated that, between 2008 - 2012:[142]

- There has been an overall **3.6 per cent improvement in public attitudes**
- There has been a **4.4 per cent improvement in people's intended behaviour** towards people with mental health problems

- There have been **mixed results on people's experiences of discrimination** –
  - between 2008 and 2011 there was a 3 per cent decrease (from 91 per cent to 88 per cent) in the number of people who reported experiencing discrimination, however this had increased to the 2008 level by 2012.
  - between 2008 and 2011 there was a significant 11.5 per cent decrease in the average levels of discrimination reported; however by 2012 some of these improvements were lost, and the overall decrease in average levels of discrimination since 2008 is 5.5 per cent.
  - There have been no improvements in the levels of discrimination experienced from health professionals.[143]
- There is a **clear and consistent link between awareness of the Time to Change campaign and having more positive attitudes** - people who had seen the campaign are more likely to have better knowledge, attitudes and behaviour towards people with mental health problems than those who have not.

Key findings and recommendations from the Time to Change evaluation include:
- National anti-stigma programs can improve intended behaviour and attitudes (to a lesser extent), but not mental health-related knowledge. Local and national activities therefore need to work together to address the range of anti-stigma outcomes. [144]
- Additional research is needed to better understand the relative contributions of different interventions (e.g., local versus national, mass-media versus one-on-one).[145]
- Additional research is needed to understand how –
  - social contact can be facilitated by social marketing
  - changes in public knowledge, attitudes and behaviour in the general public influences perceptions and experiences of stigma and discrimination
  - resources can be optimised and synergies can be created across multiple interventions
  - initiatives can be integrated across local communities and nationally, to lead to the greatest impact. [146]

Like Minds, Like Mine – New Zealand

Like Minds, Like Mine is New Zealand's national program to reduce the stigma and discrimination associated with mental illness. It includes a mass media campaign, community workers, and policy initiatives.[147] There are regular surveys monitoring the response to the program, which has shown improvements in public attitudes and behaviours. A recent survey with mental health service users has demonstrated that: [148]

- Most people (89 per cent) reported experiencing discrimination due to their mental health problem. The most common sources of discrimination were the family (30 per cent), making or keeping friends (28 per cent), being avoided by people (26 per cent), in dating or intimate relationships (24 per cent), in finding a job (22 per cent), or in marriage or divorce (21 per cent). 16 per cent of respondents reported discrimination by mental health care professionals.
- Over half (54 per cent) of all participants reported improvements in discrimination over the previous five years.
- Nearly half (48 per cent) thoughts that the 'Like Minds, Like Mine' program had assisted in reducing discrimination 'moderately' or 'a lot'.

Appendix 4: Global response to stigma reduction: new paradigms of stigma reduction

Sturt, Arboleda-Florez and Sartorius (2012)[149] propose a 'new paradigm' to conceptualise stigma. This approach has implications for the design of anti-stigma programs, as outlined below:

Program components	Paradigm Lost (Stigma myths)	New Paradigm (New understanding)
Origins of stigma	Stigma is a result of ignorance and misinformation.	Stigma occurs at multiple reinforcing levels; individual, interpersonal and structural.
The nature of stigma	Stigma is generic and homogenous across large populations.	Stigma is culturally specific, locally applied and differs depending on the mental condition considered.
Selection of program objectives	On the basis of scientific evidence.	Discussions with people who have a mental illness and their families.
Targets of anti-stigma programs	The general population.	Sharply defined groups within the population.
Scope of programs	Large, social marketing programs with considerable external funding.	Small, locally situated programs and networks of programs that managed with modest budgets and considerable volunteer support.
Duration of the program	Campaigns of short duration, say 3 to 5 years.	Anti-stigma programs that are sustainable and incorporated as a routine part of activities.
Overarching goals	Improved knowledge and attitudes.	Improved life chances for and social inclusion of people who have a mental illness; removal of social and structural barriers to full and effective social participation.
Benchmarks of success	Improved self-reported knowledge and attitudes.	Changes in discriminatory behaviours and structural inequalities.
Role of people with a mental illness	Recipients and beneficiaries of anti-stigma programs.	Active participants and leaders of programs.
Role of mental health professionals	Purveyors of clinical knowledge and leaders of anti-stigma programs.	A target for anti-stigma activities and partners in community-based anti-stigma work.
Legal provisions	Ensure protection against coercion, abuse and loss of freedom (negative rights).	Promote social inclusion through legislation that insures equitable access to housing, employment and disability supports (positive rights).

Program components	Paradigm Lost (Stigma myths)	New Paradigm (New understanding)
Organisation of services	Increased accessibility to community-based care will destigmatise people with a mental illness.	Recovery-orientated care will help people with a mental illness develop meeting.
Educational approach	Factual and didactic, drive by expert knowledge about the biological basis of mental illness.	Experiential and active, drive by personal recovery stories and personal contact.
Program evaluation	Programs are not systemically evaluated; assumed that they work.	Systematic evaluation of programs in order to create best-practice models.

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