ACKNOWLEDGEMENT

An overview of beyondblue’s STRIDE initiative

Following an open, competitive process, beyondblue with donations from the Movember Foundation, commissioned six action research partnerships to answer a key question:

“Can digital interventions, implemented at a local population level, promote change across the knowledge, attitudinal and/or behavioural components of stigma experienced and/or exhibited by men aged 30 to 64 years?”

The partnerships were all required to involve multiple perspectives – local community, academics, evaluators and designers – each contributing to an integrated innovative digital project.

The Stigma Reduction Interventions: Digital Environments (STRIDE) Initiative investigated the ‘real world’ effectiveness of evidence-informed interventions and prioritised research partnerships between the community and academics.

The six commissioned projects were:

- Better Out Than In, led by the AFL Players Association
- Contact+Connect, led by Incolink
- Out of the Blue: Pete & Dale, led by VAC
- Tell Your Story, led by UNSW Refugee Trauma and Recovery Program
- The Ripple Effect, led by National Centre for Farmer Health
- Y Fronts, led by CGA Consulting

beyondblue received results of the six projects in mid-2017. These results provided us with insights into how to best use digital channels to promote behaviour change in men in their middle years so they report less stigma around mental health and/or suicide.

More information on the STRIDE Initiative, including detailed results of the research, is available at: beyondblue.org.au/stigma.

STRIDE is a beyondblue project funded with donations from the Movember Foundation.
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EXECUTIVE SUMMARY

The purpose of the Contact+Connect program was to assess the effectiveness of a digital delivery method for information and educational resources relating to mental health stigma among unemployed males in the construction industry. This report provides an overall picture of the prevalence of stigma in the construction industry, and evaluates our program’s effectiveness in mitigating stigma among Contact+Connect participants.

It has been previously shown that males in the construction industry are at greater risk of suicide than those in the general working population. In general, construction workers tend to be male and exposed to dangerous physical and psychosocial factors. They are more likely to have high levels of stigma against mental health issues and less likely to seek help. The project-based nature of the construction industry means work is cyclical and it is common for workers to experience periods of unemployment, which further compounds the risk of mental health problems. The transient nature of the workforce can contribute to a sense of disconnectedness, forming another barrier to help-seeking.

Digital interventions have been shown to be effective in modifying attitudes towards depression and behaviour towards help-seeking. The Contact+Connect program is a digital intervention that uses SMS messages to address stigma among workers in the construction industry, specifically targeting unemployed male construction workers.

Contact+Connect participants were sent seven SMS messages over a six-week period, plus two detailed online surveys. The SMS messages contained links to online content created by our team such as videos, podcasts, infographics, written information and a specially created interactive microsite. The surveys were conducted pre- and post-program and enabled us to gauge self-stigma and suicide ideation among participants before and after completing the program.

Analyses of the baseline (pre-intervention) survey data provided valuable descriptive data on stigma, social support and suicidal ideation among construction workers. Results showed that different age groups reported notable differences in the different types of stigma (shame, self-blame, help-seeking stigma). Younger participants had higher self-blame and help-seeking inhibition while older participants had higher shame. There was a minor difference in stigma by relationship status, with the exception of widowed participants who reported slightly higher levels in stigma. Participants who were not in stable relationships with partners (e.g., divorced, separated, or never married) reported more frequent suicide ideation. We also found that participants with lower social support reported higher levels of stigma and suicide ideation. Higher levels of perceived social support were generally related to less stigma and lower suicidal ideation.

The effectiveness evaluation compared changes over time in the intervention group to changes over time in the non-intervention controls. In general, there were small reductions in stigma from prior to post-participation in both the intervention and control groups. When we compared workers with high stigma between the two groups, there was more stigma reduction in the intervention group. However, there was no statistically significant difference between the intervention and control changes. But, we did find statistically significant reduction in suicide ideation due to the intervention as compared to control.

The results of the Contact+Connect evaluation suggest that Smartphone-based brief contact interventions are feasible for communicating about mental health with construction workers. We would recommend exploring different combinations of frequency and duration of content delivery to improve on our initial successes in reducing stigma and improving mental health outcomes for our target audience.
In addition, improving social support for at-risk individuals is a promising potential target for future initiatives to reduce stigma and improve mental health in this sector through brief contact or other interventions. Digital interventions can be an effective and economical tool to initiate low-intensity contact with a wide audience, and could lead to subsequent moderate or high intensity contact with individuals who are in need of support and are therefore responsive to the initial digital intervention.

As such, while stigma often stands in the way of someone who is struggling with a mental health issue and who could benefit from seeking help, we suggest that “putting it out there” and asking questions that get participants thinking about their mental health – as our program did in both the baseline and follow up surveys – and supporting this with meaningful, engaging content that is relevant to them is worthy of further investigation.
INTRODUCTION

Background

Males in the construction industry are at greater risk of suicide than those in the general working population (Milner et al., 2014). The reasons underpinning this elevated risk are multifaceted, but are likely to involve poor help-seeking and high stigma against mental health issues. Evidence suggest, for example, that help-seeking rates for common mental health problems, including depression, are consistently lower in males than in females (Oliver et al., 2005). Internalised stigma, or self-stigma (Clement et al., 2015), and stoicism (Judd et al., 2008) may represent further barriers to help-seeking in males.

Stigma is a complex process involving labelling, separation, stereotype awareness, stereotype endorsement, prejudice, and discrimination in a context in which social, economic, or political power is exercised to the detriment of members of a social group (Hinshaw and Stier, 2008; Link and Phelan, 2001). In this project, we were particularly interested in self-stigma, which we define as a personal response to perceived mental illness stigma (Corrigan and Watson, 2002). Aside from being related to poorer mental health outcomes and suicide, self-stigma can lead to poorer employment outcomes (Nicolas Rüsch et al., 2014), and loss of previously held or desired identities (e.g., employee, parent, partner), resulting in a person’s personal devaluation (Brohan et al., 2011; Yanos et al., 2008). Therefore, addressing self-stigma may bring about positive outcomes for affected individuals.

In addition to stigma, there are other factors that are likely to contribute to the high risk of suicide in the construction industry, such as the cyclical nature of the work. More so than males employed in other industries, males in construction are more likely to experience periods of unemployment (Australian Bureau of Statistics, 2015). Research consistently demonstrates that unemployment is associated with an elevated risk of mental health problems (McKee-Ryan et al., 2005) and suicidal behaviour (Milner et al., 2013). The experience of unemployment and subsequent loss of work-related identity, social support, and sense of time, structure and activity provided by employment (Jahoda, 1981), may compound feelings of self-stigma and shame associated with a mental health problem, further contributing to suicide risk. To some extent, the experience of unemployment in the construction industry is normalised, with workers anticipating periods without work as they transition between projects.

To date, there have been a limited number of intervention studies addressing stigma, help-seeking, and overall mental health of workers in the construction industry who have recently experienced unemployment. In 2010, a meta-analysis assessed the effectiveness of interventions on work participation and mental distress for unemployed adults (Audhoe et al., 2010). This review identified six studies fitting the inclusion criteria, none of which were conducted in Australia. One of the reasons for the lack of intervention studies in this area is potentially due to unemployed workers being relatively difficult to identify and engage. Because the workplace is no longer available as an intervention setting for these individuals, recently unemployed workers no longer have regular face-to-face contact with supervisors and co-workers who could provide social support, identify potential mental health problems, and help with accessing professional help. Given the logistical and feasibility challenges of face-to-face interventions for this population (e.g., added workload for supervisors), there is a growing need to address the mental health risks associated with unemployment using different platforms, such as online (e.g., social media) and electronic devices.
Online and electronic interventions have been shown to be effective in reducing stigmatising attitudes towards depression (Griffiths et al., 2004), knowledge about evidence-based treatment (Griffiths et al., 2004), help-seeking from family and friends (Christensen et al., 2004), and symptoms of depression and anxiety (Proudfoot et al., 2013). However, their effectiveness in addressing stigma and mental health among workers in the construction industry is still unknown.

We addressed this issue by conducting the Contact+Connect project, a randomised controlled trial designed to assess the effectiveness of a digital suite of informational and educational resources to address mental health self-stigma in the construction industry.

**Study design**

Contact+Connect was an individual-level two-arm randomised controlled trial, with post-intervention follow up at the conclusion of the six-week study. Recruitment was predominantly conducted via SMS messages to unemployed Incolink members using an online communications platform called Whispir, as well as through social media and word of mouth at union meetings and training courses. Full details on our recruitment strategy are outlined on page 19.

Simple randomisation using a random numbers table generated by computerised software (Stata for Windows, version 13) was used to establish the randomisation sequence. Randomisation and allocation sequence was undertaken by a researcher outside the trial. The research team were blinded from knowing which participants were in the intervention versus (waitlist) control groups.

Participants were generally not told whether they were in the intervention or (waitlist) control group. The study was approved by Deakin University Human Research Committee (approval number 2015-194). The trial was registered with the Australian and New Zealand Clinical Trial Registry (ACTRN12615000792527).

**Key influences on the design of Contact+Connect**

The motivation for the design of Contact+Connect came from “brief contact intervention” (BCI) research in suicide prevention. BCIs are defined as a variety of strategies that seek to provide support and maintain long-term contact with individuals through different modalities. Most BCIs are managed in psychiatric hospital settings at the time of discharge from hospital for a mental health problem or suicide attempt (Milner and Carter, 2016).

Findings from BCI studies suggest that providing brief, structured contacts to suicide attempters reduces the odds of future suicidal behaviours (Luxton et al., 2013; Milner et al., 2016c). Further, process evaluation indicates that those receiving BCIs find them helpful and supportive. The reasons underpinning the efficacy of this approach are likely connected to the fact that BCIs increase social ‘connectedness’ and support among isolated suicide attempters (Luxton et al., 2013; Milner et al., 2016c). Although, there are a number of other pathways through which BCIs may influence mental health, including: 1) improving suicide prevention literacy (reducing stigma, providing information on what help is available and how to access this help); 2) improving an individual’s knowledge about suicidal behaviours or self-harm (e.g., risk and protective factors), and; 3) learning alternative coping behaviours (participants learning positive and functional alternative behaviours to self-harm) (Milner et al., 2016c).

We believe the design of BCIs is strongly compatible with the goals of the STRIDE funding because BCIs explicitly focus on reducing stigma, while optimising social support and connection with participants. Aside from this, the design of online BCIs is particularly suitable to construction workers because they
can be conducted remotely, when and where this is convenient for the participant, as well as being anonymous.

A unique aspect of the project is that it reaches out to participants, who are contacted numerous times over a number of weeks. This is not usually done in intervention studies, which tend to take a ‘one off’ training approach and rely on participants making contact with the program. It is unlikely that a cohort of unemployed construction workers will seek support themselves, hence the importance of making direct contact with participants and enrolling them in a longer-term intervention.

**Process of developing stigma reduction messages**

The intervention mapping approach (Bartholomew et al., 1998; Bartholomew et al., 2011) was used to develop and refine the Contact+Connect intervention strategy. We drew on our wealth of experience in working with construction workers to inform the needs assessment phase of this project.

We then conducted two focus groups with workers in the industry (one representing unemployed construction workers sourced from a Construction, Forestry, Mining and Energy Union (CFMEU) training centre, the other represented unions and OHS representatives). These focus groups provided critical input about the suitability and usefulness of different BCI contacts. They also suggested other areas and topics that might be relevant to the target audience. For example, on the advice of focus group participants, we included additional practical information on job seeking services.

We targeted different aspects of stigma through a staged approach, where each BCI addressed different aspects of stigma and mental health literacy. For example, the first two BCIs focused on education about depression and other common mental illnesses, while subsequent BCIs focused on reducing stigma against self, emphasised the importance of social support, and provided practical job seeking tips. We used interviews and stories from real construction workers in the industry, recognising that these were likely to have much greater impact than scripted stories from actors. We used construction-specific graphics to grab attention and to reduce tension. We worked with an external video production company (Filmtime) to write and produce video interviews with construction workers and Incolink counsellors (which we uploaded to our YouTube channel), and an animation video on help-seeking. This component of the project was completed in March 2016.

We selected Whispir as the online communications platform for Contact+Connect because it enabled us to create highly relevant, branded collateral incorporating a broad mix of content types, then distribute it to registered participants via SMS. It also proved to be an invaluable recruitment tool enabling us to reach our target audience en masse via Incolink-branded SMS messages with a link to the Contact+Connect website and an invitation to sign up.

The main focus of our intervention strategy was the delivery of SMS messages (via Whispir), with links to rich content such as videos, infographics, podcasts and text. We also created a microsite that provided additional background information and visual content to support the Whispir rich content. The microsite comprised seven pages to support the seven BCIs in the program. It was hosted on a separate URL and was structured so we could control which pages were visible to which participants, ensuring no one could see content beyond whichever BCI they were up to in the program – somewhat akin to us unveiling a new episode each week. The interface from Whispir to the microsite was seamless from a participant’s perspective, but useful from an engagement perspective. As the microsite was hosted on its own URL, we were able to use Google Analytics to measure the volume of traffic clicking through to the microsite and get a clear picture of how engaged our audience was.
PROJECT GOVERNANCE

The Contact+Connect consortium was successful because it was built on a foundation of strong governance, collaborative goal-setting, well-executed planning and delivery, and ongoing analysis throughout the program. We held regular stakeholder meetings to ensure project milestones were met, issues were resolved and each team member knew what was expected of them.

The main partners in this study were:

- Incolink, a trustee company which provides financial support for construction workers when they are without work. As an industry leader, Incolink has the support of unions and employers in the industry, and is well recognised and trusted by workers. Incolink’s responsibilities included development of program content, stakeholder management, building a recruitment website, managing the recruitment of participants and delivering the program;

- Academic researchers from the University of Melbourne and Deakin University, who were responsible for the concept and co-design of the program as well as the post-program evaluation; and,

- The Creative Works (formerly Publicity Works), which was responsible for the design of the program’s microsite and a digital wallet card App.

Consortium team members

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Responsibilities</th>
<th>Key people</th>
</tr>
</thead>
</table>
| Incolink (Program Lead)| ▪ Program design, development and delivery  
                         ▪ Creation of program content (registration website, Whispir, newsletter articles etc)  
                         ▪ Recruitment and ongoing support of participants  
                         ▪ Whispir content management and outreach  
                         ▪ Stakeholder management and PR  
                         ▪ Digital wallet card implementation | Chanh Mann  
                         Teri Cooper  
                         Lewis Burnside (until Sep 2016) |
<p>| Deakin University     | ▪ Ethics Review                                                                  | Dr Allison Millner *        |</p>
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Responsibilities</th>
<th>Key people</th>
</tr>
</thead>
</table>
| Melbourne University *                                                       | • Evaluation of program outcomes  
• Implementation of academic framework  
• Academic journal publications | Dr Katrina Witt  
Dr Tony LaMontagne |
| (from Dec 2016)                                                              |                                                                                  |                             |
| The Creative Works (formerly Publicity Works)                                | • Microsite design and development  
• Graphic design of flyers and visual content  
• Digital wallet card design  
• Work completed on ‘fee for service’ basis | Paul Thompson  
Kelly Kayne  
Adam Vecchi |

**Key roles and responsibilities**

<table>
<thead>
<tr>
<th>Name / Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Chanh Mann (from Sep 2016)                                                  | • Project oversight; budget management  
• Content development and approval  
• Stakeholder management (internal, Deakin, PubWorks, FilmTime, unions)  
• beyondblue progress reports and Board reports |
| Lewis Burnside (prior) Project Manager, Incolink                            |                                                                                                                                                   |
| Teri Cooper Project Coordinator, Incolink                                   | • Content creation (copywriting; infographics; video; photography)  
• Website development (registration website, Strikingly platform)  
• Beta testing (Whispir, registration website, microsite)  
• Script, filming and editing for BCI 5 ‘employment’ (George Ryan video)  
• Whispir content development and implementation  
• Social media strategy and management  
• Program recruitment and delivery  
• Stakeholder mgmt (agency, Incolink, Deakin, Filmtime, participants)  
• Day to day project management / point of contact  
• Reporting (monthly, quarterly, final outcomes and recommendations) |
| Dr Allison Milner Senior Investigator, Melbourne University (Dec 2016 onwards) | • Program logic, data analysis and evaluation reporting  
• Program content advice  
• Implementation of academic rigour  
• Presentations at beyondblue knowledge gathering workshops  
• Input into beyondblue milestone and final reports |
| Dr Allison Milner Dr Tony LaMontagne Dr Katrina Witt Deakin Team            |                                                                                                                                                   |
| Kelly Kayne Account Manager, The Creative Works                              | • Point of contact for dealings with agency  
• Workflow management between agency creatives and Incolink  
• Invoicing |
| Paul Thompson Director The Creative Works                                    | • Project inception and scoping (agency side)  
• Quotes for additional works, billing approvals  
• Agency oversight |

11.
MARKETING AND RECRUITMENT OF PARTICIPANTS

We set a target of 700 participants – 60 per month – for our program, with the target audience being unemployed male construction workers. Being a mental health program, and because our target audience were generally a difficult to reach cohort, we knew that recruiting sufficient participants would be a challenge. Accordingly, we developed a multi-faceted marketing strategy to give our program the widest possible exposure within the scope of our limited budget and audience sensitivities.

The primary areas from which we recruited participants to the study included:

- SMS messages to Incolink members accessing employment services or redundancy funds
- Social media (organic posts by Incolink and key stakeholders, paid Facebook ads)
- Flyers and posters placed in Incolink reception, at construction sites and in union meetings/training rooms
- Incolink website banner and information page
- A callout in the footer of all mailed member statements
- Incolink’s quarterly OnSite Magazine distributed to construction companies/sites state-wide
- Referrals from family, friends or colleagues

Examples of the breadth of our marketing efforts for the program follow over the next few pages.
Invitation letter given to walk-ins as part of recruitment pack

Figure 2. Part of the welcome pack for face-to-face visitors to Incolink.
Flyers and Posters

Figure 3. (Top) A5 flyer and (above) A1 poster distributed around CFMEU training centres, in Incolink reception and published in Incolink’s quarterly print magazine, OnSite.
Social media marketing

Figure 4. Memes we created on Canva and posted to Incolink’s Facebook page.

Figure 5. Twitter post.
Figure 6. (Top) Facebook post and (above) Facebook ad with engagement statistics.
Contact+Connect Recruitment Website

All our marketing collateral was geared to funnel the target audience to our recruitment website, shown below. We created this website as a simple, one-stop-shop where potential participants could learn more about the program, read the Plain Language Statement (terms and conditions) and register for the program. In keeping with the ethos of the Contact+Connect program, the recruitment website was fully mobile responsive and could be easily viewed on any mobile device or tablet.

Figure 7. Recruitment website (www.contactconnect/incolink.org.au).

Figure 8. Recruitment website and sign-up form.
THE INTERVENTIONS

Program Structure

Participants in Contact+Connect received seven SMS messages over a six-week period, and were asked to complete two online surveys, pre- (baseline) and post-program (follow-up). The surveys provided insights that we used to analyse the impact of the program in terms of self-stigma, suicide ideation, engagement and attitudinal shifts. The baseline survey was mandatory and participants did not proceed to the interventions unless they completed it, while the follow up survey was incentivised with a prize pool of six $500 Bunnings gift cards which only those who completed it were eligible to win.

The interventions were delivered by SMS to participants’ mobile phones, with a link to rich digital content as outlined in the table below. Each week we delved into a different aspect of mental health stigma awareness. The content was distributed and hosted on a cloud-based website called Whispir which not only supports a wide range of content types such as video, podcasts and links to websites, but importantly, enabled SMS messages to be distributed to large groups of people simultaneously.

For a complete snapshot of the program, including SMS messages, the Whispir rich content linked to each SMS message, and the Contact+Connect microsite, refer to Appendix A, attached separately.

The table below shows the structure of the Contact+Connect program.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Activity / Intervention</th>
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</table>
| Pre-start | ▪ Unemployed Incolink members receive invitation to join Contact+Connect via Whispir text message with link to registration website where they can learn more and sign up.  
▪ New participants receive Whispir text message with link to pre-start survey (in Survey Monkey) – they must complete survey to progress to next stage. Those that don’t receive three reminders and a phone call. If still no survey, they are put on hold.  
▪ Once survey completed, participants are grouped then when group size is 10 or more they commence program as per schedule below. |
| Week 1 | BCI (Brief Contact Intervention) 1 – Introduction to Contact+Connect.  
BCI 2 – Information and statistics (infographic) about poor mental health. |
| Week 2 | BCI 3 – Common myths vs. facts around mental health. |
| Week 3 | BCI 4 – Recognising the signs of poor mental health. |
| Week 4 | BCI 5 – The “best ever resource for finding a new job” plus training course info. |
| Week 5 | BCI 6 – Help seeking (where to go, who to see, what’s involved). |
| Week 6 | BCI 7 – Five ways to wellbeing (connect, get active, take notice, keep learning, give).  
Two days after receiving BCI 7 participants receive the closing survey (Survey Monkey) – once completed, program concludes. |
| Notes | *To provide validity to results, 50% of participants received the interventions and 50% acted as a control group (randomly selected). Control participants subsequently received the interventions if they submitted the follow-up survey.*  
Participants could opt out at any time via an ‘Unsubscribe’ button included with every message. 20 participants chose to do so during the program. |
SMS and Rich Text Messages (via Whispir)

Personalised SMS messages were our primary source of attracting new participants. The screenshots below are typical of what we sent to prospective participants.

Figure 9. SMS messages and accompanying rich text message (via clickable link) inviting member to sign up.
Program Content

The following pages provide examples of the types of content and tone of messaging we used in our program. It is important to note that our philosophy of ‘less is more’ with regard to the amount of text used in the messages was a conscious decision to make it easier for them to be read on a mobile phone.

Figure 10. Welcome message via SMS.

Figure 11. Welcome message (rich content).

Figure 12. Welcome message (Survey Monkey baseline survey).
Figure 13. Whispir rich messages offer a professional look and feel and are easy for users to view simply by scrolling and tapping. In BCI 3 (Myths) below, users watch an imbedded video, scroll down to an infographic, then tap through to the microsite where interactive graphics enable them to tap the screen to flip between myths and facts.

**MYTH**

Mental illness is caused by a personal weakness.

**FACT**

Anxiety and depression are caused by genetic, biological, social and environmental factors. They are not character flaws. Getting help when you need it is a sign of strength.
Contact+Connect Participant Flow

12,955 people invited to join program via SMS, F2F and social media (since Feb 2016)

868 people registered for program and were sent baseline survey

187 did not complete baseline survey

- 53 unsubscribe (pre-baseline)
- 134 placed on hold (no response to survey reminders)

681 completed baseline surveys (78%)

- 353 randomly chosen to be intervention participants
- 328 randomly chosen to be control participants

53 received prog, sent follow up survey (18 unsubscribe)

252 (75%) completed survey (83 did not)

236 (72%) completed survey (90 did not)

Notes:
1. Variance between intervention and control totals due to ‘odd number’ randomisation splits being weighted towards intervention groups.

Data final as at 26 May 2017

Figure 14. Key statistics and flow of participants through the study.
Survey data

The questionnaire comprised the following items:

- **Age** (18-19, 20-29, 30-29, 40-49, 50-59, 60-69, 70+ years)
- **Gender** (Male, Female)
- **Relationship status** (Married, Divorced, Defacto/living with a partner, Never married, Widow, Separated, Don’t know)
- **Current employment status** (Unemployed, Employed)
- **Length of unemployment** (Less than one month, Greater than one month but less than six months, Greater than 6 months but less than one year, Greater than one year)
- An adapted version of the shame, self-blame, and help-seeking inhibition aspects of the Self-Stigma of Depression Scale (SSDS) (Barney et al., 2010)
- An adapted version of the Multidimensional Scale of Perceived Social Support scale (MSPSS) (Zimet et al., 1988)
- Thoughts about suicide in the past six months, communication of suicidal intentions to another person, attempted suicide in the past six months, as adapted from the Suicidal Behaviours Questionnaire-Revised (SBQ-R) (Osman et al., 2001).

Outcome variables of interest

The primary outcomes of the study were the three subscales of the SSDS, all of which measure different aspects of the self-stigmatising attitudes (Barney et al., 2010).

The help-seeking subscale is comprised of four items:

1. I would feel embarrassed about seeking professional help for depression;
2. I would feel embarrassed if others knew I was seeking professional help for depression;
3. I would see myself as weak if I took antidepressants; and,
4. I wouldn’t want people to know that I wasn’t coping.

There is also a self-blame subscale, comprised of three items:

1. I would think I should be able to cope with things;
2. I would think I should be able to ‘pull myself together’; and,
3. I would think I should be stronger.

Finally, there is a shame subscale, comprised of four items:

1. I would feel ashamed;
2. I would feel embarrassed;
3. I would feel inferior to other people; and,
4. I would feel disappointed in myself.

Scale reliability coefficients can be seen below.

Another outcome variable of interest was suicide ideation (thoughts about suicide), the extent to which thoughts about suicide were communicated, and suicide attempts in the past six months, as measured by SBQ-R. We dichotomised the suicide-related items at the median score because the original variables were skewed (the majority of people reported no ideation, communication or attempts).
Research questions and analysis for the baseline and follow-up data

Analysis of the baseline outcome variables (discussed above) composed of descriptive statistics, including mean (average) differences and percentage differences. We also calculated the scale reliability coefficients for the subscales for the SSDS and the MSPSS. Aside from this overall description of the sample, we were particularly interested in exploring the associations between stigma, relationship status, suicidal thoughts, and social support, as described below. We were unable to assess associations with suicide attempts due to a small number of participants who reported that they had attempted suicide.

Using baseline and follow up data, we then examined whether the Contact+Connect program had any significant effects on our primary (stigma) or secondary (suicide ideation) outcomes. We used a smaller sample to conduct this analysis, as we had to use participants who had taken part in both the baseline and final evaluation. The analytic approach we used to conduct effectiveness evaluation is described below.

Research question one

*Is the presence of a romantic partner related to lower stigma and thoughts about suicide?*

Our first analysis sought to examine whether the presence of a romantic partner was related to help-seeking stigma and thoughts about suicide. The rationale for this investigation comes from past research which suggested that romantic partners play a significant role in a person’s decision to seek help for a mental health problem (Arnell, 2014). We also assessed whether those who had a partner had lower levels of thoughts about suicide, based on past findings in suicide research which suggest that relationships are protective (Corcoran and Nagar, 2010). We reported the results using descriptive statistics.

Research question two

*Are higher levels of social support related to lower stigma and thoughts about suicide?*

Second, we examined whether the presence of global social support was related to stigma, willingness to help or thoughts about suicide. This analysis differs from that described above on relationship status and stigma as the MSPSS explicitly focuses on perceived emotional support, while the variable “relationship status” does not provide information on the subjective emotional quality of a relationship. People with higher levels of perceived social support (defined as the social resources that persons perceive to be available to them) (Cohen et al., 2000) have better mental health than those with less social support (Barrera, 1986; Cohen and Wills, 1985; Kawachi and Berkman, 2001; Lakey and Orehek, 2011). Hence, we expected that people with greater scores on the MSPSS had lower levels of thoughts about suicide, and lower levels of self-stigma. We reported the results using descriptive statistics.

Research question three

*Are stigma and thoughts about suicide higher among those who are unemployed?*

Third, we assessed whether those who were unemployed had worse stigma than those who were employed. As reviewed in the introduction of this report, unemployment may result in a loss of social status related to the work role, as well as a reduction in social support from colleagues, and the sense of time, structure and activity provided by employment (Jahoda, 1981). The negative experiences
associated with job loss may compound feelings of self-stigma and shame associated with a mental health problem. We reported the results using descriptive statistics.

**Research question four**

*What is the effect of Contact+Connect on stigma?*

We assessed whether those assigned to the Contact+Connect program (intervention group) had lower levels of help-seeking, shame, and self-blame than those who had not taken part in the program (wait-list group). We conducted a repeated-measures two-way ANOVA to explore the impact of group (intervention, control) and time (baseline, follow-up) on help-seeking, shame, and self-blame. We reported the impact of interaction between group and time and the main impact of time. The impact was considered as significant if p value < 0.05.

**Research question five**

*What is the effect of Contact+Connect on suicide ideation?*

We then assessed whether those assigned to the Contact+Connect program (intervention group) had lower levels of suicide ideation than those who had not taken part in the program (wait-list group). We conducted a logistic regression model to assess the impact of the program on suicide ideation. In the model, suicide ideation was the outcome variable and the interaction between group and time was the exposure variable. We considered the impact as significant if p value < 0.05.
EVALUATION – Baseline analysis

Demographics

There were 641 participants who returned a baseline questionnaire. The majority of participants were aged 40 to 49 years and married (Table 2). A total of 75.7% were unemployed at baseline and 24.3% were employed.

Table 1. Demographic characteristics of the baseline sample.

<table>
<thead>
<tr>
<th></th>
<th>Married/Defacto (%)</th>
<th>Preferred not to say (%)</th>
<th>Never married (%)</th>
<th>Divorced/Separated (%)</th>
<th>Widowed (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-19 years</td>
<td>0.0</td>
<td>0.0</td>
<td>1.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td>20-29 years</td>
<td>7.4</td>
<td>36.7</td>
<td>29.7</td>
<td>2.5</td>
<td>28.6</td>
<td>12.5</td>
</tr>
<tr>
<td>30-39 years</td>
<td>26.2</td>
<td>13.3</td>
<td>28.0</td>
<td>21.0</td>
<td>0.0</td>
<td>25.0</td>
</tr>
<tr>
<td>40-49 years</td>
<td>328</td>
<td>33.3</td>
<td>24.6</td>
<td>33.3</td>
<td>14.3</td>
<td>31.2</td>
</tr>
<tr>
<td>50-59 years</td>
<td>25.2</td>
<td>10.0</td>
<td>13.6</td>
<td>32.2</td>
<td>42.9</td>
<td>23.6</td>
</tr>
<tr>
<td>60-69 years</td>
<td>8.4</td>
<td>6.7</td>
<td>2.5</td>
<td>9.9</td>
<td>14.3</td>
<td>7.5</td>
</tr>
<tr>
<td>Total (n)</td>
<td>405</td>
<td>30</td>
<td>118</td>
<td>81</td>
<td>7</td>
<td>641</td>
</tr>
</tbody>
</table>

Relationship status

- 60-69 years
- 50-59 years
- 40-49 years
- 30-39 years
- 20-29 years
- 18-19 years
As shown in Table 2, the majority of those people who were unemployed had been without work between one and six months, followed by being without work less than one month.

Table 2. Length of unemployment, among those unemployed at baseline.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 month</td>
<td>133</td>
<td>28.3</td>
</tr>
<tr>
<td>Greater than 1 month but less than 6 months</td>
<td>259</td>
<td>53.2</td>
</tr>
<tr>
<td>Greater than 6 months but less than 1 year</td>
<td>51</td>
<td>10.5</td>
</tr>
<tr>
<td>Greater than 1 year</td>
<td>36</td>
<td>7.4</td>
</tr>
</tbody>
</table>

The scale reliabilities, inter-item covariance and basic descriptives for the sub (and total) Self-Stigma of Depression Scale (SSDS) can be seen in Table 3. There was good reliability for help-seeking and shame, but a lower reliability coefficient for the self-blame subscale.

Based on the median split, 39.47% of workers reported stigma according to the help-seeking subscale, 31.60% reported stigma according to the self-blame subscale and 41% reported stigma according to the shame subscale.

Table 3. Descriptive statistics for the Self-Stigma of Depression Scale (SSDS)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Reliability coefficient</th>
<th>Inter-item covariance</th>
<th>Min, max</th>
<th>Mean, median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help-seeking subscale (4 items)</td>
<td>0.9</td>
<td>0.4</td>
<td>4, 16</td>
<td>9.8, 10</td>
</tr>
<tr>
<td>Self-blame subscale (3 items)</td>
<td>0.7</td>
<td>0.2</td>
<td>3, 12</td>
<td>7.7, 8</td>
</tr>
<tr>
<td>Shame subscale (4 items)</td>
<td>0.9</td>
<td>0.7</td>
<td>4, 16</td>
<td>9.6, 10</td>
</tr>
</tbody>
</table>
### Multidimensional Scale of Perceived Social Support scale (MSPSS)

Table 4. Descriptive statistics for the Multidimensional Scale of Perceived Social Support scale (MSPSS)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Reliability coefficient</th>
<th>Inter-item covariance</th>
<th>Min, max</th>
<th>Mean, median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social support friends (2 items)</td>
<td>0.7</td>
<td>0.7</td>
<td>2, 10</td>
<td>6.1, 8</td>
</tr>
<tr>
<td>Social support family (2 items)</td>
<td>0.8</td>
<td>1.1</td>
<td>2, 10</td>
<td>7.1, 8</td>
</tr>
<tr>
<td>Social support special person (2 items)</td>
<td>0.7</td>
<td>0.9</td>
<td>2, 10</td>
<td>7.5, 8</td>
</tr>
<tr>
<td>Total social support scale (3 items)</td>
<td>0.8</td>
<td>2.0</td>
<td>6, 30</td>
<td>20.7, 22</td>
</tr>
</tbody>
</table>

The total social support scale produced a higher scale reliability coefficient (0.70) than the three subscales. This is likely because there are only two scales in each subscale.
Suicidality – thoughts, communication and actions

Nearly 18% of participants reported thinking about suicide in the six months prior to the study starting. In Table 5, a smaller proportion of participants had communicated to others that they had thought about suicide (7.5%) and an even smaller proportion of participants reported that they had attempted suicide (3.4%). Thirty-one people did not respond to this question and were thus excluded from all analyses on thoughts about suicide.

Table 5. Statistics for thoughts, communication and suicide attempts over past 6 months.

<table>
<thead>
<tr>
<th>Had suicide thoughts</th>
<th>Communicated suicidal thoughts (%)</th>
<th>Attempted suicide (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>82.3</td>
<td>92.5</td>
</tr>
<tr>
<td>Yes</td>
<td>17.7</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Suicidality reporting

Stigma by age

Table 6 shows notable differences in stigma by age. Higher values on each of these subscales represented higher levels of stigma. It appears that younger participants had higher levels of self-blame and help-seeking stigma than older participants. However, descriptive results suggested that older participants had higher levels of shame than those who were younger.

Table 6. The self-blame, help-seeking and shame subscales of the SSDS by age.
Research question one

*Is the presence of a romantic partner related to lower stigma and thoughts about suicide?*

Table 7 shows that participants who were widowed had higher stigma than those in other relationship status groups (albeit based on a small sample). There were similar levels of stigma across all other relationship status groups.
Table 7. The self-blame, help-seeking and shame subscales of the SSDS by relationship status.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Error</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-blame</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>7.6</td>
<td>0.1</td>
<td>7.4</td>
<td>7.7</td>
</tr>
<tr>
<td>Preferred not to say</td>
<td>7.6</td>
<td>0.3</td>
<td>6.9</td>
<td>8.2</td>
</tr>
<tr>
<td>Never married</td>
<td>7.9</td>
<td>0.2</td>
<td>7.7</td>
<td>8.3</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>7.7</td>
<td>0.2</td>
<td>7.3</td>
<td>8.1</td>
</tr>
<tr>
<td>Widowed</td>
<td>8.1</td>
<td>0.7</td>
<td>6.8</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Help-seeking</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>9.7</td>
<td>0.1</td>
<td>9.4</td>
<td>10.0</td>
</tr>
<tr>
<td>Preferred not to say</td>
<td>10.2</td>
<td>0.4</td>
<td>9.4</td>
<td>11.1</td>
</tr>
<tr>
<td>Never married</td>
<td>10.2</td>
<td>0.2</td>
<td>9.7</td>
<td>10.7</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>9.5</td>
<td>0.3</td>
<td>8.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Widowed</td>
<td>10.7</td>
<td>1.1</td>
<td>8.5</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Shame</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>9.6</td>
<td>0.2</td>
<td>9.3</td>
<td>9.9</td>
</tr>
<tr>
<td>Preferred not to say</td>
<td>9.5</td>
<td>0.4</td>
<td>8.7</td>
<td>10.4</td>
</tr>
<tr>
<td>Never married</td>
<td>10.0</td>
<td>0.3</td>
<td>9.5</td>
<td>10.5</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>9.6</td>
<td>0.3</td>
<td>8.9</td>
<td>10.2</td>
</tr>
<tr>
<td>Widowed</td>
<td>9.9</td>
<td>1.7</td>
<td>6.6</td>
<td>13.1</td>
</tr>
</tbody>
</table>

Table 8 shows participants who were divorced, separated, never married, or widowed reported higher levels of thoughts about suicide than those who were married.
### Table 8. Thoughts of suicide by relationship status

<table>
<thead>
<tr>
<th></th>
<th>No (%)</th>
<th>Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced/Separated</td>
<td>11.7</td>
<td>18.4</td>
</tr>
<tr>
<td>Preferred not to say</td>
<td>4.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Married/De facto</td>
<td>64.7</td>
<td>55.3</td>
</tr>
<tr>
<td>Never married</td>
<td>18.0</td>
<td>20.2</td>
</tr>
<tr>
<td>Widowed</td>
<td>0.8</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Total (n)</strong></td>
<td>529</td>
<td>114</td>
</tr>
</tbody>
</table>

### Research question two

*Are higher levels of social support related to lower stigma and thoughts about suicide?*

Table 9 shows that participants with low social support had much higher mean levels of shame and help-seeking stigma, while differences with the self-blame scale were less apparent.

### Table 9. Stigma by low, low-medium, medium-high, and high levels of social support.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Error</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shame</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total social support – low</td>
<td>10.7</td>
<td>0.3</td>
<td>10.1</td>
<td>11.2</td>
</tr>
<tr>
<td>Total social support - low and medium</td>
<td>10.2</td>
<td>0.2</td>
<td>9.8</td>
<td>10.6</td>
</tr>
<tr>
<td>Total social support - medium and high</td>
<td>9.6</td>
<td>0.2</td>
<td>9.1</td>
<td>10.0</td>
</tr>
<tr>
<td>Total social support – high</td>
<td>8.3</td>
<td>0.2</td>
<td>7.9</td>
<td>8.7</td>
</tr>
<tr>
<td><strong>Self-blame</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total social support – low</td>
<td>8.0</td>
<td>0.2</td>
<td>7.7</td>
<td>8.3</td>
</tr>
<tr>
<td>Total social support - low and medium</td>
<td>7.9</td>
<td>0.1</td>
<td>7.7</td>
<td>8.2</td>
</tr>
<tr>
<td>Total social support - medium and high</td>
<td>7.7</td>
<td>0.1</td>
<td>7.4</td>
<td>7.9</td>
</tr>
</tbody>
</table>
Table 10 shows that participants who reported thoughts of suicide more frequently reported low social support than those who did not report thoughts of suicide.

Table 10. Thoughts of suicide by low, low-medium, medium-high, and high levels of social support.

<table>
<thead>
<tr>
<th>Social support levels</th>
<th>No (%)</th>
<th>Yes (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total social support – low</td>
<td>18.7</td>
<td>30.7</td>
<td>20.8</td>
</tr>
<tr>
<td>Total social support - low and medium</td>
<td>30.4</td>
<td>37.7</td>
<td>31.7</td>
</tr>
<tr>
<td>Total social support - medium and high</td>
<td>20.2</td>
<td>8.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Total social support – high</td>
<td>30.6</td>
<td>22.8</td>
<td>29.2</td>
</tr>
<tr>
<td><strong>Total (n)</strong></td>
<td><strong>529</strong></td>
<td><strong>114</strong></td>
<td><strong>643</strong></td>
</tr>
</tbody>
</table>
Research question three

Is stigma and thoughts about suicide higher among those who are unemployed?

Table 11 shows that participants who were unemployed had slightly higher mean levels of self-blame, help-seeking, and shame stigma than those who employed.

Table 11. The self-blame, help-seeking and shame subscales of the Self-Stigma of Depression Scale (SSDS) by employment status.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Error</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-blame</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>7.6</td>
<td>0.2</td>
<td>7.3</td>
<td>7.9</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7.7</td>
<td>0.1</td>
<td>7.5</td>
<td>7.8</td>
</tr>
<tr>
<td><strong>Help-seeking</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>9.7</td>
<td>0.2</td>
<td>9.2</td>
<td>10.1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>9.9</td>
<td>0.1</td>
<td>9.6</td>
<td>10.1</td>
</tr>
<tr>
<td><strong>Shame</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>9.4</td>
<td>0.2</td>
<td>8.9</td>
<td>9.8</td>
</tr>
<tr>
<td>Unemployed</td>
<td>9.7</td>
<td>0.1</td>
<td>9.5</td>
<td>10.0</td>
</tr>
</tbody>
</table>
Table 12 shows no marked difference between participants who did and did not report thoughts of suicide by employment status.

Table 12. Thoughts of suicide by employment status.

<table>
<thead>
<tr>
<th>Overall suicidality</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>156</td>
<td>83.3%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>487</td>
<td>81.9%</td>
</tr>
<tr>
<td>Total (n)</td>
<td>643</td>
<td>529</td>
</tr>
</tbody>
</table>
Research question four

Overall, 56% of participants who agreed to participate completed the follow-up survey. Beyond this, a further 12 were excluded from the effectiveness evaluation upon data cleaning because of ineligible participant numbers. Based on a total of 245 participants in the intervention group and 231 participants in the control group, we conducted effectiveness evaluation.

What is the effect of Contact and Connect on stigma?

Table 13 shows a reduction in help-seeking inhibition from baseline to follow-up in the intervention group. A repeated, measured two-way ANOVA was conducted to explore the impact of group (intervention, control) and time (baseline, follow-up) on help-seeking inhibition. The interaction effect between group and time was not statistically significant, F(1,448)=2.32, p=0.13. There was no statistically significant main effect for time, F(1,448)=2.88, p=0.09.

We also analysed help-seeking stigma as a binary variable based on the median (50% percentile), as can be seen below. There was a 4.2% reduction in the intervention group and a 2.6% reduction in the control.

Table 13. Effectiveness of Contact+Connect intervention on help-seeking inhibition.

<table>
<thead>
<tr>
<th>Stigma subscale</th>
<th>Intervention group (n=252)</th>
<th>Control group (n=236)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow-up</td>
</tr>
<tr>
<td>Mean</td>
<td>10.0</td>
<td>9.6</td>
</tr>
<tr>
<td>s.d.</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>9.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Low stigma (&lt;9) %</td>
<td>57.4</td>
<td>61.5</td>
</tr>
<tr>
<td>High stigma (&gt;10) %</td>
<td>42.6</td>
<td>38.5</td>
</tr>
</tbody>
</table>

s.d.: standard deviation. CI: confidence interval.
Table 14 shows a reduction in self-blame from the baseline to follow-up. This reduction was greater in the intervention group than the control group. Using the same model above as for help-seeking, results on self-blame showed that the interaction effect between group and time was not statistically significant, \( F(1,453)=0.02, p=0.896 \). There was no statistically significant main effect for time, \( F(1,453)=0.67, p=0.412 \). We also analysed self-blame stigma as a binary variable based on the median (50% percentile), as can be seen below. There was a 5.8% reduction in the intervention group, and a 3.3% reduction in the control.

Table 14. Effectiveness of Contact+Connect intervention on self-blame.

<table>
<thead>
<tr>
<th></th>
<th>Intervention group (n=252)</th>
<th>Control group (n=236)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow-up</td>
</tr>
<tr>
<td>Mean</td>
<td>7.6</td>
<td>7.5</td>
</tr>
<tr>
<td>s.d.</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>7.5</td>
<td>7.2</td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>7.8</td>
<td>7.7</td>
</tr>
<tr>
<td>Low stigma (&lt;8) %</td>
<td>69.8</td>
<td>75.6</td>
</tr>
<tr>
<td>High stigma (&gt;9) %</td>
<td>30.2</td>
<td>24.4</td>
</tr>
</tbody>
</table>

s.d.: standard deviation. CI: confidence interval.
Table 15 shows a reduction in shame in both the intervention and control groups. Using the same model above as for help-seeking, results on shame suggest that the interaction effect between group and time was not statistically significant, $F(1,461)=0.02, p=0.880$. However, there was statistically significant main effect for time, $F(1,461)=8.25, p=0.004$, indicating that all participants reported significantly lower levels of shame in follow-up compared to baseline. We also analysed self-blame stigma as a binary variable based on the median (50% percentile), as can be seen below. There was a 6.4% reduction in the intervention group, and a 2.2% reduction in the control.
Table 15. Effectiveness of Contact+Connect intervention on shame.

<table>
<thead>
<tr>
<th></th>
<th>Intervention group (n=252)</th>
<th>Control group (n=236)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow-up</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>9.7</td>
<td>9.3</td>
</tr>
<tr>
<td><strong>s.d.</strong></td>
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<td>0.2</td>
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<tr>
<td><strong>Lower 95% CI</strong></td>
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<tr>
<td><strong>Upper 95% CI</strong></td>
<td>10.0</td>
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<tr>
<td><strong>Low stigma (&lt;10) %</strong></td>
<td>56.3</td>
<td>62.7</td>
</tr>
<tr>
<td><strong>High stigma (&gt;11) %</strong></td>
<td>43.7</td>
<td>37.3</td>
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</table>

s.d.: standard deviation. CI: confidence interval.
Research question five

*What is the effect of Contact and Connect on suicide ideation?*

Table 16 shows a significant reduction in suicide ideation from baseline to follow-up in the intervention group (22.7% to 14.7%, p<0.001), which equates to an improvement of 8.0%. There was a smaller, though still significant, reduction for Control participants whose baseline result was 12.0% compared with 6.9% in the follow up survey, equating to a 5.1% improvement.

Table 16. Effectiveness of Contact+Connect intervention on suicide ideation.

<table>
<thead>
<tr>
<th></th>
<th>Intervention group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (N=343)</td>
<td>Follow-up (N=245)</td>
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<tr>
<td>Frequency</td>
<td>78</td>
<td>36</td>
</tr>
<tr>
<td>% suicide ideation</td>
<td>22.7%</td>
<td>14.7%</td>
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<tr>
<td>Effectiveness (+/-)</td>
<td>+8.0%</td>
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Effectiveness on suicide ideation

- Intervention: Baseline 22.7%, Follow-up 14.7%, Effectiveness +8.0%
- Control: Baseline 12.0%, Follow-up 6.9%, Effectiveness +5.1%
PROGRAM PERFORMANCE

The following pages summarise the key metrics and outcomes for Contact+Connect at the completion of the 12-month program.

<table>
<thead>
<tr>
<th>Group</th>
<th>Group size</th>
<th>Intervention</th>
<th>Control</th>
<th>Unsubs crd</th>
<th>Qty sent</th>
<th>Done</th>
<th>% Done</th>
<th>Survey 1 baseline</th>
<th>BOI 1 sent</th>
<th>BOI 2 sent</th>
<th>BOI 3 sent</th>
<th>Wallet</th>
<th>BOI 4 sent</th>
<th>BOI 5 sent</th>
<th>BOI 6 sent</th>
<th>BOI 7 sent</th>
<th>Date survey 2 sent</th>
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<th>Survey 2 Control</th>
<th>% who finish</th>
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<th>Control</th>
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</table>

Figure 15. Chart shows program delivery and completion data for each of the 24 groups who went through the Contact+Connect program between Mar 2016 and Apr 2017.
Figure 16. Scorecards for the study, showing rates of completion (ie submission of follow up survey) for each group.

Figure 17. The overall participation summary, including unsubscribers, for each group.
Figure 18. The above chart shows monthly recruitment performance vs targets, while the table (top) provides the actual data for each month that the program ran.

<table>
<thead>
<tr>
<th>Range</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<th>Feb</th>
<th>Mar</th>
<th>Total</th>
<th>Weekly av.</th>
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<td>5</td>
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<td>7</td>
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<td>264</td>
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</table>

| Month total | 59  | 28  | 69  | 90  | 65  | 67  | 53  | 63  | 100 | 15  | 38  | 213 | 8    | 868     |
|-------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-------|----------|
| Running total| 59  | 87  | 156 | 246 | 311 | 378 | 431 | 494 | 594 | 609 | 647 | 860 | 868  | 868     |

| Mnthly target | 60  | 60  | 60  | 60  | 50  | 60  | 60  | 60  | 60  | 50  | 50  | 50  | 50   | 700     | 700     |
| MTD +/-      | -1  | -32 | 9   | 30  | 5   | 7   | -7  | 3   | 40  | -45 | -12 | 163 | 8    | 168     | 168     |

| Accrued target | 61  | 93  | 84  | 54  | 49  | 49  | 46  | 46  | 6   | 41  | 53  | 0   | 641   | 613     | 544     | 454     | 389     | 322     | 268     | 206     | 106     | 91      | 53      | -160    | -168    | 0       |

| Balance      | 641 | 613 | 544 | 454 | 389 | 322 | 268 | 206 | 106 | 91  | 53  | -160 | -168  | 0     | 899     |
Figure 19. The first chart relates to the % of respondents who have received all interventions and returned their final survey; the second shows how people found out about Contact+Connect.
PARTICIPANT ENGAGEMENT SURVEY

To gauge the post-program benefits (if any) of participants of the Contact+Connect program, we sent all our participants a feedback survey after the completion of the Contact+Connect Program. Considering that participants had already completed two or three surveys for us, we had a fairly high rate of response with 117 participating completing a survey. The key outcomes are provided below.

Most respondents are between 40 and 60 years of age which is our targeted cohort.

Figure 20. Age of Respondents
Equal number of employed and unemployed participants responded and the largest cohort of those who were unemployed have been out of work for 6 to 12 months.

**Figure 21. Respondent’s Employment Status**

**Figure 22. Duration of Unemployment**
Twenty percent of respondents spoke with a mental health professional since completing program. Before joining the program, only 34% had ever had professional counselling.

Figure 23. Help-seeking behaviour post-program participation

Figure 24. Prior mental health support exposure
Since their participation in the program, 42% had assisted someone who was experiencing a mental health issue and in the majority of cases by referring them to a mental health professional.

**Figure 25. Awareness raising outcome**

**Figure 26. Referral pathways to support**
Most encouraging is their motivation to join the program regardless of incentives as 81% would have enrolled and participated in the program.

Figure 27. Motivation and interest in program
DISCUSSION

Results of the baseline data

Our findings suggest that self-blame and help-seeking stigma were much higher among younger than older persons, who instead had higher average values of shame. Differences in attitudinal factors and stigma regarding mental health by age have also been found in past research (Farrer et al., 2008; Fisher and Goldney, 2003), suggesting the importance of taking age-specific approaches to addressing stigma in public health campaigns (Farrer et al., 2008). However, we would note that there has been limited previous research on this specific stigma scale by age in the construction work. We would encourage more research on this. More generally, there is a well-established body of research on the adverse effects of stigma on help-seeking for a mental health problem (Clement et al., 2015; Schnyder et al., 2017). Our study adds to these findings and indicates the importance of recognising that different types of stigma may be more problematic in different age groups.

Overall, there was a relatively high proportion of thoughts about suicide in the sample (18%) within six months of the survey. Estimates in the general Australian population have suggested a 12-month prevalence of thoughts about suicide ranging from 2.3% (Johnston et al., 2009) to about 13% (Milner et al., 2016b). The high proportion of thoughts about suicide is perhaps unsurprising considering the range of risk factors in the sample, e.g., construction workers and unemployed persons usually have higher rates of suicide (Milner et al., 2014; Milner et al., 2013).

Aside from these overall observations, our baseline analysis of Contact+Connect provided answers to the following questions.

1. **Is the presence of a romantic partner related to lower stigma and thoughts about suicide?**

Our analysis suggests that there was little difference in stigma by relationship status (although, those who were widowed had slightly higher levels of stigma than those in other relationship groups). However, we did find that those who were divorced, separated, or never married more frequently reported thoughts about suicide. This finding aligns with past suicide research (Corcoran and Nagar, 2010), and emphasises the importance of particular attention to persons who are not in a stable relationship. It is also interesting to note that these same people don't necessarily have elevated levels of stigma, which suggests that stigma and suicidality are independent constructions with different determinants and risk factors.

2. **Are higher levels of social support related to lower stigma and thoughts about suicide?**

Our second analysis concerned the role of perceived social support on stigma. Perceived social support refers to the extent a person feels as though they have people (e.g., friends, family, significant other) to talk to and whom will provide emotional support (Zimet et al., 1988). Thus, this represents a separate construct from relationship status, which provides no information as to the emotional quality of a relationship. Our findings suggest that those who reported lower social support also reported higher levels of stigma and a greater likelihood of thoughts about suicide. As in past Australian research, these findings emphasise the importance of social support as a buffer against mental health (Milner et al., 2016a) and suicide (Miller et al., 2015; Milner et al., 2015). It appears that perceived social support – rather than simply the presence of support – is might be a more important influence on stigma. From an intervention perspective, this indicates the need to convey a sense of genuine care to those who may be at risk of mental health problems and suicide, and who have high levels of stigma.
3. **Are stigma and thoughts about suicide higher among those who are unemployed?**

Last, we found that employment status had only a slight effect on levels of stigma. This was contrary to our expectations, as we expected large differences between those who were unemployed and employed. In many ways, this is a positive finding as it means that interventions may be able to target stigma in unemployed and employed workers in a similar way.

**Results of the follow-up data**

The evaluation of the Contact+Connect program suggests that it was associated with a reduction in both stigma and suicidality. The program effectiveness for each is discussed below.

4. **What is the effect of Contact+Connect on stigma?**

We observed a small reduction in stigma for both intervention and control groups for self-blame and shame while there was a small reduction in the intervention group for help-seeking stigma but none in the control group. When we compared workers with high stigma between the two groups, there was more stigma reduction in the intervention group than the control group for each of the three categories (help-seeking inhibition, self-blame and shame.) However, it is important to note that there were no statistically significant differences between the intervention and control groups. This may be due to the placebo effect where the mere participation in a program increased participants’ awareness of mental health stigma, and the control participants’ perception may have been altered by the need to reflect on these issues while responding to the surveys. Also, a small number of intervention participants may not have engaged with the contents and were only interested in the incentives.

There was a considerable drop off between sign up and completion with only 57% of those who registered for the program going on to complete it. This drop off might be attributable to the mental health literacy of control group participants, in that those with a more favourable mental wellbeing may have been more inclined to complete the final survey. The demands we put on control participants was not insubstantial in that they were asked to complete two relatively long surveys without the benefits of accessing the program content. Control participants who submitted both surveys may have had greater awareness and lower levels of stigma than those who dropped out, which may explain their overall improvements in primary and secondary outcomes. This issue means that there was a less observable difference between the intervention and control group at follow up. We would also note the possibility of reporting bias in that participants may report overall better outcomes than they actually experience. To some extent, this may be connected to the use of incentives (i.e., participants may have felt they needed to report better outcomes in order to receive their incentive).

Regardless, the fact that there was a decrease in mental health stigma and suicidality over the period of the study is good news, particularly since construction workers are at particularly elevated risk of suicide. The shame and help-seeking stigma (which were particularly high at baseline) subscales of the SSDS experienced some of the largest declines over the period of the study. Considering both of these factors can be considered as factors that inhibit individuals identifying symptomology and seeking help (Gulliver et al., 2012), these findings can definitely be considered as a step in the right direction.

To some extent, the findings of this study align with a previous meta-analysis of programs aimed at stigma reduction (Griffiths et al., 2014). This meta-analysis found that, by and large, stigma interventions were effective, though also acknowledging the fact that there was a lack of research on stigma intervention in workplaces and schools. To date, most stigma interventions have been conducted in tertiary settings, where people might be expected to have relatively high mental health literacy. We would argue that the population
we targeted in Contact+Connect were particularly challenged for a number of reasons including gender norms and higher levels of stigma in the construction industry.

5. *What is the effect of Contact+Connect on suicide ideation?*

While we found a significantly high number of suicide ideation amongst the participants as compared to general population, most encouragingly we found that the program had a significant impact on suicide ideation with a reduction of 8% in the intervention group and 5.1% in the control group. Again, we observe that being in the program affected stigma in the control participants but we found that there is a significant difference between intervention and control groups to indicate effectiveness of the program.

**Feedback from participants**

The following were reported in our follow-up survey by participants from the program. The majority of participants (70%) enjoyed participating in the program. The distribution of employment status was even between control and intervention. The program content that attracted the most engagement was related to mental health information. Video contents were the most well-received format. And the majority of participants said they benefitted from the program and would recommend it to others.

![Graph](image1)

*Figure 28. Participation engagement receptiveness*

![Graph](image2)

*Figure 29. Employment status*
Figure 30. Content engagement by participants

Figure 31. Content format
Limitations and challenges

**Recruitment targets**

Meeting our monthly recruitment targets and keeping participants on board for the duration of the 6-week program were our two biggest challenges. Specifically, the baseline and follow up surveys were a barrier for a significant proportion of participants because as well as being rather long (28 and 39 questions respectively), the questions were of a personal nature that some people did not feel comfortable answering. For this reason, 22% of those who registered for the program did not complete the baseline survey (and therefore did not receive the interventions), and 26% of those who did complete the baseline survey did not submit the follow up survey at the completion of the program.

Other reasons for people in our target demographic either not signing up or not completing the program included having a limited understanding, or a mistrust, of technology, not possessing a Smartphone, returning to the workforce and dropping out of the program, not being engaged by the content we created for our program, or not being inclined to participate in a mental health program.
Incentives and attrition

At the project outset we anticipated that completing the surveys may be a barrier for some people. As such we incentivised the survey process in an effort to maximise completion rates.

Everyone who completed the baseline survey was sent a $20 gift card, and those who completed the follow up survey were entered into the draw for one of five monthly $500 gift cards.

Nevertheless the program had an overall attrition rate of 27% between those who submitted the baseline survey and those who went on to complete the program and submit the follow up survey. As high as this sounds, we were able to attract a critical mass of participants and obtain meaningful data on the mental health related stigma of our target demographic, so it was a worthwhile activity.

Further, although completing the baseline and follow up surveys was a barrier for some participants, we would argue that the fact that an Incolink staff member chased up all those who had registered for the study with text messages and a phone call, increased the likelihood of representativeness.

Suicide ideation

Finally, 18% of the participants who registered for the program were anonymously referred to counsellors at Incolink after their responses to the questions about suicide in the baseline and follow up surveys triggered a warning. As Incolink provides a holistic wellbeing and support service, we were able to offer a safety net to those who may need further support with in-depth and face-to-face support.

[Figure 34 Responses to suicide-related survey questions]

[Figure 35 Degrees of suicide ideation]
Another weakness relates to the fact we had to shorten some scales to ease participant burden. This was done after careful consideration and discussion with stakeholders in the construction industry. The original study was targeted at unemployed men only, but a number of employed people and females were recruited into the study after expressing interest in taking part.

**Effectiveness of the Whispir Communications Platform**

Delivering Contact+Connect to Smartphones via the Whispir online platform was a good fit for us, enabling us to reach and engage a difficult to reach target audience of unemployed male construction workers.

It was also useful in helping us reach people in regional areas because location was immaterial, all that was needed to participate was an internet-enabled Smartphone. Further, because the program was delivered via
SMS, they had the flexibility of viewing the material at their own convenience, without the hassle or anxiety that speaking with someone face-to-face about their mental health can sometimes instil.

The key benefits of delivering Contact+Connect via the Whispir digital platform include:

- Anyone with an internet-enabled Smartphone could participate, no matter where they lived;
- Participants could view the content on a Smartphone or tablet, whatever their preference;
- It is an efficient way of distributing information to large numbers of people;
- We were able to target a difficult to reach cohort (unemployed male construction workers), and those living in regional areas where fewer mental health services are available to them;
- Participants were able to send queries and comments via SMS, and initiate a conversation with Incolink;
- Messages had a professional look and feel, and because Whispir supports a wide variety of content types (such as video, podcasts, links to web pages, text and graphics) we were able to provide a quality educational experience straight to their mobile phone;
- Whispir messages can be personalised to engage and foster trust with participants;
- Analytics ensured we were able to measure the engagement of our audiences;
- An unsubscribe button enabled participants to easily opt out if they wished to;
- Navigating messages on a mobile phone was easy, even for rudimentary phone users, as they simply needed to scroll or tap to read/watch/listen to the various types of content; and,
- Because Whispir is a cloud-based application it can be accessed from any Internet-connected location.

Outputs

Aside from our analysis of the baseline data, there have been several other outputs from Contact+Connect to date, including the following publication, which have contributed to the development and design of the program:


RECOMMENDATIONS

Our analysis of the baseline data set of Contact+Connect suggests the need to consider age and social support differences when designing de-stigma campaigns. We also suggest the importance of recognising stigma as a risk factor for suicide among those working in the construction industry.

We also can make the following recommendations in regards to the design of the digital delivery:

One week between interventions may be too long as we’ve noted a steep drop off in engagement between week 2 and week 3, a trend which sees fewer participants each week clicking through to messages and on to the microsite. We believe momentum is lost by the week-long break between messages. Two messages per week would increase the chance of retention, at the very least at the beginning of the program where “connectedness” (retention) needs to be established before moving to a weekly message.

Also, persuading new recruits to complete the pre-start survey which is a pre-requisite for commencement of the program was a barrier. While the delivery was digital, it was a human connection (i.e. for those who were reluctant, phone contact or repeated reminders were required to set them in motion). Again, “connectedness” played a role in recruitment as well.

Recruitment of Incolink members proved to be the most successful channel, while social media also contributed positively to the effort. And it is important to remember that nearly 20% of site visitors are women and that they do play a significant advocacy and/or support role that should be leveraged.

In term of evaluation, we would suggest the importance of conducting further follow up with participants who take part in stigma related interventions in order to assess whether results are sustained over time. Our team is particularly interested in assessing whether the positive results we observed regarding stigma flowed through to impact help-seeking or help-offering behaviours, or the extent to which construction workers had better knowledge available support pathways and networks.
REFERENCES


Lakey, B., Orehek, E., 2011. Relational regulation theory: a new approach to explain the link between perceived social support and mental health. Psychological review 118, 482-495.


APPENDIX A: Contact+Connect – Full Program Content

This appendix summarises the complete Contact+Connect program according to the respective channel on which each piece of content was distributed to participants or prospective participants. In terms of content flow, each SMS contains a link to the Whispir rich content which contains a link to the Microsite.

<table>
<thead>
<tr>
<th>PRE START</th>
<th>INVITATION TO JOIN PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verbal sign up welcome message</strong> <em>(sent to people who call or visit Incolink and wish to sign up)</em></td>
<td></td>
</tr>
<tr>
<td><strong>SMS</strong></td>
<td>Hi Richie, thanks for the call, we'd love you to join Incolink Contact+Connect. Click here for more details about the program and to sign up &lt;link&gt; Thanks, we'll be in touch again soon.</td>
</tr>
<tr>
<td><strong>WHISPIR</strong></td>
<td>Hi Richie, thanks for getting in touch, it was great to talk with you. As mentioned on the phone, please click the link below to register for Contact+Connect. Signing up is easy and you can read more about the program while you're there. You'll also find our contact details so you can get in touch with any queries, it'll be great to have you on board. Thanks, The Incolink Contact+Connect team <a href="#">Click here to sign up to Contact+Connect.</a></td>
</tr>
<tr>
<td><strong>MICROSITE</strong></td>
<td>Not required for this section</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PRE START</th>
<th>WELCOME MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Web sign up welcome</strong> <em>(sent to all who registered without prior contact, eg via Facebook or the Incolink website)</em></td>
<td></td>
</tr>
<tr>
<td><strong>SMS</strong></td>
<td>Hi Richie, thanks for signing up for Incolink Contact+Connect. We'll be kicking off soon and will send you an SMS to let you know, so stay tuned. Thanks again, the Contact+Connect team. <em>(This SMS welcome message goes to new sign ups without email. See Wufoo below for email welcome message.)</em></td>
</tr>
<tr>
<td><strong>WHISPIR</strong></td>
<td>Not required for this section</td>
</tr>
<tr>
<td><strong>MICROSITE</strong></td>
<td>Not required for this section</td>
</tr>
<tr>
<td><strong>WUFOO</strong> <em>(Cloud-based online forms website)</em></td>
<td>The following automatic email goes to new sign-ups via recruitment website. Thanks for signing up to Contact + Connect. We'll send you your first SMS message soon. In the meantime if you have any questions please contact Teri at Incolink on 03 9668 3061.</td>
</tr>
</tbody>
</table>
## PRE START | BASELINE SURVEY

*Link to Survey Monkey (survey must be completed to proceed to intervention stage)*

<table>
<thead>
<tr>
<th>SMS</th>
<th>Hi Richie, please click the link for info about the 1st survey for Contact+Connect. Please complete the survey so we can get you started on the program. Thanks, Incolink [link]</th>
</tr>
</thead>
</table>
| WHISPIR | Hi Richie,  
It's great to have you on board for Contact+Connect. As we mentioned when you signed up, there's a short survey we need you to take before we can get you started on the program.  
[CLICK HERE](#) to take the pre-start survey (it’ll take around 5 minutes to complete – and you can do it straight from your phone).  
Many thanks, we'll be in touch. 
The Contact+Connect team. |
| MICROSITE | Not required for this section |
Hi Richie,

Thanks for joining Incolink's Contact+Connect community. We're looking forward to your company over the next few weeks.

**About the program**

We created Contact+Connect specifically for **Smartphones** – you don't need a home computer. You'll receive one text message from us each week with a link to the Contact+Connect website.

Each week there'll be something new to read, watch or listen to, and you'll generally need 5-10 minutes to check it out. We recommend choosing a time when you won't be interrupted.

STRIDE (Contact+Connect) is a **beyondblue** project funded with donations from the Movember Foundation. Here's how it works...

To get the ball rolling, watch this short video from Incolink Chairman Tommy Watson as he introduces Contact+Connect.

And finally, check out this **cool little animation** we created to sum up what Contact+Connect is all about.

Now that you've read this introduction, we'll send you another text message shortly to officially begin the program. See you soon.
WELCOME TO THE CONTACT+CONNECT WEBSITE.
This website contains useful information about mental health, finding work and staying healthy.
Don't forget to come back every week to see what new stuff we've added.
If you ever feel a bit rough and want to talk to someone about it, you can take action by calling an Incolink counsellor on 03 9668 3061 for free and confidential support. There is also a range of support available in your local community. Watch the short animation below to find out more.

To talk to somebody please call Incolink on 03 9668 3061
**BCI 2**  
**INFORMATION ABOUT MENTAL HEALTH**

**SMS**

Hi Richie,
welcome back to Contact+Connect. Click the link to dive right in. [link]

---

**WHISPIR**

Hi Richie,

**Mental health – what is it?**

Experiencing a period of mental ill health is something most of us will experience from time to time. Relationship break ups, losing someone close to us, or losing our job can all cause us to experience poor mental health.

Unlike physical health issues like catching a cold or twisting an ankle, a mental health problem can be hard to recognise in ourselves or in others. It’s also common for people to try and hide a mental health problem - but hiding them will rarely make them go away.

Mental ill health can cause real distress to a person experiencing it, and those close to them. The good news is that help is available. It’s important to remember that most mental health problems can be sorted out through a combination of lifestyle factors and treatment.

[Tap here](#) to crunch some numbers about mental health that may surprise you.

---

**DID YOU KNOW HOW WIDESPREAD AND COMMON DEPRESSION REALLY IS?**

- **1 in 5 Australians experience mental ill health in any given year**
- **45%**
- **In any given year around 1 million adults have depression and 2 million have anxiety**

- **Men are 4 more likely to die by suicide than women**
- **In Victoria workers are 7x more likely to die by suicide than in a workplace accident**

For more information about mental health, visit these websites...

To talk somebody please call Inqolink on 03 8668 3061
Hi Richie, welcome back to Contact+Connect. Click the link to check it out. <link>

Hi Richie,

We know that having a period of poor mental health is not a sign of weakness and it can happen to anyone. Watch James’ story below to hear how a period of poor mental health affected him and those close to him.

We’ve come a long way in regards to how we think about mental health, but people’s attitudes & beliefs still play big part in how people experiencing distress may feel about themselves and putting their hand up for help.

Tap here to bust some myths about mental health.
[Participants read the myth then tap their phone to reveal the fact]

**MYTH 1**
Mental illness only affects a few people.

**FACT**
In 2017, 45% of Australians aged 16-84 years, or 7.3 million people, had at some point in their lifetime experienced a mental disorder. Mental illness is common and affects people of all ages, genders and social backgrounds.

**MYTH 2**
Mental illness is caused by a personal weakness.

**FACT**
Anxiety and depression are caused by genetic, biological, social and environmental factors. It is not a character flaw. Getting help with it is a sign of strength.

**MYTH 3**
Mental illness is forever.

**FACT**
Just like a physical health problem, for most people a period of mental ill health will come and go. Talking about it to someone will help.

**MYTH 4**
Suicide can’t be prevented.

**FACT**
Most people contemplating suicide don’t really want to die. They are often seeking an end to intense mental and/or physical pain, or interventions can save lives. Many are having a period of mental ill health that will pass.

**MYTH 5**
Asking someone if they are suicidal might make them do it.

**FACT**
If you are worried about someone, asking if they are thinking about suicide can actually help. Encouraging someone to open up and share their troubles can help ease their pain and find solutions.

---

**Humour can sometimes help. Tap here to listen.**

To talk to somebody please call Incolink on 03 9688 3001

---

Beyond Blue
Depression, Anxiety.
Hi Richie,

Welcome back to Contact+Connect. We touch on a really important issue this week.

Hi Richie,

It’s not as easy to recognise the signs and symptoms of depression in yourself or others. Watch Steve’s story to see how a period of poor mental health crept up on him.

We can experience depression in four main ways:

Someone experiencing symptoms of depression might:

- Feel like everything’s a chore
- Have no energy
- Not be able to shake off negative or anxious thoughts
- Isolate themselves and stop doing things they enjoy

Every person is unique so there’s no rule book for how different people may experience poor mental health. Check out our interactive guide to recognizing the signs of poor mental health.

Participants scroll and tap to reveal the various symptoms of each facet of poor mental health.
Hi Richie,
welcome back to Contact+Connect. Let's go! [link]

Hi Richie,

Being unemployed can be tough. That's why this week we're concentrating on helping you get back into the workforce. We've put together the best ever guide to getting a construction job (you can access it at the bottom of this message). It includes a stack of resources like links to job sites, tips on writing a resumé, how to nail job interviews and lots more.

But first, check out Anthony's clip below to see how he managed a long stint out of work.

[Video Clip]

---

The best ever guide to getting a construction job!
Participants tap each heading to reveal drop down lists of services providers, linked direct to relevant websites.
Hi Richie,

welcome to week 6 of C+C. Click to get started <link>.

Hi Richie,

It can be hard acknowledging that you’re not running right, but times are changing and more and more men are taking action by putting their hand up when they need some support.

It’s important we look after ourselves so we can look after those who depend on us. But who do we ask and where do we go?

Incolink is a great place to start. Watch the video to find out more about the free and confidential [counselling services](#) offered by Incolink.

To talk to a counsellor at Incolink, please call 03 9668 3061 or 0419 568 605.

Tap through to the Contact & Connect website to see the full range of support services available in your local area.
WHERE DO I GO TO TALK TO SOMEONE?

INCOLINK
For Incolink members the best place to start is with our Member Services team on (03) 9666 3081.

GP
The next step to access mental health services is to see your local GP who can refer you through Medicare to a range of providers.

COMMUNITY SUPPORT
For more severe mental health issues Victoria has a specialist mental health service divided into two service types: clinical and non-clinical.
Clinical services focus on assessment and treatment while non-clinical services assist people to manage their own recovery.
Both clinical and non-clinical services operate within local communities.

To find services in your area click below.
For useful general information click below.

Or click here to listen about depression & how to carry on

To talk to somebody please call Incolink on 03 9666 3081
# BCI 7 | 5 WAYS TO WELLBEING

<table>
<thead>
<tr>
<th><strong>SMS</strong></th>
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| Hi Richie,  
welcome to the penultimate week of Contact+Connect. Let's dive in | |

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<tr>
<th><strong>WHISPİR</strong></th>
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</table>
| Hi Richie,  
**LOOK AFTER YOUR WELLBEING**  
Guess what? This is the final module of Contact+Connect - you made it! Thanks so much for participating, we hope you got some value from the program.  
We'd really appreciate your feedback and will be sending you a survey, similar to the one you did at the beginning, in the next few days. Once you've completed it you'll automatically go into the draw for one of three major prizes...stay tuned for details!  
| | |
| | |
| Today's final instalment is all about maintaining good physical and mental wellbeing, and actions we can take if we're starting to slide.  
They are called the Five Ways to Wellbeing. By keeping them in the back of your mind, you'll have a bunch of useful tools you can call on if ever you need them.  
**Tap here** to see the 5 Ways to Wellbeing (they're like a toolbox for your mind!)  
Thanks again for participating,  
the Incolink Contact+Connect team. |
CLOSE OUT | FOLLOW UP SURVEY

SMS
Hi Richie,
please do this short survey to wrap up the Contact+Connect program. Thank you.<link>

Hi Richie,
Thanks for participating. We hope you got a lot out of the program. Now comes the easy part!
Make sure you’re in the running for our monthly Bunnings gift card giveaways by doing the short survey below (it takes less than 5 minutes). The sooner you do the survey, the more chances you’ll have to win!
CLICK HERE to do the survey.
Thanks again,
The Contact+Connect team

WHISPIR

MICR
OSITE
Not required for this section