Draft report

Strengthening Community Understanding of Mental Health: A Literature Review

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### Abbreviations

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<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
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<td>CEO</td>
<td>Chief Executive Officers</td>
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<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>MHCA</td>
<td>Mental Health Council of Australia</td>
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<td>NGO</td>
<td>Non-government organisation</td>
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<td>NSMHWB</td>
<td>National Survey of Mental Health and Wellbeing</td>
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<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
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<td>RCT</td>
<td>Randomised controlled trial</td>
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<td>SHIP</td>
<td>Survey of High Impact Psychosis</td>
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<td>SME</td>
<td>Small to Medium Enterprise</td>
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Executive summary

Community understanding of mental health: the current situation in Australia

- In any 12-month period, anxiety, affective and substance use disorders affect 20% of Australians aged 16-85, while psychotic illnesses affect 0.45% of Australians aged 18-64. Rates of mental illness in Aboriginal and Torres Strait Islander peoples are between 50% and three times higher.
- With a contribution of 24% to the non-fatal burden of disease in Australia in 2003, mental illnesses were the leading cause.
- People with mental illness must cope with their symptoms and also with the limitations of community understanding of mental illness, that is, the erroneous beliefs, stereotypes and prejudice that result from misconceptions about mental illness. These stigmatising attitudes are often nominated as a central concern for people with mental illness.
- Beliefs about the unpredictability and dangerousness of people with mental disorders are among the most common stigmatising attitudes and are highest for people with schizophrenia.
- Experiences of stigma and discrimination are common among people with mental illness, with almost 40% of people with psychotic illness reporting such experiences in a 12-month period.
- There is evidence that poor community understanding of mental illness adversely affects health service utilisation, due to limited ability or recognise mental illness, beliefs that standard treatments are unhelpful and stigmatising attitudes. Aboriginal and Torres Strait Islander peoples and CALD communities may be particularly disadvantaged in this area.
- Experiences of discrimination from health professionals may also limit health service utilisation.
- There is evidence that poor community understanding of mental illness also contributes to social isolation and limits access to employment, stable housing and legal services.
- Improving community understanding of mental illness in order to reduce barriers to accessing services and social participation is a feature of federal and state mental health policies in Australia.
- Many Mental Health NGOs, which are a key part of Australia’s mental health system, also play a valuable role in raising public awareness and health education to improve community understanding of mental illness.
Summary of national trends in best practice

- While there are a number of Australian initiatives that aim to improve mental health literacy and reduce stigma, relatively few of these have been evaluated.
- Whole-of-community campaigns may be beneficial in improving mental health literacy, but there is inconclusive evidence that they result in reductions in stigmatising attitudes.
- There is sufficient evidence to suggest that in-person psycho-education, particularly Mental Health First Aid (MHFA), improves mental health literacy and reduces stigmatising attitudes in the general community and CALD populations.
- There is sufficient evidence to suggest that web-based interventions improve mental health literacy, but there is inconclusive evidence that they reducing stigmatising attitudes.
- There is limited evidence to suggest that interventions targeted to Australian health professionals, particularly MHFA, improve mental health literacy and reduce stigmatising attitudes.
- There is sufficient evidence to suggest that workplace-based interventions, particularly MHFA, improve mental health literacy and reduce stigma.
- While some studies of school-based and tertiary institution-based interventions have been conducted in Australia, these are of insufficient quantity or quality to allow conclusions about effectiveness to be drawn.

Summary of international trends in best practice

- There is sufficient evidence to suggest that whole-of-community campaigns improve mental health literacy and may also lead to increases in professional help seeking.
- There is sufficient evidence to suggest that in-person psycho-education interventions improve mental health literacy, although there is no evidence that such interventions increase help-seeking behaviour.
- There is limited evidence to suggest that web-based, school-based and workplace-based interventions improve mental health literacy.
- There is limited evidence to suggest that interventions targeted to health professionals improve mental health literacy.
- There is inconclusive evidence of the effectiveness of interventions to improve mental health literacy in staff and students of tertiary education institutions.
- Evidence suggests that long-term campaigns may be effective in reducing stigmatising attitudes and reducing experiences of discrimination.
- There is sufficient evidence to suggest that psycho-education interventions reduce stigmatising attitudes, with face-to-face contact more effective than contact by video.
• There is limited evidence to suggest that school-based and workplace-based interventions (in police) reduce stigma. However, evidence for long-term effects is inconclusive.

• There is evidence that educational and contact interventions are effective in reducing stigmatising attitudes in many types of health professionals in the short term. Evidence for long-term effects is inconclusive.

**Assessment of current policy and practice against the evidence**

• In the area of improving community understanding of mental illness, Australia demonstrates a number of strengths when compared to other countries. These include the roles of:
  o *beyondblue* in improving mental health literacy regarding depression
  o MHFA in improving mental health literacy and reducing stigma in a variety of settings and populations
  o web-based interventions in improving mental health literacy and reducing stigma

• In-person psycho-education and web-based interventions may have a valuable role to play in addressing stigma in health professionals, an area of significant concern to consumers.

• Further work is needed to evaluate the effects of interventions to improve mental health literacy and reduce stigma in schools, tertiary education institutions and workplaces, all relatively under-researched areas in Australia.

• There is a clear need for interventions to address mental health literacy and stigma in Aboriginal and Torres Strait Islander populations.

• In the area of whole-of-community campaigns to improve mental health literacy, further work should address mental health literacy relating to anxiety disorders.

• Whole-of-community campaigns to address stigma and discrimination may benefit from an improved understanding of the nature of events that are regarded as stigmatising, a further exploration of the impacts of the biomedical model of mental illness on stigma and the incorporation of an understanding of stigma as a multidimensional construct that varies according to disorder.

• Evaluation of anti-stigma interventions should include the measurement of discrimination experienced by those with mental illness as well as assessment of stigmatising attitudes.
Aims of the literature review

The literature review is designed to answer the following questions:

- What is the national and international evidence-based good practice in the area?
- What are the elements of a good practice service/support/policy/approach?
- Is the evidence applied and found in the Australian context?
- What are the Australian examples of good practice services, polices or approaches?
- What are the current areas of debate or contention indicated in the literature?
- What are (if any) the contentious or debated areas for various stakeholders?
- Where are the gaps in our knowledge, data, perspective or services?
- Does the literature indicate where enhanced effort, or scaling up, would yield the greatest impact and improvement, in terms of system change, individual outcomes or experience of care, treatment or services?
Definition of terms

The following definitions were used to provide clarification of the scope and purpose of the project:

Mental disorders include high-prevalence disorders such as depression and anxiety disorders, as well as lower-prevalence disorders such as schizophrenia, bipolar disorder and personality disorders. Substance misuse disorders are not covered, other than issues around co-morbid mental health problems and substance misuse.

Community understanding (also referred to as ‘social understanding’ or ‘social attitudes’) of mental health is defined as beliefs and attitudes about mental disorders that act as barriers to accessing services and to participation in society. Beliefs and attitudes cover:

- knowledge of help-seeking options and available treatments
- stigmatising attitudes
- beliefs about prevention and causes
- recognition of disorders
- first-aid skills to support others who are developing a mental disorder or in a mental health crisis
- knowing effective self-help strategies for milder problems
- the attitudes of the general population and professional groups providing relevant services.

Services include treatment and other services including housing, welfare and legal services. These may be provided by government, non-government organisations or other organisations.

Participation in society covers participation in work, higher education and social relationships.

Consumers are people who use or have used a mental health service (Department of Health and Ageing 2009).

Carers are people who have a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer (Department of Health and Ageing 2009).

Mental Health Non-government Organisations (NGOs) are not-for-profit, community managed organisations that provide community support services for people affected by mental illness and their families and carers. NGOs may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental
illness, and their carers, or have a psychosocial rehabilitation role (Department of Health and Ageing 2009).

**Mental Health Services** are services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers (Department of Health and Ageing 2009).

**Peer Support** refers to social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition.
1 Community understanding of mental health: the current situation in Australia

1.1 Introduction

The aims of this section of the literature review are to describe the current situation in Australia with regard to the impact of community understanding on accessing services and on participation in society, and to describe current policies and practices nationally and in other jurisdictions. Data relating to Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse (CALD) groups is included when available.

1.2 Prevalence of mental illness in Australia

The 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB), which focused on anxiety, affective and substance use disorders, estimated that these disorders affect 20% of Australians aged 16-85 in any 12-month period (Slade, Johnston et al. 2009). Twelve-month prevalence rates for anxiety, affective and substance use disorders were estimated to be 14.4%, 6.2% and 5.1% respectively. The lifetime prevalence rate for these disorders was estimated to be 45.5%.

The 2010 Survey of High Impact Psychosis (SHIP), which focused on the less common but more severe psychotic illnesses (including schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder), estimated that these disorders affect 0.45% of Australians aged 18 to 64 in any 12-month period (Morgan, Waterreus et al. 2011). The most frequently recorded of these disorders was schizophrenia, which accounted for 47% of diagnoses.

While there are no equivalent studies indicating the prevalence of eating disorders, it is estimated that anorexia nervosa occurs in less than 0.5% of young women and is uncommon in the general population; bulimia nervosa occurs in 1% of young western women and that partial eating disorder syndromes or eating disorder not otherwise specified (EDNOS), occur in between 2 and 5% of young women (Hay, Mond et al. 2008).

1.2.1 Prevalence of mental illness in Aboriginal and Torres Strait Islander peoples

A recent review of 11 population surveys that identified Aboriginal and Torres Strait Islander people and included a measure of mental health, concluded that indigenous adults were consistently found to have a higher prevalence of self-reported psychological distress than the general community (Jorm, Bourchier et al. 2012). Rates were between 50% and three times higher.
1.2.2 Prevalence of mental illness in people from culturally and linguistically diverse backgrounds

The 2007 NSMHWB estimated that the prevalence of mental disorders for people born overseas was 17.7% for males and 19.9% for females (Slade, Johnston et al. 2009). For people born in non-English speaking countries the prevalence of mental disorders was 8.4% for males and 16.2% for females. Prevalence of affective and anxiety disorders does not vary significantly by country of birth. However, the survey showed a modest trend for people from non-English speaking countries to have a lower prevalence of affective and anxiety disorders compared to those born in Australia or another English-speaking country (Slade, Johnston et al. 2009).

However, research suggests that whilst many migrants arrive in Australia with good mental health, this may deteriorate after the first 12 months spent in Australia, which may be due to the stressful process of acculturation, language and social difficulties, and difficulties in finding employment (Anikeeva, Bi et al. 2010). It should also be noted that assessment of mental health in CALD communities is complicated by the differences in conceptualisation of mental illness between cultures and in the social acceptability of reporting symptoms.

1.3 Mental illness and disability

Mental illnesses are the main source of disability burden worldwide and their impact begins early in life (Murray, Vos et al. 2012). In 2003, mental illness accounted for 13% of the total burden of disease in Australia and ranked third for morbidity and mortality after cancer and cardiovascular diseases (Begg, Vos et al. 2007). With a contribution of 24%, mental illnesses were the leading cause of the non-fatal burden of disease in 2003. According to the 2010 SHIP, people with psychotic illness also frequently experience poor physical health outcomes (Morgan, Waterreus et al. 2011). For example, 26.8% of survey participants had heart or circulatory conditions and 20.5% had diabetes, a rate more than three times that seen in the general population.

1.4 Stigma, discrimination and mental illness

People with mental illness are among the most disadvantaged in society, and many experience social and economic hardship as a direct result of their illness. They must cope with the symptoms of their illnesses and also with the limitations of community understanding of mental illness, that is, the erroneous beliefs, stereotypes and prejudice that result from misconceptions about mental illness. These stigmatising attitudes are often nominated as a central concern for people with mental illness (McNair, Highet et al. 2002; Corrigan, Thompson et al. 2003).
1.4.1 Stigmatising attitudes

Stigmatising attitudes towards mental disorders have been conceptualised and measured in different ways. Although stigma is often discussed as a single construct, cumulative evidence clearly indicates that it is complex and multidimensional (Griffiths, Christensen et al. 2004; Watson, Miller et al. 2005; Stansfield, Blackmore et al. 2008). A number of components of stigma have been identified, including personal stigma, stigma perceived in others, internalized self-stigma, perception of mental disorders as due to weakness, reluctance to disclose to others, perceived dangerousness, desire for social control, goodwill, and desire for social distance (Jorm and Oh 2009). Several scales to assess stigma have been developed. One of the more common measures is the social distance scale (SDS: Link, Phelan et al. 1999), which assesses the desire to avoid contact with a particular group of people. Other measures that may be used to assess stigma towards depression and anxiety disorders include the Depression Stigma Scale (DSS; Griffiths, Christensen et al. 2004), the Generalised Anxiety Stigma Scale (GASS; Griffiths, Batterham et al. 2011), the Self-Stigma of Depression Scale (SSDS; Barney, Griffiths et al. 2010). More recent work in this area has involved the measurement of experiences of discrimination (Brohan, Clement et al. 2013).

In 2011, the National Survey of Mental Health Literacy and Stigma assessed stigmatising attitudes in the Australian population (Reavley and Jorm 2011). In this telephone survey, over 6000 members of the general community were read a vignette describing a person with one of the following illnesses: depression, depression with suicidal thoughts, early schizophrenia, chronic schizophrenia, social phobia and post-traumatic stress disorder (PTSD). After being presented with the vignette, respondents were presented with two sets of statements, one assessing the respondent’s personal attitudes towards the person described in the vignette (personal stigma) and the other assessing the respondent’s beliefs about other people’s attitudes towards the person in the vignette (perceived stigma) (See Figures 1 and 2). Respondents were also asked about their willingness to have contact with the person described in the vignette in a range of situations (See Figures 3 and 4). The results showed that:

- Perceptions of discrimination, dangerousness and unpredictability were generally highest for chronic schizophrenia, while beliefs in the problem as a sign of personal weakness or ‘not a real medical illness’ were generally higher for social phobia than for other illnesses.
- For both personal and perceived stigma, across all illnesses, the statements with which respondents were most likely to agree or strongly agree involved a perception of other people’s belief in unpredictability, the belief that most other people would not tell anyone and the belief that most other people would not employ someone with the problem.
• Desire for social distance was most common for the items relating to working closely with a person with a mental illness or having the person marry into one’s family.
• Desire for social distance was highest for chronic schizophrenia and lowest for social phobia and PTSD.
Figure 1 Percentage of respondents who ‘agree’ or ‘strongly agree’ with statements about personal attitudes to mental illness

Social Phobia
Depression
Early Schizophrenia
PTSD
Depression with suicidal thoughts
Chronic Schizophrenia

- I would not vote for a politician with this problem
- I would not employ someone with this problem
- If I had this problem I wouldn’t tell anyone
- People with this problem are unpredictable
- Avoid people with this problem
- People with this problem are dangerous
- Problem is not a real medical illness
- Problem is a sign of personal weakness
- Person could snap out of the problem

Percentage
Figure 2 Percentage of respondents who ‘agree’ or ‘strongly agree’ with statements about perceived attitudes to mental disorders

- Social Phobia
- Depression
- Early Schizophrenia
- PTSD
- Depression with suicidal thoughts
- Chronic Schizophrenia

<table>
<thead>
<tr>
<th>Statement</th>
<th>Social Phobia</th>
<th>Depression</th>
<th>Early Schizophrenia</th>
<th>PTSD</th>
<th>Depression with suicidal thoughts</th>
<th>Chronic Schizophrenia</th>
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<tr>
<td>I would not vote for a politician with this problem</td>
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<tr>
<td>I would not employ someone with this problem</td>
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<tr>
<td>If I had this problem I wouldn’t tell anyone</td>
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<td>People with this problem are unpredictable</td>
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<tr>
<td>Avoid people with this problem</td>
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<td></td>
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<tr>
<td>People with this problem are dangerous</td>
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<tr>
<td>Problem is not a real medical illness</td>
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<tr>
<td>Problem is a sign of personal weakness</td>
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<tr>
<td>Person could snap out of the problem</td>
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Figure 3 Percentage of respondents ‘probably unwilling’ or ‘definitely unwilling’ to socially interact with the person described in the vignette.

- Social phobia
- PTSD
- Depression
- Depression with suicidal thoughts
- Early schizophrenia
- Chronic schizophrenia

Bar chart showing the percentage of respondents’ attitudes towards different statements for each condition.
1.4.2 Experiences of stigma and discrimination

The 2010 SHIP reported that 37.9% of participants (46.9% of females and 31.8% of males) said they had experienced stigma or discrimination in the past year as a result of their mental disorder (Morgan, Waterreus et al. 2011). Fear of discrimination stopped 22.7% of participants doing some of the things they had wanted to do, while 20.3% said that it was the actual experience of stigma or discrimination that had stopped them. Stigma was nominated by 11.6% of participants as one of their top three challenges for the coming year.

A 2011 survey conducted by the Mental Health Council of Australia (MHCA) that involved 427 consumers and 200 carers recruited through the MHCA membership and database contacts, assessed the experiences of stigma in the general community (Mental Health Council of Australia 2011). The results showed that:

- 34.7% of respondents reported being treated as less competent once others learned that they had a mental illness
- 20.6% had been shunned and avoided when their mental illness was revealed
• 60.2% had experienced negative hurtful and offensive attitudes from the general population
• 48.3% had experienced negative hurtful and offensive attitudes from the media
• 22.5% had been advised to lower their expectations in life often or very often
• 52.9% had been treated fairly by those who knew they were a person with mental illness

Carers’ experiences were broadly similar to those of consumers. The results showed that:

• 30% of respondents avoided telling those outside their immediate circle that they were mental health carers
• 52.8% had family or friends that were understanding and supportive on learning that they person was a mental health carer
• 10.6% reported being treated as less competent once others learned that they were a mental health carer
• 8.1% had been shunned and avoided when it was revealed that they were a mental health carer
• 49.5% had experienced negative hurtful and offensive attitudes from the general population
• 67.5% were treated fairly by others who knew they were a mental health carer
• 49.0% had experienced negative hurtful and offensive attitudes from the mass media
• 12.0% worried that other would view them unfavourably because they were mental health carers

1.5 Community understanding of mental health and health service utilisation

1.5.1 Professional help seeking

According to the 2007 NSMHWB, only around one third of those meeting the criteria for a mental disorder seek professional help (Burgess, Pirkis et al. 2009). The 2010 SHIP, which collected data on health service use by people with a psychotic disorder who were in contact with public specialised mental health services, estimated that 95.3% of people with a psychotic disorder had accessed health services for their mental health problems, and 81.0% had accessed health services for their physical health problems (Morgan, Waterreus et al. 2011). More than a third (34.8%) of people with psychotic illness had one or more psychiatric admitted patient episodes in the past year, with an average of 40 days in hospital.
There are a number of factors affecting help seeking and these interact to determine when and how people seek help for mental health problems (Rickwood, Deane et al. 2007). They include structural factors, such as having sufficient treatment resources available, and individual factors, including mental health literacy, which has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm, Korten et al. 1997). A number of components of mental health literacy affect whether an individual suffering from a mental disorder receives appropriate treatment. These include the ability to recognise specific illnesses, knowledge of causes and risk factors, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking.

Much of what we know about the current levels of mental health literacy in the Australian community comes from the 2011 National Survey of Mental Health Literacy and Stigma, which consisted of a general community survey and a youth survey. In the general community survey, over 6000 participants aged 15+ were read a vignette describing a person with one of the following illnesses: depression, depression with suicidal thoughts, early schizophrenia, chronic schizophrenia, social phobia and post-traumatic stress disorder (PTSD). After being presented with the vignette, respondents were asked what, if anything they thought was wrong with the person described in the vignette; how the person could best be helped; a series of questions about the likely helpfulness of a wide range of interventions (rated as likely to be helpful, harmful or neither for the person described in the vignette); a series of questions about the likely result for the person in the vignette with and without "the sort of professional help you think is most appropriate"; about their knowledge of causes and risk factors; about beliefs associated with stigma and discrimination; about their health; and about contact with people like those in the vignette (Reavley and Jorm 2011; Reavley and Jorm 2011).

In the youth survey, 3021 participants aged between 15 and 25 were read a vignette describing a person with one of the following illnesses: depression, depression with suicidal thoughts, depression with substance abuse, psychosis/schizophrenia, social phobia and PTSD. Respondents were then asked what, if anything, they thought was wrong with the person described in the vignette; what they would do if they had the problem; a series of questions about the likely helpfulness of a wide range of interventions (rated as likely to be helpful, harmful or neither for the person described in the vignette); about their beliefs about prevention; about their first aid beliefs; about contact with people like those in the vignette; about exposure to mental-health related media; about beliefs associated with stigma and discrimination; and about their mental health (Reavley and Jorm 2011; Reavley and Jorm 2011).

1.5.1.1 Recognition of illness
It is generally agreed that recognition of a problem is the necessary first step to seeking help from an appropriate professional, with failure to recognise signs and symptoms likely to delay help seeking (Thompson, Issakidis et al. 2008). This is of importance as there is evidence that early recognition and treatment may improve long-term outcomes for those with mental illness (Wang, Simon et al. 2003; McGorry, Purcell et al. 2007). Moreover, the use of correct psychiatric labels may facilitate communication with health professionals and it has been shown that GPs are more likely to diagnose mental illness if patients ask them about these directly (Bowers, Jorm et al. 1990; Haller, Sanci et al. 2009; Wright, Jorm et al. 2011).

The 2011 National Survey of Mental Health Literacy and Stigma showed that:

- In both general community and youth surveys, approximately 75% of those given the depression vignette were able to correctly label the disorder.
- Approximately one third of those given the schizophrenia and PTSD vignettes gave the correct label.
- In the general community, only 9% of those given the social phobia case description gave the correct label while, in among young people, only 3% did so.

1.5.1.2 Beliefs about treatments

Beliefs about treatments, including professional help, medications and other interventions also impact on help seeking. If a person believes that consulting a health professional or taking a medication is unhelpful, they are less likely to receive appropriate medical help or may not comply with treatment (Pyne, Rost et al. 2005). Negative attitudes towards medications such as antipsychotics and antidepressants are common in several countries (Angermeyer, Daumer et al. 1993; Priest, Vize et al. 1996; Jorm, Korten et al. 1997). In contrast, psychological therapies are viewed more positively, as are complementary therapies (such as vitamins and herbs) and self-help strategies such as exercise and relaxation (Jorm, Korten et al. 1997; Angermeyer, Breier et al. 2005).

As part of the 2011 National Survey of Mental Health Literacy and Stigma, respondents were asked about the helpfulness of different types of professional help, medications and other interventions. The results showed that, in the general community survey (Reavley and Jorm 2011):

- GPs were generally considered the best source of help for depression and schizophrenia, while counselling was generally considered the most helpful for anxiety disorders.
- Antidepressants for depression (along with antipsychotics for schizophrenia) were generally considered the most helpful medications, while lifestyle interventions such
as physical activity, reading about the problem, getting out more and learning relaxation also received very high ratings of helpfulness.

In young people (Reavley and Jorm 2011):

- When asked where they would go for help if they had a problem like the person in the vignette, across all disorders, a GP or family doctor was the most commonly mentioned source of help. Parents, friends and counsellors were also highly rated, with between 20 and 30% of respondents nominating them as likely sources of help. When various family members were considered together, informal help-seeking from family was the most common.
- The great majority reported that they would seek help, with help seeking most likely for symptoms of depression with suicidal thoughts and PTSD.
- Intentions to seek help from informal sources such as family and friends were most common.
- Being too embarrassed or shy was the most highly endorsed barrier to young people’s help seeking.
- When asked specifically about the helpfulness of various people and health professionals, close friends received the highest ratings of helpfulness, closely followed by GPs and counsellors.
- For depression, depression with substance abuse and social phobia, vitamins were rated as the most helpful, while antidepressants were rated as the most helpful for the other disorders.
- For all disorders, the most highly-rated lifestyle interventions were physical activity, support groups, relaxation training, and cutting down on alcohol, cigarettes and marijuana.

Beliefs about treatment for eating disorder have also been assessed in community surveys (Mond, Hay et al. 2004; Darby, Hay et al. 2012). In the case of anorexia nervosa, GPs and psychiatrists or psychologists were considered the most helpful treatment providers, while obtaining information about the problem and available services, followed by family therapy, were considered the most helpful interventions. (Darby, Hay et al. 2012). For bulimia nervosa, GPs, counsellors, or dieticians were more likely than psychologists or psychiatrists to be perceived as helpful. Self-help interventions, including the use of vitamins and minerals, were also highly regarded, while a minority of participants believed that antidepressant medication would be helpful (Mond, Hay et al. 2004).

1.5.1.3 Beliefs about causes and risk factors

Professionals working in the area of mental illness generally consider that these disorders arise as a result of a complex interplay of biological, psychological and social factors. However, public beliefs about causes of mental illness are generally less sophisticated.
Previous surveys of mental health literacy have shown that many people believe that social factors are more likely to be the causes of mental illness than genetic factors, particularly in the case of depression (McKeon and Carrick 1991; Matschinger and Angermeyer 1996; Priest, Vize et al. 1996; Jorm, Korten et al. 1997; Link, Phelan et al. 1999; Lauber, Falcato et al. 2003). Another relatively common belief is that personal weakness is a cause of mental illness (Jorm, Korten et al. 1997; Link, Phelan et al. 1999; Taskin, Sen et al. 2003). While this belief is less common than those about social factors, it is of concern as it reflects stigmatising attitudes towards mental illness.

As part of the 2011 National Survey of Mental Health Literacy and Stigma, general community respondents were asked about their views of a range of factors as the causes of mental illness (Reavley and Jorm 2011). Results showed that:

- Across each disorder, beliefs in social factors, such as day-to-day problems, death of someone close, traumatic event, and problems from childhood as likely causes were common. In addition, having a chemical imbalance was commonly rated as a likely cause.
- Approximately 40% of participants assigned the depression and anxiety disorder vignettes said that weakness of character was a likely cause of mental illness. This factor was less likely to be seen as a cause for those assigned the schizophrenia vignettes.

1.5.1.4 Beliefs about first aid

As the prevalence of mental illness is relatively high, it is likely that most members of the public will, at some time, have had contact with someone with a mental disorder. Help given by members of a person’s social network, which may be defined as ‘first-aid behaviours’ can have an important role to play in providing support and encouraging appropriate help seeking. There is evidence that a person with a mental disorder is more likely to seek help if another person recommends it (Dew, Bromet et al. 1991; Cusack, Deane et al. 2004).

As part of the 2011 National Survey of Mental Health Literacy and Stigma, respondents were asked about what they would do if the person described in the vignette was someone they knew well or cared about (Reavley and Jorm 2011; Rossetto, Jorm et al. (in submission)). The results showed that, in the general community:

- For all illnesses, listening and talking with the person was the most commonly nominated response.
- For all illnesses other than social phobia, encouraging the person to see a doctor was the next commonly nominated response.

In young people (Yap, Reavley et al. 2012):
• The most helpful first-aid intentions were considered to be: listening to the person’s problems in an understanding way, rallying friends to cheer the person up, suggesting that the person seek professional help and encouraging physical activity.
• For social phobia and depression with substance abuse, there were increases since 2006 in helpfulness ratings for suggesting that the person seek professional help.
• For all disorders other than depression, there were increases in helpfulness ratings for making an appointment to see a GP.

1.5.1.5 Stigmatising attitudes

Stigmatising attitudes may also inhibit help seeking. For example, someone who thinks depression or social phobia is due to weakness of character or who believes that others will view them negatively are less likely to seek professional help (Link, Struening et al. 1997; Corrigan 2004; Barney, Griffiths et al. 2006; Barney, Griffiths et al. 2009). However, evidence suggests that stigmatising attitudes vary according to type of mental illness and that there is a need to explore attitudes to different illnesses separately (Jorm and Wright 2008; Wolkenstein and Meyer 2008).

1.5.2 Community understanding of mental health and health service utilisation in Aboriginal and Torres Strait Islander people

Concepts of mental health among Aboriginal and Torres Strait Islander people may differ from that of the mainstream population and between groups. In general, Aboriginal and Torres Strait Islander people have a more holistic view of health and mental health is considered to be an interaction between the individual, the community, and the environment, involving spiritual, social, cultural, physical, and mental well-being and issues related to land and way of life (Swan and Raphael 1995). They may be less likely to view aberrant behaviour as mental illness and less likely to seek professional help (Isaacs, Pyett et al. 2010). Other barriers to utilisation of mental health services relating to community understanding include the negative influence of the social support network, stigma/shame, lack of trust in mainstream services, gender issues, fears of being locked up and staff ignorance of indigenous culture (Isaacs, Pyett et al. 2010).

1.5.3 Community understanding of mental health and health service utilisation in CALD communities

Attitudes towards mental illness vary according to cultural background. There is some evidence that stigmatising attitudes are higher in CALD communities, with mental illness linked to greater shame, humiliation and loss of face. People from CALD communities may have poorer knowledge of mental illness (Copelj and Kiropoulos 2011), be less likely to disclose symptoms, more likely to report physical rather than mental symptoms (Kiropoulos, Klimidis et al. 2004; Zaroff, Davis et al. 2012) and less likely to seek treatment (Maheshwari
and Steel 2012). In some cultures, mental illness is more likely to be attributed to being possessed by malicious spirits, past misdeeds and inherited bad luck (Kiropoulos, Blashki et al. 2005; Federation of Ethnic Communities Councils of Australia 2011).

1.5.4 Health professionals and stigma

The relationship between a health professional and a person with a mental disorder can play a key role in recovery. Experiences of discrimination, which may involve a health professional’s lack of interest in a client’s personal circumstances or an unwillingness to include the person in treatment decisions may limit help seeking and adherence to treatment (Schulze 2007; Horsfall, Cleary et al. 2010). There is also mounting evidence that people with mental illness receive inadequate physical health care and that the attitudes of health professionals may contribute to this (Lambert and Newcomer 2009).

1.5.4.1 Attitudes of health professionals

A number of studies have attempted to assess health professionals’ attitudes to those with mental illness, including beliefs about the person’s functioning in social roles, clinical outcomes, desire for social distance, beliefs about dangerousness and restriction of individual rights (Caldwell and Jorm 2001; Nordt, Rossler et al. 2006; Bjorkman, Angelman et al. 2008; Rao, Mahadevappa et al. 2009). In some cases, such attitudes were more negative than those held by the general public (Jorm, Korten et al. 1999; Nordt, Rossler et al. 2006; Schulze 2007), while other studies suggest that health professionals hold less stigmatising beliefs (Jorm, Reavley et al. 2012). A recent survey of Australian health professionals found that GPs were more likely to have stigmatising attitudes than psychiatrists and psychologists (Reavley, Mackinnon et al. 2013). Comparison with attitudes in the general community showed that health professionals were less likely to have stigmatising attitudes.

1.5.4.2 Experiences of discrimination from health professionals

In a 2005 report, for which data was collected through community consultations and surveys disseminated to members, the MHCA reported that negative, dismissive and stigmatising attitudes by health professionals towards people with mental illness were very common (Mental Health Council of Australia 2005). Family members also commonly reported feeling discounted or ignored by health workers.

A 2011 survey conducted by the MHCA that involved 413 consumers and 200 carers recruited through the MHCA membership and database contacts, assessed the experiences of stigma from mental health and other health professionals (Mental Health Council of Australia 2011). The results showed that:

- 34.1% of consumers agreed or strongly agreed they had been advised to lower their expectations for accomplishments in life
- 29.0% had been shunned or avoided by the professional treating their mental illness
- 44.7% indicated that their service provider had changed their behaviour toward them once finding out about their mental illness
- 28.7% reported that professionals were not comfortable talking to them
- 61.1% reported a lack of understanding about the lived experience of mental illness from their service providers.

On a more positive note:

- 60.6% reported that their health professional had treated them fairly
- 59.8% reported that their health professional had treated them with dignity and respect
- 64.7% reported that their health professional had treated them been understanding and supportive
- 55.2% reported that their health professional had been optimistic about their recovery
- 58.5% reported that their health professional had encouraged them to make plans for the future
- 31.4% felt more listened to by professionals treating their mental illness than by professionals treating their other illnesses.

For carers, the results showed that:

- 43.8% reported that the person they cared for was treated as less competent by professionals treating his/her mental illness than by professionals treating other illnesses that he/she has had
- 21.3% had seen the person they cared for be shunned or avoided by professionals when it was revealed they had a mental illness
- 40.6% had heard health professionals tell the person that they should lower their expectations for accomplishments in life
- 38.9% worried that worried that health professionals would view the person unfavourably once they found out they would be treating them for mental illness
- 43.9% indicated that their service provider behaved differently when they found out that the person they care for had a mental illness
- 61.4% felt that the health professionals treating the person with mental illness didn’t really understand what it means to have a mental illness
- 34.0% felt that health professionals were not comfortable talking to the person with mental illness
- 25.0% felt that they were an equal member of the team deciding on the treatment plan, when talking to health professionals about the mental illness of the person they cared for.
• 46.2% reported that health professionals had been understanding and supportive
• 56.7% reported seeing the person treated fairly by health professionals
• 28.0% felt that health professionals were optimistic about the person’s recovery
• 53.6% felt that knowing the person was seeing a health professional made them feel more hopeful about the future
• 42.0% found that health professionals encouraged the person to make plans for the future
• 49.2% reported that health professionals had treated the person with the same dignity and respect given to people with physical illnesses
• 20.1% felt more listened to by health professionals treating the person’s mental illness than by professionals treating their other illnesses.

There is a clear need for mental health professionals to be aware of their own attitudes to those with mental illness and the adverse consequences that stigmatising attitudes and discriminatory behaviours might have for patients and clients (Caldwell and Jorm 2000).

1.6 Community understanding of mental health and social isolation

Loneliness and social isolation can make it harder for people with a mental disorder to recover or cope with their mental health problems. Social support is a key factor in facilitating recovery, but some people with mental illness may not have the social skills necessary for forming supportive social networks. Moreover, continuing symptoms of illness and stigma impact on their capacity to develop and maintain social relationships. The 2007 NSMHWB (Slade, Johnston et al. 2009) showed that:

• 28% of people who had never been married had a 12-month mental disorder, compared to 15% of people who were married or living in a de facto relationship.
• 33% of people with no family members to rely on had a 12-month mental disorder, compared with 17% of people with three or more family members to rely on.
• 25% of people with no friends to rely on had a 12-month mental disorder, compared with 18% of people with three or more friends to rely on.
• 20% of people who had contact with friends had a 12-month mental disorder, compared to 38% of people who had contact with friends.

According to the 2010 SHIP, 37.2% of participants identified loneliness/social isolation as an important challenge to be faced in the coming year (second only to financial matters which was nominated by 42.7% of participants) (Morgan, Waterreus et al. 2011). Other findings from the survey were as follows:
• 63.2% of people with psychosis were rated as having marked impairment in socialising over the past year
• 69.3% said their illness made it hard for them to maintain a close relationship
• 48.8% had never been married or in a long term de facto relationship
• 47.5% said they needed and would like more friends
• 22.4% felt socially isolated and lonely
• 13.3% reported having no friends at all
• 14.1% had no-one to rely on at times of serious need
• 15.4% had never had anyone to confide in.

A 2005 survey conducted by SANE Australia involving 182 consumers and 76 carers, also showed that loneliness was a significant issue, with 72% of respondents feeling lonely ‘often’ or ‘all the time’ (Elisha and Hocking 2005). Respondents reported that having a mental illness has a strong effect on friendship; 85% of respondents felt that mental illness made maintaining close friendships harder and only 8% believed that mental illness led to no change in maintaining friendships. Friendship was considered to play a key role in recovery from illness, with 61% of respondents nominating close friendships as ‘very important’.

A 2009 survey by SANE Australia using a convenience sample of 424 people who completed a questionnaire anonymously via the SANE website, examined the impact of mental illness on personal relationships and physical intimacy (SANE Australia 2009). Results showed that:

• 49% of participants had no close relationship with another person
• 13% had no physical contact with another person for 12 months
• 35% had no sexual contact for 12 months

The 2011 National Survey of Mental Health Literacy and Stigma showed assessed willingness to have social contact with a person with a range of mental illnesses. This was generally greatest for the items relating to making friends with the person and least for the items relating to working closely with a person with a mental illness or having the person marry into one’s family. When the level of willingness to have social contact was assessed according to disorder, this was generally lowest for chronic schizophrenia and highest for PTSD (See section 1.4.1 and Figures 3 and 4).
1.7 Community understanding of mental health and access to employment

1.7.1 Mental illness and unemployment

A number of Australian studies have shown a link between poor mental health and unemployment (Wilhelm, Mitchell et al. 2003; Butterworth, Leach et al. 2012). Data from the 2007 NSMHWB (Slade, Johnston et al. 2009) showed that:

- 29% of unemployed people had a 12-month mental disorder, compared to 20% of employed people
- 15.9% of unemployed people had a 12-month affective disorder, compared to 5.7% of employed people.

Data from the 2010 SHIP (Morgan, Waterreus et al. 2011) showed that:

- at 30.5% the labour force participation rate of participants was under half that of the general population participation rate (65.3%)
- at 27.4% the unemployment rate of participants was five times that of the general population rate (5.0%).

1.7.2 Disclosure of mental illness in the workplace

Data from the 2010 SHIP revealed that just over half (56.2%) of those who were employed had told their employer about their mental illness. Females were less likely to disclose than males (48.1% compared to 61.4%, respectively) and younger people were less likely to disclose than older people (51.9% compared to 60.9% respectively) (Morgan, Waterreus et al. 2011). In 2011 SANE Australia carried out a survey of 520 people living with mental illness, 89% of whom were in current employment and 45% of whom had been diagnosed with depression (SANE Australia 2011). Results showed that 64% had disclosed their mental disorder.

1.7.3 Experiences of discrimination in the workplace

Findings of the 2011 SANE Australia survey referred to above also included the following:

- 37% of respondents reported that their mental disorder had been a barrier to finding work, partly due to a lack of workplace support from managers and colleagues
- 53% had experienced stigma at some time at work
- 43% had managers who understood mental illness
- 30% had been offered flexible work arrangements
- 7% had received support through an Employee Assistance Program (EAP)
1.7.4 Attitudes to mental health in the workplace

In 2012, the not-for-profit employment services provider, WISE Employment commissioned a survey of Chief Executive Officers (CEOs), General Managers and other managers in Small to Medium Enterprises (SMEs) involved in making decisions about employing new staff (McNair Ingenuity Research 2012). The results showed that:

- 21% of SMEs weren’t inclined to hire people who have a mental illness, believing their behaviour would be unpredictable and changeable
- 32% of those surveyed indicated that in the future they would be likely to employ a person with a mental illness, compared to 46% for someone with a physical disability
- 61% of respondents indicated that the organisation for which they worked did not have a policy regarding the employment of people with a disability
- 44% of respondents said they would be more likely to consider hiring someone with a mental illness in the future knowing they had ongoing support and follow-up for their organisation from an outside agency
- Only 21% of all respondents were aware of any types of support available to organisations that choose to hire a person with a mental illness.

A 2008 qualitative study involving representatives from more than 80 organisations examined employer attitudes to employing people with mental illness (DEEWR 2008). Focussing on communication with human resource (HR) managers and CEOs, the study showed that employers were highly reluctant to recruit people with mental illness but were more receptive to the idea of retaining an existing employee with a mental disorder. A common perception was that employees with mental illness would be incapable, unpredictable, unreliable and could be disruptive (or even dangerous), or could cost the organisation in terms of time, resources and lost business.

The National Survey of Mental Health Literacy and Stigma 2011 asked participants to rate their agreement with the statement “I would not employ someone with this problem”. The percentages of those who agreed or strongly agreed with the statement varied according to vignette: depression 23.4%, depression with suicidal thoughts 23.6%, early schizophrenia 27.5%, chronic schizophrenia 37.0%, social phobia 16.2% and PTSD 15.4% (See Figure 1) (Reavley and Jorm 2011). When asked to rate their agreement with the statement “Most other people would not employ someone with this problem”, the percentages increased considerably: depression 70.5%, depression with suicidal thoughts 70.3%, early schizophrenia 75.9%, chronic schizophrenia 84.7%, social phobia 65.1% and PTSD 58.1%. Participants were also asked about their willingness to work closely with a person with a problem similar to that described in the vignette. Percentages of those unwilling or definitely unwilling to do this were as follows: depression 15.5%, depression with suicidal
thoughts 15.8%, early schizophrenia 18.5%, chronic schizophrenia 30.0%, social phobia 13.2% and PTSD 10.4% (See Section 1.4.1 and Figures 3 and 4).

1.8 Community understanding of mental health and access to stable housing

The 2007 NSWHWB found that, in those who had been homeless at some point in their lives, the 12-month prevalence of mental illness was over two and a half times higher (53.6%) than that in the general population (20.0%) (Slade, Johnston et al. 2009). Affective disorders and anxiety disorders were found to be significantly higher among people who reported prior homelessness (27.7% and 39.4% respectively) than in the general population (6.2% and 14.4% respectively).

The 2010 SHIP found that, at the time of interview, 5.2% of participants reported being homeless, with 12.8% of participants having been homeless in the 12 months prior to the interview (Morgan, Waterreus et al. 2011). This compares with an estimated rate of homelessness in the general population of 0.5%. The proportion of those who were homeless in the past year was higher for males than females (15.4% and 8.9% respectively) and for those in the younger age group (16.4% for 18-34 years compared with 10.1% for 35-64 year olds).

Homelessness may be both a risk factor for and a consequence of mental illness. Lack of appropriate housing and housing support represents a major obstacle to a person’s recovery from a mental disorder and maintenance of mental health, whereas access to stable housing can assist a person to manage their illness and the ability to cope with day-to-day life. Poor community understanding and discrimination act as barriers to stable accommodation for people with mental illness (Mental Health Council of Australia 2009). Landlords may be unwilling to rent to people with mental illness; they may set different terms and conditions for rental agreements; or may not allow reasonable adjustments to be made (for example, allowing family members to co-sign a lease) (Corrigan 2004).

In a 2008 survey using a convenience sample of 372 people who completed a questionnaire via their helpline or website, SANE Australia reported that nearly 90 per cent of respondents who had a mental illness believed that they had been discriminated against in their search for appropriate housing, particularly when seeking private rental accommodation (SANE Australia 2008).

1.9 Community understanding of mental health and access to legal services

People with mental illness may face barriers to accessing appropriate legal services and participating effectively in the legal system (Karras, McCarron et al. 2006). A lack of
community understanding may result in failure to recognise a person’s mental disorder and a perceived lack of credibility. Failure to identify or recognise a person’s mental illness may mean that no allowance is made to cater to an individual’s needs, or that the illness is not taken into consideration in determining the outcome of the matter. Community Legal Centres may provide free legal services to people living with mental illness who have legal problems that relate to their mental disorder. However, if a disorder remains unidentified, access to these services is not possible.

People with mental illness may be viewed as lacking credibility due to the perception that they are unable to perceive the ‘reality’ of events and are therefore not telling the truth. It has been reported that, in some circumstances, lawyers have difficulties believing or taking seriously a complaint from a person with a mental illness, particularly if what they are saying is not clear (Karras, McCarron et al. 2006). This may be exacerbated by communication problems between lawyers and clients. Not being taken seriously could also prevent people from addressing their legal issues.

Similarly, in the legal system people with a mental illness (particularly those who have been the victim of sexual assault) may not be taken seriously when they are giving evidence or even making a complaint to police. This can in turn deter those who have been the victim of an assault from making a complaint to the police. People with a mental illness who are viewed as being ‘excessive complainants’ are also seen to lack credibility. Where people have legitimate complaints, perceptions that they are being vexatious may prevent them from being taken seriously by people in the legal system (Karras, McCarron et al. 2006).

1.10 Community understanding of mental health and participation in higher education

Mental disorders have their first onset before age 24 in 75% of cases (Slade, Johnston et al. 2009). At this age, many young people are in tertiary education and while many enjoy and effectively manage their responsibilities, analysis of data from Australian national surveys reveals that tertiary students are at higher risk of moderate (but not high) psychological distress compared to non-students (Cvetkovski, Reavley et al. 2012). In an effort to support students with mental illness, Australian tertiary education institutions typically offer a number of services, including counselling services and disability liaison units.

Tertiary students need to know how to take action to deal with mental health problems, whether that is professional help seeking or appropriate self-help behaviours. However, the majority of young people with depression and related disorders either do not seek or delay seeking professional help, and there is some evidence that they are also reluctant to access formal disability support services in tertiary education institutions (Salzer, Wick et al. 2008; Slade, Johnston et al. 2009). As with other members of the general community, poor mental health literacy and stigma act as barriers to help seeking. If help is not sought when it is
needed, levels of psychological distress may remain high and, in students, these have been associated with a reduced capacity for work (Stallman 2008). Mental health problems have been shown to affect both exam performance and tertiary education drop-out rates (Kessler, Foster et al. 1995; Andrews and Wilding 2004; Hysenbegasi, Hass et al. 2005), educational impacts which may have lifelong consequences, particularly if students do not complete their courses.

1.11 Addressing poor community understanding of mental illness: current Australian policies and practices

1.11.1 Government policies and practices

The National Mental Health Strategy, which has guided mental health reform in Australia since 1992, has a focus on stigma reduction, mental health promotion and mental illness prevention (Department of Health and Ageing 2009). It contains the following action items:

- Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.
- Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.

Such policies and programs aim to facilitate early treatment seeking by improving recognition of mental disorder signs and symptoms, knowledge of appropriate treatments and minimising the impact of stigma as a barrier to help seeking. Stigma reduction interventions also seek to benefit those with diagnosed disorders by minimising the negative impacts of disclosure and maximising the positive aspects. In addition, one of the priorities of the Council of Australia Governments (COAG) Roadmap for National Mental Health Reform 2012-2022 is to improve the social and economic participation of people with mental illness.

Most Australian states and territories have policies relating to improving community understanding of mental illness and reducing stigma, and carry out activities related to these policies. See Appendix A for more details.

1.11.2 Non-government organisations

Mental Health non-government organisations (NGOs) are a key part of Australia’s mental health system and deliver a wide range of services. It is estimated that there are close to 800 Mental Health NGOs in Australia. Mental Health NGOs may promote self-help and provide support and advocacy services for people with a mental illness and their carers. They may also have a psychosocial rehabilitation role. Services provided by these organisations include housing support, individual support, day programs, prevocational training, education, residential services, home-based outreach and respite care.
In 2010, the National Health Workforce Planning & Research Collaboration carried out a study of the mental health NGO workforce (National Health Workforce Planning & Research Collaboration 2011). They obtained valid responses from 268 organisations (34% of the sector). Among the participating organisations, 243 reported providing the following types of health education or public awareness:

- 15% were involved in campaigns to challenge stigma
- 16% were involved in mental health awareness media campaigns
- 60% provide community events for mental health awareness
- 55% provide mental health information pamphlets or newsletters
- 29% provide web-based mental health information.

See Table 1 for a description of Australia’s major mental health NGOs and their activities.
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Principal activities</th>
<th>Target populations</th>
</tr>
</thead>
</table>
| Beyondblue (www.beyondblue.org.au) | Raising community awareness about depression and anxiety and reducing stigma associated with illnesses | • All Australian population  
• Aboriginal and Torres Strait Islander peoples  
• Gay, lesbian, bisexual, transgender, intersex (GLBTI) community  
• CALD communities  
• Perinatal women  
• Workplaces  
• Young people  
• Older people  
• Health professionals |
| SANE Australia (www.sane.org) | Raising community awareness about mental illness  
StigmaWatch (anti-stigma media campaign) | • All Australian population  
• People with a mental illness  
• Media organisations  
• Workplaces |
| Mental Health Carers ARAFMI (Association of Relatives and Friends of the Mentally Ill) Australia (MHCAA) (www.arafmiaustralia.asn.au) | Promoting positive community attitudes towards mental illness, improving acceptance and reducing stigma. | • All Australian population  
• Carers of families and of persons affected by mental illness |
<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Council of Australia (MHCA) (<a href="http://www.mhca.org.au">www.mhca.org.au</a>)</td>
<td>Promoting mentally health communities, education on mental health issues, conducting research into mental health issues and reforming Australia’s mental health system</td>
<td>• All Australian population</td>
</tr>
</tbody>
</table>
| Schizophrenia Fellowship of New South Wales (www.sfnsw.org.au) | Providing education (Remind Mental Health Training & Education program), information and resources on all aspects of mental illness | • NSW population  
• Health professionals  
People living with mental illness, their carers and families |
| Mental Illness Fellowship of Australia (www.mifa.org.au) | Providing information about services, education about mental illness and ongoing personal and practical support, building community understanding and a more effective mental health system | • People living with mental illness and their families  
• All Australian population  
State/territory peak bodies and state/territory governments |
| Mental Illness Fellowship Victoria (www.mifellowship.org) | Providing mental illness advocacy and community education activities | • People living with mental illness and their families  
Victorian population |
<table>
<thead>
<tr>
<th>Organization</th>
<th>Mission</th>
<th>Target Population</th>
</tr>
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<tbody>
<tr>
<td>Mental Health Foundation Australian Capital Territory (<a href="http://www.mhf.org.au">www.mhf.org.au</a>)</td>
<td>Promoting improved mental health and reducing stigma of mental illness</td>
<td>People living with mental illness and their families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Australian Capital Territory population</td>
</tr>
<tr>
<td>Mental Illness Fellowship of Western Australia (<a href="http://www.mifa.org.au/mifwa">www.mifa.org.au/mifwa</a>)</td>
<td>Promoting an understanding of issues relating to mental illness in the community</td>
<td>People living with mental illness and their families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Western Australian population</td>
</tr>
<tr>
<td>Mental Illness Fellowship of Northern Territory (<a href="http://www.mifa.org.au/mhcnt">www.mifa.org.au/mhcnt</a>)</td>
<td>Offering support, education, information, and respite to all people whose lives are affected by mental illness to reduce community restrictions experienced by all people affected by mental illness and improve their quality of life.</td>
<td>People living with mental illness and their families in the Northern Territory</td>
</tr>
<tr>
<td>Mental Illness Fellowship of South Australia (<a href="http://www.mifsa.org">www.mifsa.org</a>)</td>
<td>Promoting acceptance of mental illness in the community through community education programs</td>
<td>South Australian population</td>
</tr>
<tr>
<td>Mental Health Carers Tasmania (mentalhealthcarerstas.org.au)</td>
<td>Providing community awareness and education by assisting individuals, families and friends, and the wider community to receive information and gain a better understanding of mental ill health and</td>
<td>Tasmanian families, friends, carers and people with mental health issues and mental illness</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Target Groups</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Mental Health Foundation of Australia (Victoria) | Promoting mental health and positive attitudes towards mental health and working to remove the stigma associated with mental ill health | • All Australian population  
• Health professionals |
| Mental Health First Aid Australia (www.mhfa.com.au) | Empowering community members to provide support to one another in times of mental health problems and mental health crises, with positive and inclusive attitudes towards people with mental health problems | • All Australian population  
• Health professionals  
• Adults working with adolescents  
• Adults working with Aboriginal or Torres Strait Islanders |
| Black Dog Institute (www.blackdoginstitute.org.au) | Improving community understanding of mood disorders (depression and bipolar disorder) and reducing the stigma associated with mental illnesses through community programs | • All Australian population  
• Health professionals  
• Workplaces  
• Young people |
<p>| Inspire Foundation (inspire.org.au)               | Increasing young people’s knowledge of mental health and wellbeing (mental health and wellbeing service website) | • Young people (14-25 years) |</p>
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Description</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Infant, Child, Adolescent and Family Mental Health Association</td>
<td>Promoting the mental health and well-being of infants, children, adolescents and their families/carers</td>
<td>All Australian population</td>
</tr>
<tr>
<td>(AICAFMHA)</td>
<td></td>
<td>Agencies and professionals who have contact with young people</td>
</tr>
<tr>
<td>(<a href="http://www.aicafmha.net.au">www.aicafmha.net.au</a>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifeline</td>
<td>Promoting emotional health and wellbeing and building community capacity through education</td>
<td>All Australian population</td>
</tr>
<tr>
<td>(<a href="http://www.lifeline.org.au">www.lifeline.org.au</a>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>headspace</td>
<td>Promoting mental health and help-seeking for mental health problems</td>
<td>Young people (12-25 years)</td>
</tr>
<tr>
<td>(<a href="http://www.headspace.org.au">www.headspace.org.au</a>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Coalition of Australia</td>
<td>Working to reduce stigma and increase an understanding of mental illness and its prevention</td>
<td>South Australian population</td>
</tr>
<tr>
<td>(<a href="http://www.mhcsa.org.au">www.mhcsa.org.au</a>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Coordinating Council</td>
<td>Supporting community based organisations to deliver appropriate services to people with mental health issues</td>
<td>Workers and managers who provide mental health related services</td>
</tr>
</tbody>
</table>
Mental Health Council of Tasmania  
(www.mhct.org)  
Educating the community about mental health and wellbeing  
- Tasmanian population

Mental Health Community Coalition ACT  
(www.mhccact.org.au)  
Dispelling the stigma and increasing knowledge of mental illness and dimensions of culture  
- CALD communities  
- Workplaces

Reconnexion  
(www.reconnexion.org.au)  
Increasing community awareness of anxiety disorders, depression, benzodiazepine or analgesic dependency through education  
- All Australian population  
- Health professionals

Orygen Youth Health Research Centre  
(www.oyh.org.au)  
Training and communications program provides training and resources to improve the understanding of mental health issues in young people and to promote the capacity of services and the general public in supporting young people.  
- Health professionals  
- Schools  
- Corporate organisations
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Description</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland Alliance for Mental Health</td>
<td>Promoting mental health and anti-stigma initiatives in the community, reducing mental health discrimination in workplaces.</td>
<td>All Australian population, Workplaces</td>
</tr>
<tr>
<td><a href="www.qldalliance.org.au">www.qldalliance.org.au</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Prevention Australia</td>
<td>Providing community awareness and public education on suicide and self harm prevention</td>
<td>All Australian population</td>
</tr>
<tr>
<td><a href="www.suicidepreventionaust.org">www.suicidepreventionaust.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT Mental Health Consumer Network</td>
<td>Increasing mental health literacy through participation and education</td>
<td>Mental health consumers, Mental health service providers</td>
</tr>
<tr>
<td><a href="www.actmhcn.org.au">www.actmhcn.org.au</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamp Inc.</td>
<td>Practical training and skills development opportunities in wellbeing and mental illness.</td>
<td>Mental health service providers, Emergency service providers</td>
</tr>
<tr>
<td><a href="www.lampinc.org.au">www.lampinc.org.au</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mind Australia</td>
<td>Providing education about mental health and recovery and challenging the stigma surrounding these</td>
<td>Mental health professionals, Mental health carers and families, All Australian population</td>
</tr>
<tr>
<td><a href="www.mindaustralia.org.au">www.mindaustralia.org.au</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Association NSW</td>
<td>Increasing community awareness and knowledge of mental health issues.</td>
<td>NSW population</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Mental Illness Education ACT
(www.mieact.org.au)

Providing education to the community about mental illness to reduce stigma and discrimination, improve knowledge, and to raise awareness about the importance of getting help early.

- ACT population
- Schools

Mentally Healthy WA
(www.actbelongcommit.org.au) See Section 2.3.1.1.1 for evaluation

Promoting wellbeing and mental health

- WA population
- Workplaces

PTSD Limited
(www.ptsdlimited.com)

Increasing awareness of the symptoms of Post-traumatic Stress Disorder

- All Australian population

Anxiety Recovery Centre Victoria
(www.arcvic.org.au)

Increasing knowledge and skills that will build resilience and recovery and reduce the impact of anxiety disorders

- People and families living with anxiety disorders

Australasian Centre for Rural & Remote

Promoting and raising awareness of mental health

- Rural and remote Australian communities
- Aboriginal and Torres Strait Islander
Mental Health illness prevention and early intervention communities

(www.acrrmh.com.au)
In summary, in any 12-month period, anxiety, affective and substance use disorders affect 20% of Australians aged 16-85 while psychotic illnesses affect 0.45% of Australians aged 18-64. Rates of mental illness in Aboriginal and Torres Strait Islander peoples are between 50% and three times higher. With a contribution of 24%, mental illnesses were the leading cause of the non-fatal burden of disease in Australia in 2003.

People with mental illness must cope with their symptoms and also with the limitations of community understanding of mental illness, that is, the erroneous beliefs, stereotypes and prejudice that result from misconceptions about mental illness. These stigmatising attitudes are often nominated as a central concern for people with mental illness. Beliefs about the unpredictability and dangerousness of people with mental disorders are among the most common stigmatising attitudes and are highest for people with schizophrenia. Experiences of stigma and discrimination are common among people with mental illness, with almost 40% of people with psychotic illness reporting such experiences in a 12-month period.

There is evidence that poor community understanding of mental illness adversely affects health service utilisation, due to limited ability or recognise mental illness, beliefs that standard treatments are unhelpful and stigmatising attitudes. Aboriginal and Torres Strait Islander peoples and CALD communities may be particularly disadvantaged in this area. Experiences of discrimination from health professionals may also limit health service utilisation.

There is evidence that poor community understanding of mental health also contributes to social isolation and limits access to employment, stable housing and legal services.

Improving community understanding of mental illness in order to reduce barriers to accessing services and social participation is a feature of federal and state mental health policies in Australia. Many mental Health NGOs, which are a key part of Australia’s mental health system also play a valuable role in raising public awareness and health education to improve community understanding of mental health.
2 Summary of national trends in best practice

2.1 Introduction

Evidence of the impact of poor community understanding of mental disorders on access to services and participation in society, has led to efforts to improve mental health literacy and reduce stigma. The first National Survey of Mental Health Literacy was carried out in 1995 and a second survey in 2003/4 (Jorm, Korten et al. 1997; Jorm, Nakane et al. 2005). Comparison of the results of these surveys with the 2011 National Survey of Mental Health Literacy has shown better recognition of depression and early schizophrenia, as well as more positive beliefs about a range of interventions, including help from mental health professionals, medications, psychotherapy and psychiatric ward admission (Jorm, Christensen et al. 2006; Reavley and Jorm 2012). Changes in beliefs about causes and risk factors for mental illness have also been shown, with greater belief in multi-factorial causation (Jorm, Christensen et al. 2005; Pilkington, Reavley et al. 2013). Studies conducted in South Australia examined changes in mental health literacy in regard to depression between 1998, 2004 and 2008 (Goldney, Fisher et al. 2005; Goldney, Dunn et al. 2009). Results showed that there was a significant increase in the proportion of people recognising depression in a vignette, acknowledging personal experience of depression, and perceiving professional assistance to be more helpful and less harmful. However, relatively little is known about mental health literacy in relation to anxiety disorders (Wright and Jorm 2009; Coles and Coleman 2010).

As stigmatising attitudes depression and schizophrenia were assessed in both the 2003/4 and 2011 national surveys of mental health literacy, comparison of the results of these surveys offers the opportunity to assess changes in stigmatising attitudes in Australia over an 8-year period. The results of such analyses have shown decreases in social distance scores for the depression with suicidal thoughts vignette and increases in beliefs about dangerousness and unpredictability (Reavley and Jorm 2012).

While it is difficult to ascribe specific causes to such changes, there is evidence that interventions to improve mental health literacy and reduce stigma may have played a role.

The principal aim of this section of the literature review are to outline the Australian evidence for the impact of interventions or policy and practice changes on improving community understanding of mental disorders. A further aim is to assess the strength of the evidence that interventions or policy changes have directly reduced barriers to accessing services and to participation in society, or have impacted on mediating factors, including mental health literacy and stigma.
2.2 Methods

Interventions to review were identified by searching PubMed, PsycINFO and the Cochrane Database of Systematic Reviews using the following terms: (mental disorder OR mental illness OR depression OR schizophrenia) AND (mental health literacy OR stigma* OR anti-stigma OR attitudes OR knowledge) using descriptors or subject headings. The initial search was restricted to reviews published in the last five years.

These searches returned 756 separate search results. Of these, 60 abstracts were screened for relevant intervention studies, with 39 studies included in this section of the review.

Subsequently, searches for literature relating to specific population groups or intervention types additionally used specific terms: (web OR internet), (work OR workplace OR employ*), (school OR university OR college), (housing OR accommodation), (social inclusion OR social participation) and (health professional OR medical professional OR helping professional OR nurs* OR doctor). The resulting list was searched manually for Australian studies. Preference was given to reviewing recent meta-analyses or systematic reviews where they were available and these were checked for Australian studies. Reference lists and citations of included studies were also checked. This led to the inclusion of a further 6 studies.

Grey literature was searched through Google searches, using the same search terms on June 11th 2013. The top 50 websites produced by this search were scrutinised for information relevant to the review. The titles of interventions reported in these top 50 websites were entered into Google search engine in order to identify any additional relevant references to these interventions, and to determine if any evaluations of these interventions were available on the internet. Links to websites within the top 50 websites produced by the search judged to be potentially relevant were also examined for content pertinent to the review. This led to the inclusion of a further 2 studies.

In addition, manual searches of federal and state government websites and NGOs (full members and associate members of the Mental Health Council of Australia) were conducted. Approaches were also made to these organisations through an email from the MHCA asking for evaluation reports of their activities. However, none were received.

Interventions were included in the review if they reported evaluation of activities that were designed to improve community understanding of mental illness or if they were designed to improve access to services or social participation through improving community understanding.

2.3 Results

The resulting interventions were divided into those targeting mental health literacy or stigma, and into subcategories within these, according to the target population (whole of
community or individuals within particular population groups, such as CALD communities), the mode of delivery (in-person or web-based) and the intervention setting (workplaces, schools, tertiary education institutions). Strength of evidence was assessed according the framework outlined by Mihalopoulos and colleagues (2011) (see Figure 5).
Classifying the strength of evidence of intervention studies

<table>
<thead>
<tr>
<th>Conventional approach based on epidemiological study designs: evidence from Level I-III study designs</th>
<th>Additional categories utilized in the ACE-Prevention study: evidence from Level IV studies, indirect¹ or parallel evidence², and/or from epidemiological modeling using a mixture of study designs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Sufficient evidence of effectiveness&quot; Effectiveness is demonstrated by sufficient evidence from well-designed research: (a) The effect is unlikely to be due to chance, e.g., p &lt; 0.05, and (b) the effect is unlikely to be due to bias, e.g., evidence from³: - a Level I study design; - several good-quality level II studies; or - several high-quality level III-1 or III-2 studies from which effects of bias and confounding can be reasonably excluded on the basis of the design and analysis.</td>
<td>&quot;Likely to be effective&quot; Effectiveness results are based on: (a) Sound theoretical rationale and program logic; and (b) Level IV studies, indirect evidence¹ or parallel evidence² for outcomes; or (c) epidemiological modeling to the desired outcome using a mix of evidence types or levels. The effect is unlikely to be due to chance (the final uncertainty interval does not include zero and there is no evidence of systematic bias in the supporting studies). Implementation of this intervention should be accompanied by an appropriate evaluation budget.</td>
</tr>
<tr>
<td>&quot;Limited evidence of effectiveness&quot; Effectiveness is demonstrated by limited evidence from studies of varying quality: (a) The effect is probably not due to chance, e.g., p &lt; 0.10, but bias—although not certainly an explanation for the effect—cannot be excluded as a possible explanation; e.g., evidence from³: - one level II study of uncertain or indifferent quality; - evidence from one level III-1 or III-2 study of high quality; - evidence from several level III-1 or III-2 studies of insufficiently high quality to rule out bias as a possible explanation; or - evidence from a sizeable number of level III-3 studies that are of good quality and consistent in suggesting an effect.</td>
<td>&quot;May be effective&quot; Effectiveness results are based on: (a) Sound theoretical rationale and program logic; or (b) Level IV studies, indirect¹ or parallel evidence² for outcomes; or (c) epidemiological modeling to the desired outcome using a mix of evidence types or levels. The effect is probably not due to chance, but bias—although not certainly an explanation for the effect—cannot be excluded as a possible explanation. The intervention would benefit from further research and/or pilot studies before implementation.</td>
</tr>
<tr>
<td>&quot;Inconclusive evidence of effectiveness&quot; Inadequate evidence due to insufficient research or research of inadequate quality. No position could be reached on the presence or absence of an effect of the intervention (e.g., no evidence from Level I or Level II studies; Level III studies are available, but they are few and of poor quality).</td>
<td>&quot;No evidence of effectiveness&quot; No position could be reached on the likely credentials of this intervention. Further research may be warranted.</td>
</tr>
</tbody>
</table>

¹Indirect evidence: information that strongly suggests that the evidence exists (e.g., a high and continued investment in food advertising is indirect evidence that there is positive (but proprietary) evidence that food advertisements increases sales of those products (Swinburn et al. 2005). ²Parallel evidence: evidence of intervention effectiveness for another public health issue using similar strategies (e.g., the role of social marketing, regulation, or behavioral change initiatives in tobacco control, sun exposure, speeding, etc.) (Swinburn et al. 2005). ³The evidence classifications below are based on those of the Natl. Health Med. Res. Coun. (2000). I: evidence obtained from a systematic review of all relevant randomized controlled trials. II: evidence obtained from at least one properly designed randomized controlled trial. III-1: evidence obtained from well-designed pseudo-randomized controlled trials (alternate allocation or some other method). III-2: evidence obtained from comparative studies with concurrent controls and allocation not randomized (cohort studies), case-control studies, or interrupted time series with a control group. III-3: evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group. IV: evidence obtained from either present or posttest case series. Source: Table is based on Haby et al. (2006).
2.3.1 Reducing the impact of poor community understanding on health service utilisation

2.3.1.1 Improving mental health literacy

Interventions to improve mental health literacy fall into three principal categories: whole-of-community mass media campaigns, in-person psycho-education and web-based interventions. They may be conducted in a variety of settings, including in the general community, workplaces, educational institutions, healthcare settings and targeted to particular populations, including young people, health (and other) professionals and CALD communities. All these types of interventions have been carried out and evaluated in Australia.

2.3.1.1.1 Whole-of-community campaigns

**Description:** Whole-of-community campaigns use various means to achieve their aims, including mass media campaigns, educating journalists, enlisting prominent people to speak about mental illness, sponsoring artistic and sporting events, and free information through printed materials, telephone services and the internet.

**Strength of evidence:** May be effective

**Review of effectiveness:** While whole of community campaigns are relatively common, few have been evaluated. As randomised trials are not usually possible, the most common types of evaluations are those involving pre-post community surveys with, in some cases, comparison with an unexposed population. Six such studies have been conducted in Australia.

*beyondblue*, the Australian national government-funded national depression initiative has been in operation since 2000. Its aims include raising community understanding of depression and related disorders. In its early years of operation, *beyondblue* was more active in some Australian states than others, thus allowing for comparisons between lower-activity and higher activity states. Data from national surveys of mental health literacy conducted in 1995 and 2003-2004 were analysed to see if states and territories that funded *beyondblue* (the high-exposure states) had greater changes than those that did not (the low-exposure states). The results showed that awareness of *beyondblue* in the states that provided funding was found to be around twice the level of those that did not. The high-exposure states had greater change in beliefs about some treatments, particularly counselling and medication, and about the benefits of help-seeking in general. While recognition of depression improved greatly at a national level, the increase was slightly greater in the high-exposure states (Jorm, Christensen et al. 2005). Moreover, treatment seeking in the high-exposure states increased by 14.6% while, in the low-exposure states, the increase was 6.0% (Jorm, Christensen et al. 2006).
The Compass Strategy, a community awareness campaign designed to improve mental health literacy and early help seeking for depression amongst young people was implemented in the western metropolitan Melbourne and Barwon regions of Victoria, Australia (Wright, McGorry et al. 2006). The campaign included the use of multimedia, a website, and an information telephone service. A cross-sectional telephone survey of mental health literacy was undertaken before and after 14 months of the campaign, with randomly selected independent samples of 600 young people aged 12-25 years from the experimental region and another 600 from a comparison region, interviewed at each time point. The results showed that the intervention increased awareness of mental health campaigns, self-identified depression, help for depression sought in the previous year, correct estimate of prevalence of mental health problems, increased awareness of suicide risk, and a reduction in perceived barriers to help seeking.

The Australian National Community Awareness Program was a four-year program commencing in 1995 and funded as part of the National Mental Health Strategy (Rosen, Walter et al. 2000). The aim was to develop a national public advertising campaign to increase community awareness regarding all mental illnesses. Evaluation was based on a benchmark survey of 1200 participants and pre-post tracking design. However, outcome effects were small, with the results showing small increases in the awareness of local services.

Jorm and colleagues (2003) carried out a community-based randomized controlled trial with 1094 people selected at random from the community who screened positive for depressive symptoms and agreed to participate. Participants were mailed either an evidence-based consumer guide to treatments for depression or, as a control, a general brochure on depression. The results showed that, for attitudes to some treatments (cognitive-behaviour therapy, electroconvulsive therapy and St John’s wort), positive changes were greater in the group who received the consumer guide to treatments.

The Western Australian Act-Belong-Commit campaign has also been evaluated (Anwar-McHenry, Donovan et al. 2012). A population-based campaign which ran between 2005 and 2010, it combined a community development and social marketing approach to improve community understanding of mental health. The campaign targeted individuals to engage in activities that enhanced their mental health while encouraging campaign and community partners (including health service providers, local government organisations, and community organisations that provide mentally healthy activities) to promote its activities under the campaign banner. The evaluation incorporated telephone interviews with 1113 randomly sampled adults, with questions covering campaign reach, the impact of the campaign on individual beliefs and behaviours, and perceived societal impact of the campaign on stigma and openness to mental health issues. The results showed that 75% of participants were familiar with the campaign logo or other activities and that, among those
exposed to the campaign, 25% reported changing the way they thought about mental health and mental illness, and 20% reported some behaviour change. The campaign was perceived to be effective in making people more open about mental health issue (77% of those reached by the campaign) and reducing stigma surrounding mental illness (68% of those reached by the campaign).

In a recent Australian study, Koh and Shrimpton (2013) assessed the effectiveness of exhibitions of art by people with experience of mental illness in improving awareness of mental health issues in the general community. The study involved a survey of 10,000 people who had viewed exhibitions of art produced by people with experience of mental illness. The results showed that over 90% of respondents agreed that the exhibitions helped them gain a better understanding of mental illness; gain a more sympathetic understanding of the suffering of people with mental illness; and appreciate the ability and creativity of people with mental illness.

**Conclusion:** Available studies suggest that whole-of-community campaigns conducted in Australia may be beneficial in improving mental health literacy and professional help seeking.

2.3.1.1.2 *In-person psycho-education*

**Description:** In-person psycho-education interventions, which may be delivered by a trained individual, provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours, where to seek help, as well as how to assist someone with a mental illness.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** One of the best known interventions of this type is the Mental Health First Aid (MHFA) training course (www.mhfa.com.au), which was developed in Australia in 2001 (Kitchener and Jorm 2008). MHFA is a 12-hour course that teaches adults (18 years and over) how to provide initial support to adults who are developing a mental illness or experiencing a mental health crisis. There is also a 14-hour youth course for adults working or living with adolescents. Four randomized controlled trials have been carried out to assess the effects of the course (Jorm, Kitchener et al. 2004; Kitchener and Jorm 2004; Jorm, Kitchener et al. 2010; Jorm, Kitchener et al. 2010). These have all used wait-list controls and have all shown improvements in knowledge, confidence in providing help and actual helping behaviours. These changes are maintained for 5-6 months after course completion. Other controlled trials have assessed the effects of the MHFA course in health professionals and CALD communities (O’Reilly, Bell et al. 2011; Morawska, Fletcher et al. 2013) (see Sections 2.3.1.1.7 and 2.3.1.1.8 for more details).
In another study of an in-person intervention, Buckley and Malouff (2005) compared the impact on attitudes towards professional help seeking of a 30-minute video with first-person accounts of positive experiences of psychotherapy with a control video. Participants were university students and community member volunteers, and the results showed beneficial effects post-test and two weeks later. In another study, researchers evaluated the effects of an 8-week group peer-support intervention designed to improve knowledge, coping skills and social connectedness in children of parents with a mental illness (Fraser and Pakenham 2008). The results showed beneficial effects on mental health literacy.

In a community-based trial, Hay and colleagues (2007) randomised 122 young with eating disorder symptoms to receive either a brief eating disorders mental health literacy (ED-MHL) intervention (comprising information about treatments, reputable self-help books and where to go for further information and/or services) or information about local mental health services only. The results showed that both interventions improved recognition of eating disorders and knowledge.

Using a treatment and waitlist-control design study with pre- and post-treatment, and 8 week follow up, Fraser and colleagues (2008) evaluated the effectiveness of a group peer-support intervention for children (aged 12-18) of a parent with mental illness. The intervention involved three 6-hour group sessions held fortnightly. The groups were compared on a number of variables, including mental health literacy (knowledge of mental illness, and awareness of parent’s mental illness). The results showed that compared to the control group, more intervention participants had clinically significant improvements in mental health literacy. These treatment gains were maintained 8 weeks after treatment.

**Conclusion:** There is sufficient evidence that in-person psycho-education conducted in Australia, particularly MHFA, improves mental health literacy.

### 2.3.1.1.3 Web-based interventions

The rapid growth of the internet means that websites are now a very important source of information on mental disorders and providing web-based information about mental illness is a common activity for governments (e.g. [http://www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au)) and mental health NGOs (National Health Workforce Planning & Research Collaboration 2011). However, there is very little evaluation of the effects of this web-based information on attitudes, knowledge and particularly, behaviour (Reavley and Jorm 2010).

**Description:** Web-based interventions, which are delivered via the internet (or on CD), provide education about mental illness. They may incorporate videos and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help. They may also incorporate skills training. Interventions discussed in this section cover studies of members of the general community,
who may have elevated symptoms of psychological distress but who do not have diagnosed disorders. It does not cover interventions accessed via clinical services.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** Two of the best-known Australian web-based interventions are the depression information website BluePages (www.bluepages.anu.edu.au), and the cognitive-behavioural therapy (CBT) skills training website MoodGYM (www.moodgym.anu.edu.au). In the first Australian RCT to test the effectiveness of web-based depression treatment, Christensen and colleagues (2004) found that both sites improved knowledge of evidence-based treatments, including cognitive behaviour therapy. In another study, 414 people with elevated scores on a depression assessment scale were randomly allocated to BluePages: MoodGYM or an attention control condition (Christensen, Leach et al. 2006). The results showed that use of BluePages was associated with decreases in seeking support from friends and family, the use of music and of everyday treatments, but no increase in seeking evidence-based interventions. MoodGYM was associated with the report of help seeking for CBT, massage and exercise. A follow-up study found these therapeutic benefits to be maintained over 12 months (Mackinnon, Griffiths et al. 2008).

The effectiveness of MoodGYM in improving mental health literacy relating to depression has also been assessed in teenage males (O'Kearney, Gibson et al. 2006) and teenage girls (O'Kearney, Kang et al. 2009). However, no beneficial effects were found, although poor adherence may have contributed to the non-significant findings.

In a more recent study, 155 callers to Lifeline, who met the criteria for moderate to high psychological distress were randomly assigned to 1 of 4 conditions: (1) Web CBT (MoodGYM and BluePages) plus weekly telephone tracking, (2) Web CBT only, (3) weekly telephone tracking only, and (4) neither website nor telephone tracking. Participants were assessed at pre-intervention, post-intervention, and 6 and 12 months post-intervention (Farrer, Christensen et al. 2012). Results showed that those in the Web-only and Web-plus-tracking conditions had significantly higher depression literacy at post-intervention, and this was maintained in the Web-only condition at 6-months' follow-up. No significant differences were found in depression literacy between conditions at 12 months.

Australian research on online interventions also includes a study conducted by Gulliver and colleagues (2012) involving a randomized controlled trial of three brief fully automated web-based mental health help-seeking interventions with 59 young elite athletes. The interventions consisted of a mental health literacy and anti-stigma condition, a feedback condition providing symptom levels, and a minimal content condition comprising a list of help-seeking resources, compared with a control condition (no intervention). The results showed that none of the interventions had a significant effect on help-seeking attitudes, intentions, or behaviour relative to control. However, there was a trend toward a greater
increase in help-seeking behaviour from formal sources for the mental health literacy and anti-stigma intervention compared with control. This intervention was also associated with increased mental health literacy relating to depression and anxiety. However, the small sample size makes it difficult to draw conclusions about the effects of the intervention.

Costin and colleagues (2009) compared the effects of sending two depression e-cards (with mental health literacy and help seeking information) with control e-cards containing information on a general health issue. The results showed that depression e-cards were associated with improved beliefs about the overall efficacy of formal help sources, but were not associated with an increase in formal help-seeking behaviour, improved beliefs about depression treatments; ability to recognize depression; knowledge of the help-seeking process; or depressive symptoms.

Another Australian website, Reach Out Central (ROC), an online gaming program designed to support the mental health of people aged 16–25 has also been evaluated using a pre-post study design involving 266 young people (Shandley, Austin et al. 2010). Improvements in mental health literacy were seen post-intervention.

A web-based intervention (MIDonline: www.midonline.com.au) has also been shown to improve mental health literacy relating to depression in Greek and Italian-born immigrants (Kiropoulos, Griffiths et al. 2011) (See section 2.3.1.1.7).

Hart and colleagues (2012) conducted a study in which web users who downloaded MHFA guidelines from the website were invited to respond to an initial questionnaire and then, one month later a follow-up questionnaire assessing their views of the usefulness of the documents and whether they had influenced behaviour. Results showed that among 154 of those who responded to the second questionnaire, 63 had provided first aid and 23 people had sought care themselves.

**Conclusion:** There is sufficient evidence that some web-based interventions conducted in Australia improve mental health literacy. However, longer-term effects are unknown.

### 2.3.1.1.4 School-based interventions

**Description:** Interventions delivered in schools that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help.

**Strength of evidence:** Inconclusive evidence of effectiveness

**Review of effectiveness:** MindMatters is a federal government-funded initiative which uses a whole school approach to mental health promotion. According to the evaluation conducted by the Australian Council for Education Research, which involved an online
survey of 197 schools and a more in-depth survey of 70 schools, there have been improvements in knowledge, awareness, skills and attitudes towards mental health problems (MindMatters 2005). Using a pre-test, post-test design with a wait-list control group, Robinson and colleagues (2009) assessed the impact of a 2-hour workshop on mental health literacy in 14-16 year old boys. Results showed that the program led to an increased likelihood of seeking help and of rating a relevant professional as helpful. Rickwood and colleagues (2004) evaluated a school-based program that aimed to increase knowledge and help seeking related to mental health problems. Participants were 457 high school students and a pre-post evaluation showed improved knowledge and help-seeking intentions after the intervention. A pre-post evaluation of a primary school-based intervention (30 minute information session and a 90-minute workshop) aimed at assisting teachers to support children of parents with a mental illness showed improvements in knowledge, understanding and confidence to provide help (Joyce, Allchin et al. 2003).

**Conclusion:** While some studies of school-based interventions have been conducted in Australia, these are of insufficient quality to allow conclusions about effectiveness to be drawn.

### 2.3.1.1.5 Tertiary education institution-based interventions

**Description:** Interventions delivered in tertiary education institutions that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours, where to seek help and, in some cases, how to help others with a mental illness.

**Strength of evidence:** Inconclusive evidence of effectiveness

**Review of effectiveness:** Reavley and colleagues (2013; 2013) conducted a cluster randomized trial to assess the effects of a multifaceted mental health literacy intervention (MindWise) on staff and students of a multi-campus university in Melbourne, Victoria. The intervention was designed to be whole-of-campus and to run over two academic years with their effectiveness assessed through recruitment of a monitoring sample of students from each campus. Interventions included emails, posters, campus events, factsheets/booklets and MHFA training courses. Participants had a 20-minute computer-assisted telephone interview at baseline, at the end of academic year 1 and at the end of year 2. The interview assessed mental health literacy, help seeking, psychological distress, alcohol use and knowledge of NHMRC guidelines for safe consumption of alcohol. The results showed that, in students, there were few improvements in mental health literacy. However, students with a mental health problem in the intervention group were more likely to have taken actions rated as helpful by clinicians at the end of year 2 (Reavley, McCann et al. 2013).

In another Australian study, Hart and colleagues (2012) conducted a repeated measures, uncontrolled trial involving 73 students in university residences to evaluate a 4-hour MHFA
training course specifically addressing eating disorders. Results showed that the training was effective in changing knowledge, with changes maintained at 6-month follow-up. However, sustained significant changes in attitudes and behaviours were less clear.

**Conclusion:** There is inconclusive evidence of the effectiveness of interventions to improve mental health literacy in students of tertiary education institutions.

### 2.3.1.1.6 Workplace-based interventions

**Description:** Interventions delivered in workplaces that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours, where to seek help and, in some cases, how to help others with a mental illness.

**Strength of evidence:** Sufficient evidence of effectiveness in relation to the workplace as an intervention setting.

Two RCTs of MHFA have been conducted in workplace settings, one in high school staff and one in public servants (Kitchener and Jorm 2004; Jorm, Kitchener et al. 2010). Both showed improvements in knowledge, confidence in providing help and actual helping behaviours.

The results of the MindWise mental health literacy intervention discussed in Section 2.3.1.1.5 showed that, among staff, those in the intervention group had better recognition of depression and greater knowledge of the guidelines for safe levels of drinking, as well as a greater intention to seek help for alcohol misuse from a general practitioner (Reavley, McCann et al. 2013). However none of these studies included work-related outcome measures (e.g. absenteeism, productivity).

**Conclusion:** There is sufficient evidence of the effectiveness of interventions to improve mental health literacy in workplaces, particularly in the case of MHFA. However, none of the studies have used work-related outcome measures.

### 2.3.1.1.7 Improving mental health literacy in CALD communities

**Description:** Interventions targeted to CALD communities that provide education about mental illness. They may incorporate videos, seminars and written material delivered in a culturally appropriate way. They typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help, as well as how to assist someone with a mental illness.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** Morawska and colleagues (2013) evaluated the effectiveness of MHFA in CALD settings. A total of 458 participants, who were recruited from multicultural organizations, participated in a series of MHFA training courses. Participants completed
questionnaires pre and post the training course, and 6-month follow-up interviews were conducted with a subsample of participants. Findings suggested that MHFA training increased participant recognition of mental illnesses, concordance with primary care physicians about treatments, confidence in providing first aid, actual help provided to others, and a reduction in stigmatizing attitudes. These improvements were maintained at 6-month follow-up. Other studies evaluating the effect of MHFA in members of the Chinese and Vietnamese communities have shown improved knowledge of mental disorders and improved knowledge of appropriate treatments (Minas, Colucci et al. 2009; Lam, Jorm et al. 2010).

Kiropoulos and colleagues (2011) evaluated the effects of a multilingual information website (MIDonline) intervention on the levels of depression literacy in Greek-born and Italian-born immigrants living in Australia. 202 Greek- and Italian-born immigrants aged 48 to 88 years were randomly allocated to an online depression information intervention or a depression interview control group. Participants allocated to the information intervention only had access to the website during the 1- to 1.5-hour intervention session. The results showed a significant difference between the MIDonline group and the control group, with those in the MIDonline intervention displaying higher depression literacy scores post-assessment and at the follow-up assessment.

**Conclusion:** There is sufficient evidence to suggest that interventions targeted to CALD communities in Australia, particularly MHFA, improve mental health literacy.

### 2.3.1.1.8 Improving mental health literacy in health professionals

**Description:** Interventions targeted at health professionals that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours, where to seek help, as well as how to assist someone with a mental illness.

**Quality of evidence:** Limited evidence of effectiveness

**Review of effectiveness:** The impact of MHFA on the mental health literacy of pharmacy students has been evaluated (O’Reilly, Bell et al. 2011). In 2009, third year pharmacy students at the University of Sydney (n = 272) were invited to participate in one of two MHFA training courses. Of these, 174 students applied for the training, with 60 randomly selected and offered the training. Comparison of those who underwent the training with those who did not showed that the training improved ability to correctly identify mental illness and improvements in recognition of helpful interventions, with participants' views becoming more concordant with health professional views about treatments for depression and schizophrenia. Participants were also significantly more confident to provide pharmaceutical services to consumers with a mental illness following the training.
Mellor and colleagues (2010) used a pre-test, post-test design to evaluate the efficacy of the beyondblue Depression Training Program in 148 aged-care staff and compared the outcomes with 96 control staff. The results showed that training improved carers’ knowledge about depression, their self-efficacy in responding to signs of depression and their attitudes towards working with depressed aged care recipients.

**Conclusion:** There is limited evidence to suggest that interventions targeted to Australian health professionals, particularly MHFA, improve mental health literacy.

### 2.3.2 Reducing stigma

Anti-stigma initiatives typically take three main approaches: education to challenge inaccurate stereotypes, interpersonal contact with a person with a mental illness, and social activism or protest (Corrigan, Morris et al. 2012).

There are many stigma reduction programs that have been carried out or are currently being carried out in Australia. However, very few of these have been evaluated.

#### 2.3.2.1 Whole-of-community campaigns

**Description:** Whole-of-community campaigns use various means to achieve their aims, including mass media campaigns, educating journalists, enlisting prominent people to speak about mental illness, sponsoring artistic and sporting events, and free information through printed materials, telephone services and the internet.

**Strength of evidence:** Inconclusive effective of effectiveness

**Review of effectiveness:** While there have been a number of whole-of-community anti-stigma initiatives in Australia (see Table 1) there has been very little evaluation. The Australian National Community Awareness Program, a four-year program commencing in 1995 assessed attitudes to people with mental illness using a benchmark survey of 1200 participants and pre-post tracking design (Rosen, Walter et al. 2000). The results showed small improvements in attitudes to mental illness: those who were aware of the advertising campaign were more willing than those who were unaware, to accept people with a mental illness socially or at work; and people who had experienced a mental illness reported that following the campaign they felt better about themselves. The researchers concluded that the fairly tolerant attitudes found in the Australian community at the outset were maintained, but not increased. However, there was also no clear evidence that the treatment of people with mental illness improved in relation to employment, social situations and access to services. Qualitative research suggested that the campaign had no practical impact on community attitudes or behaviour towards people with mental illness, with consumers reporting that stigma and discrimination remained at the level that existed before the campaign.
**Conclusion:** Studies of whole-of-community, anti-stigma interventions in Australia are of insufficient quality or number to allow conclusions about effectiveness to be drawn.

### 2.3.2.2 In-person psycho-education

In-person psycho-education interventions, which may be delivered by a trained individual, provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help, as well as how to assist someone with a mental illness. These interventions often incorporate a presentation by, or interaction with a person with a history of mental illness. This may be in-person or, more commonly, by video.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** MHFA has been shown to have beneficial effects in terms of reducing stigmatising attitudes. A review of intervention studies found decreased desire for social distance from people with mental disorders (Kitchener and Jorm 2006). MHFA has also been shown to reduce some stigmatising attitudes in high-school teachers (Jorm, Kitchener et al. 2010).

**Conclusion:** In-person psycho-education conducted in Australia, particularly MHFA, is effective in reducing stigmatising attitudes.

### 2.3.2.3 Web-based interventions

**Description:** Web-based interventions, which are delivered via the internet (or on CD), provide education about mental illness. They may also incorporate skills training and education to challenge inaccurate stereotypes about mental illness.

**Strength of evidence:** Limited evidence of effectiveness

**Review of effectiveness:** Griffiths and colleagues (2004) conducted a trial in which a sample of 525 individuals with elevated scores on a depression assessment scale were randomly allocated to a depression information website (BluePages), a cognitive-behavioural skills training website (MoodGYM) or an attention control condition. Personal stigma (personal stigmatising attitudes to depression) and perceived stigma (perception of what most other people believe) were assessed before and after the intervention. The results showed that the internet sites significantly reduced personal stigma, although the effects were small. BluePages had no effect on perceived stigma and MoodGYM was associated with an increase in perceived stigma relative to the control.

In more recent study, 155 callers to Lifeline, who met the criteria for moderate to high psychological distress were randomly assigned to 1 of 4 conditions: (1) Web CBT (MoodGYM...
and BluePages) plus weekly telephone tracking, (2) Web CBT only, (3) weekly telephone tracking only, and (4) neither Web CBT nor telephone tracking. Participants were assessed at pre-intervention, post-intervention, and 6 and 12 months post-intervention (Farrer, Christensen et al. 2012). Results showed that those in the Web-only and Web-plus-tracking conditions had significantly lower levels of stigma than participants in the control condition at post-intervention. This was true for participants in the Web-only and Web-plus-tracking conditions at 6 months. However, no significant differences were found in stigmatising attitudes between conditions at 12 months.

The effects of MHFA training delivered by e-learning have also been assessed in a randomized controlled trial was carried involving 262 members of the Australian public (Jorm, Kitchener et al. 2010). Participants were randomly assigned to complete an e-learning CD, read an MHFA manual or be in a waiting list control group. The effects of the interventions were evaluated using online questionnaires pre- and post-training and at 6-months follow up. The results showed that both e-learning and the printed manual reduced stigma. The e-learning intervention was superior to the printed manual in reducing stigma.

In another recent study, Gulliver and colleagues (2012) conducted a randomized controlled trial (RCT) of three brief fully automated Internet-based mental health interventions with 59 young elite athletes. The interventions consisted of a mental health literacy and anti-stigma condition, a feedback condition providing symptom levels, and a minimal content condition comprising a list of help-seeking resources, compared with a control condition (no intervention). The results showed that the mental health literacy and anti-stigma intervention was associated with a reduction in depression stigma relative to control at post-intervention and anxiety stigma at 3-month follow-up. The feedback and help-seeking list interventions did not decrease stigmatizing attitudes. However, the study was underpowered, limiting the ability to draw conclusions.

**Conclusion:** There is limited evidence to suggest that studies of web-based, anti-stigma interventions in Australia are effective. However, longer-term effects are unknown.

### 2.3.2.4 School-based interventions

**Description:** Interventions delivered in schools that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help. They may also incorporate education to challenge inaccurate stereotypes about mental illness.

**Strength of evidence:** Inconclusive evidence of effectiveness

**Review of effectiveness:** Rickwood and colleagues (2004) evaluated a school-based program that aimed to decrease stigmatising attitudes to mental health problems through
presentations given by volunteers who had either lived with or cared for someone with mental illness. Participants were 457 high school students and the results of the pre-post evaluation showed reduced stigma after the intervention.

**Conclusion:** While some studies of school-based interventions have been conducted in Australia, these are of insufficient quality and quantity to allow conclusions about effectiveness to be drawn.

### 2.3.2.5 Workplace-based interventions

**Description:** Interventions delivered in workplaces that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help. They may also incorporate education to challenge inaccurate stereotypes about mental illness.

**Strength of evidence:** Sufficient evidence of effectiveness in relation to the workplace as an intervention setting.

**Review of effectiveness:** Two RCTs of MHFA have been conducted in workplace settings in Australia, one in high school staff and one in public servants (Kitchener and Jorm 2004; Jorm, Kitchener et al. 2010). Both showed reductions in stigmatising attitudes.

**Conclusion:** There is sufficient evidence of the effectiveness of interventions to improve mental health literacy in workplaces, particularly in the case of MHFA. However, none of the studies have used work-related outcome measures.

### 2.3.2.6 Reducing stigma in CALD communities

**Description:** Interventions targeted to CALD communities that provide education about mental illness. They may incorporate videos, seminars and written material delivered in a culturally appropriate way. They typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help, as well as how to assist someone with a mental illness. They may also incorporate education to challenge inaccurate stereotypes about mental illness.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** Morawska and colleagues (2013) assessed the effects of MHFA on stigmatising attitudes in 458 participants recruited from multicultural organizations who participated in a series of MHFA training courses. Participants completed questionnaires pre and post the training course, and 6-month follow-up interviews were conducted with a subsample of participants. Results showed that the course led to a reduction in stigmatising attitudes. Other studies evaluating the effect of MHFA in members of the Chinese and
Vietnamese communities have shown similar reductions in stigmatising attitudes (Minas, Colucci et al. 2009; Lam, Jorm et al. 2010).

Blignault and colleagues (2009) investigated attitudes and beliefs towards mental illness in 100 members of the Macedonian community in Sydney (24 clients of the mental health service, 23 carers and 53 community members) and used the findings to inform a community intervention (involving education broadcasts on Macedonian radio and education sessions with community leaders and Macedonian staff in a local hospital) to reduce stigma and improve mental health literacy. The results of a pre-post evaluation showed that the intervention improved understanding of mental illness and its impact.

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Kiropoulos and colleagues (2011) evaluated the effects of a multilingual information website (MIDonline) intervention on depression-related stigma in Greek-born and Italian-born immigrants living in Australia. 202 Greek- and Italian-born immigrants aged 48 to 88 years were randomly allocated to an online depression information intervention or a depression interview control group. Participants allocated to the information intervention only had access to the website during the 1- to 1.5-hour intervention session. The results showed a significant difference between the MIDonline group and the control group, with those in the MIDonline intervention displaying significantly greater decreases in personal stigma. However, there were no changes in perceived stigma.

**Conclusion:** In-person psycho-education, particularly MHFA, is effective in reducing stigmatising attitudes in CALD communities. There is limited evidence for web-based interventions.

### 2.3.2.7 Reducing stigma in health professionals

**Description:** Interventions targeted to health professionals that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help, as well as how to assist someone with a mental illness. They may also incorporate education to challenge inaccurate stereotypes about mental illness.

**Quality of evidence:** Limited evidence of effectiveness

**Review of effectiveness:** The impact of MHFA on stigmatising attitudes of pharmacy students has been evaluated (O’Reilly, Bell et al. 2011). In 2009, third year pharmacy students at the University of Sydney (n = 272) were invited to participate in one of two MHFA training courses. Of these, 174 students applied for the training, with 60 randomly selected and offered the training. Comparison of those who underwent the training with those who did not showed that the training reduced stigmatising attitudes, in particular, the desire for social distance from someone previously hospitalised for schizophrenia. Another
study of pharmacy students assessed the impact of education provided by mental health consumer-educators on the attitudes of pharmacy students toward people with mental illness (Bell, Johns et al. 2006). The study used a 2 group, nonrandomized, clustered, comparative design, with 4 tutorial classes allocated to receive standard pharmacist-led instruction (comparison group), and 5 tutorial classes to receive standard pharmacist-led instruction plus additional input from mental health consumer-educators receiving ongoing treatment for illnesses including schizophrenia, bipolar disorder, and major depression (intervention group). 229 third-year pharmacy students were invited to participate. The results showed that students who received the consumer intervention had decreased desire for social distance and lower stigmatising attitudes. Another study of pharmacy students aimed to compare the effectiveness of a direct (face-to-face) contact intervention with an indirect (film based) contact intervention in reducing the mental health stigma (Nguyen, Chen et al. 2012). The results showed that direct contact had a stronger impact than indirect contact but for most key measures of stigma the impact of the two contact interventions was equivalent.

Given the evidence for the role of contact with people with a mental illness in reducing stigma, researchers have assessed the feasibility of training mental health consumers as tutors for 4th year medical students in psychiatry (Owen and Reay 2004). A training package for consumer tutors and a curriculum in interviewing skills for medical students was developed through a partnership between a consumer network and the University of Sydney Academic Unit of Psychological Medicine. Student attitudes to mental health consumers were measured pre and post the program and the results showed a general trend towards improved attitude across all measures.

**Conclusion:** There is limited evidence to suggest that interventions targeted to Australian health professionals (pharmacy students), particularly MHFA, reduce stigma.

### 2.4 Summary

In summary, there are a number of Australian initiatives that aim to improve mental health literacy and reduce stigma. These generally target mental illness generally or in some cases, schizophrenia or depression. However, only a relatively small number of these initiatives have been evaluated. High quality evaluations (randomized controlled trials) are rarer still. However, the following conclusions relating to the Australian evidence may be drawn:

- **Whole-of-community campaigns may be beneficial in improving mental health literacy and professional help seeking, but there is inconclusive evidence that they result in reductions in stigmatising attitudes**
- **There is sufficient Australian evidence to suggest that in-person psycho-education, particularly MHFA, improves mental health literacy and reduces stigma in the general community and CALD populations**
- There is sufficient Australian evidence to suggest that some web-based interventions improve mental health literacy, but there is inconclusive evidence that they reduce stigmatising attitudes.
- There is limited Australian evidence to suggest that interventions targeted to Australian health professionals, particularly MHFA, improve mental health literacy and reduce stigma.
- There is sufficient Australian evidence to suggest that workplace-based interventions, particularly MHFA, improve mental health literacy and reduce stigma.
- While some studies of school-based and tertiary-institution-based interventions have been conducted in Australia, these are of insufficient quantity or quality to allow conclusions about effectiveness to be drawn.
3 Summary of international trends in best practice

3.1 Introduction

As in Australia, evidence of the impact of poor community understanding of mental disorders on access to services and participation in society, has led to efforts to improve mental health literacy and reduce stigma. Surveys in a number of countries suggest that there have been improvements in mental health literacy and in some aspects of stigma (Angermeyer and Matschinger 2005; Angermeyer and Matschinger 2005; Angermeyer and Matschinger 2005; Silton, Flannelly et al. 2011). A recent review of studies of changes in attitudes towards mental illness in the general population in a number of countries found two major trends: a trend towards belief in a biological model of mental illness, and greater acceptance of professional help for mental health problems (Schomerus, Schwahn et al. 2012). However, these changes were not paralleled by reductions in stigmatising attitudes, which either did not change or, in some cases, appeared to increase.

The principal aim of this section of the literature review is to outline the international evidence for the impact of interventions, or policy and practice changes, on improving community understanding of mental disorders. A further aim is to assess the strength of the evidence that interventions or policy changes have directly reduced barriers to accessing services and to participation in society, or have impacted on mediating factors, including mental health literacy and stigma.

3.2 Methods

Interventions to review were identified by searching PubMed, PsycINFO and the Cochrane Database of Systematic Reviews using the following terms: (mental disorder OR mental illness OR depression OR schizophrenia) AND (mental health literacy OR stigma* OR anti-stigma OR attitudes OR knowledge) using descriptors or subject headings. The initial search was restricted to reviews published in the last five years.

These searches returned 756 separate search results. Of these, 60 abstracts were screened for relevant intervention studies, with 41 studies included in this section of the review.

Subsequently, searches for literature relating to specific population groups or intervention types additionally used specific terms: (web OR internet), (work OR workplace OR employ*), (school OR university OR college), (housing OR accommodation), (social inclusion OR social participation) and (health professional OR medical professional OR helping professional OR nurs* OR doctor). The resulting list was searched manually. Preference was given to reviewing recent meta-analyses or systematic reviews where they were available. Reference
lists and citations of included studies were also checked. Where these meta-analyses or reviews include Australian studies referred to above, this is noted. This led to the inclusion of a further 10 studies.

Grey literature was searched through Google searches, using the same search terms on June 11th 2013. The top 50 websites produced by this search were scrutinised for information relevant to the review. The titles of interventions reported in these top 50 websites were entered into Google search engine in order to identify any additional relevant references to these interventions, and to determine if any evaluations of these interventions were available on the internet. Links to websites within the top 50 websites produced by the search judged to be potentially relevant were also examined for content pertinent to the review. This led to the inclusion of one further study.

Interventions were included in the review if they reported evaluation of activities that were designed to improve community understanding of mental illness, or if they were designed to improve access to services or social participation through improving community understanding.

3.3 Results

The resulting interventions were divided into those targeting mental health literacy or stigma, and into subcategories within these, according to the target population (whole of community or individuals within particular population groups, such as CALD communities), the mode of delivery (in-person or web-based) and the intervention setting (workplaces, schools, tertiary education institutions). Strength of evidence was assessed according the framework outlined by Mihalopoulos and colleagues (2011) (see Figure 5).

3.3.1 Reducing the impact of poor community understanding on health service utilisation

3.3.1.1 Improving mental health literacy

Interventions to improve mental health literacy fall into three principal categories: whole-of-community mass media campaigns, in-person psycho-education and web-based interventions. They may be conducted in a variety of settings, including in the general community, workplaces, educational institutions, healthcare settings and targeted to particular populations, including young people, health (and other) professionals and CALD communities.

3.3.1.1.1 Whole-of-community campaigns

Description: Whole-of-community campaigns use various means to achieve their aims, including mass media campaigns, educating journalists, enlisting prominent people to speak
about mental illness, sponsoring artistic and sporting events, and free information through printed materials, telephone services and the internet.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** Dumesnil and Verger (2009) reviewed the evidence for the effectiveness of public awareness campaigns about depression and suicide. Their review covered the years 1987-2007 and included 39 publications that described 13 media or community campaigns/programs in eight countries (including three from Australia referred to in Section 2.3.1.1.1). While they reported that comparing the programs was difficult because of the diversity of their objectives and the methods used to deliver the programs and to evaluate them, they concluded that these programs contributed to a modest improvement in public knowledge of and attitudes toward depression or suicide. Short-term campaigns improved intentions to seek care for depression by, at most, 10%, and longer-term campaigns led to increases in willingness to seek professional help of between 5 and 25% (depending on the source). However, they noted that there was very little evaluation of longer-term effects.

Two interventions are discussed in more detail here, as they have led to increases in professional help-seeking. In Germany, a 2001-2002 community campaign known as the Nuremberg Alliance Against Depression (NAD), involved a public information campaign, interventions with GPs and community facilitators (e.g. teachers, police, clergy), and interventions with consumers and their relatives (Dietrich, Mergl et al. 2009). Community surveys of mental health literacy were carried out in Nuremberg and a nearby city that had not participated in the intervention. NAD increased awareness of depression, attitudes towards antidepressants became more positive and there was a decrease in the belief that depression was due to a lack of self-discipline. More importantly, there was a greater reduction in suicidal acts in Nuremberg and this change was found to persist one year after the end of the intervention (Hegerl, Mergl et al. 2010). These successes led to the formation of the European Alliance Against Depression in 2004 and the extension of the approach to 17 countries. Wang and colleagues (2013) assessed the impact of ‘Blues-out’, a depression awareness campaign targeting the gay/lesbian community in Geneva, Switzerland. Cross-sectional surveys conducted in 2007 and 2011 showed that awareness of Blues-out was linked to greater recognition of depression and an increased likelihood of believing that specialists and psychological therapies were helpful.

In Norway, the Treatment and Intervention in Psychosis (TIPS) program was designed to reduce the duration of untreated psychosis in first-episode schizophrenia (Joa, Johannessen et al. 2008). Run in two areas on Norway between 1997 and 2000, TIPS involved an intensive, multifaceted information campaign for the general public, schools and GPs about how to recognize psychosis, and an early detection team that could be contacted by anyone. During the intervention, the median duration of untreated psychosis in the TIPS areas was 5
weeks while in the control regions it was 16 weeks. Between 2002 and 2004 the information campaign was stopped while the early detection team continued to operate. As a result, the duration of untreated psychosis increased to a median of 15 weeks, supporting the conclusion that the information campaign was critical to the success of the intervention.

**Conclusion:** International studies suggest that there is sufficient evidence that whole-of-community campaigns improve mental health literacy and may also lead to increases in professional help seeking.

### 3.3.1.1.2 In-person psycho-education

**Description:** In-person psycho-education interventions, which may be delivered by a trained individual, provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help, as well as how to assist someone with a mental illness.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** Gulliver and colleagues carried out a systematic review of published randomised controlled trials targeting help-seeking attitudes, intentions or behaviours for depression, anxiety, and general psychological distress. They identified six studies, four of which were delivered in-person and two of which were delivered online (see Sections 2.3.1.1.2 and 2.3.1.1.3 for details of the Australian studies). Three of the trials targeted university students participating in the interventions for psychology course credit (Donohue, Dickens et al. 2004; Han, Chen et al. 2006; Sharp, Hargrove et al. 2006). Mental health literacy content was shown to be effective in improving help-seeking attitudes in the majority of studies at post-intervention. However, there were no effects on help-seeking behaviour.

**Conclusion:** There is sufficient evidence to suggest that in-person psycho-education interventions improve mental health literacy, although there is no evidence that such interventions increase help-seeking behaviour.

### 3.3.1.1.3 Web-based interventions

**Description:** Web-based interventions, which are delivered via the internet (or on CD), provide education about mental illness. They may incorporate videos and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help. They may also incorporate skills training. Interventions discussed in this section cover studies of members of the general community, who may have elevated symptoms of psychological distress but who do not have diagnosed disorders. It does not cover interventions accessed via clinical services.
**Strength of evidence:** Limited evidence of effectiveness

**Review of effectiveness:** MoodGYM has also been evaluated in a Norwegian study involving 163 university students with elevated psychological distress who were randomised to MoodGYM or to a wait-list control group (Lintvedt, Griffiths et al. 2013). The results showed that MoodGYM was effective in increasing depression literacy at 2-month follow up.

Other web-based studies have also shown benefits. Using a pre-post survey design, Iloabachie and colleagues (2011) assessed the effects of CATCH-IT (Competent Adulthood Transition with Cognitive Behavioural and Interpersonal Training), a US web-based intervention on attitudes to depression treatments and intentions to seek help. Post-intervention, participants showed more positive attitudes to counselling and the role of behaviour change in managing depression symptoms.

Another US RCT using a wait-list control assessed the effects of a web-based program providing working parents with the knowledge and skills necessary for prevention and early intervention of mental health problems in young people (Deitz, Cook et al. 2009). Those in the intervention group showed significantly greater knowledge about anxiety, depression, and treatment options.

Li and colleagues (2013) evaluated the effectiveness of a fully automated, web-based, social network electronic game (designed according to cognitive-behavioral approaches) in enhancing mental health knowledge. A pre/post-test design was used, with 73 undergraduates self-assessing their mental health literacy before and after completing the game within a 3-week period. The results showed that the gaming approach was effective in enhancing young people's mental health literacy.

Other studies have shown beneficial effects of web-based interventions conducted in workplaces (Billings, Cook et al. 2008) (See Section 3.3.1.1.6) and among health professionals (Irvine, Billow et al. 2012) (See Section 3.3.1.1.7).

**Conclusion:** There is limited evidence to suggest that web-based interventions improve mental health literacy.

3.3.1.4 School-based interventions

**Description:** Interventions delivered in schools that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help.

**Strength of evidence:** Limited evidence of effectiveness
**Review of effectiveness:** The authors of a systematic review of the effectiveness of school mental health literacy programs to enhance knowledge and improve help-seeking behaviours reported that most included studies showed improvements (Wei, Hayden et al. 2013). Their review included 10 secondary school-based studies which assessed change in knowledge and three which assessed change in help-seeking. However, only two of these studies were RCTs, one of which was conducted in China (Chan, Mak et al. 2009) and the other in Pakistan (Rahman, Mubbashar et al. 1998), and they were assessed as having moderate and high risk of bias, respectively.

**Conclusion:** There is limited evidence to suggest that school-based interventions improve mental health literacy.

### 3.3.1.1.5 Tertiary education institution-based interventions

**Description:** Interventions delivered in tertiary education institutions that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours, where to seek help and, in some cases, how to help others with a mental illness.

**Strength of evidence:** Inconclusive evidence of effectiveness

**Review of effectiveness:** One recent controlled trial of a social marketing campaign with UK university students involved the use of posters and postcards to convey information about depression and its treatment (Merritt, Price et al. 2007). Improvements were found in recognition of depression and attitudes towards antidepressants, but no change in belief that depression can be treated effectively. The web-based intervention described in Section 3.3.1.1.3 was effective in improving mental health literacy in Norwegian university students (Lintvedt, Griffiths et al. 2013). A lower quality US study of a gatekeeper training program for suicide prevention found beneficial effects of the intervention on knowledge and attitudes (Tompkins and Witt 2009).

**Conclusion:** There is inconclusive evidence of the effectiveness of interventions to improve mental health literacy in staff and students of tertiary education institutions.

### 3.3.1.1.6 Workplace-based interventions

**Description:** Interventions delivered in workplaces that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help.

**Strength of evidence:** Limited evidence of effectiveness in relation to the workplace as an intervention setting.
Review of effectiveness: Billings and colleagues (2008) conducted an RCT to evaluate the effectiveness of a web-based workplace health promotion program designed to help reduce stress and to prevent depression, anxiety, and substance abuse. 309 working adults were randomly assigned to the web-based condition or to a wait-list control condition. The results showed greater increases in knowledge of depression and anxiety, and more positive attitudes toward treatment in the web-based intervention group. The intervention also led to small improvements in productivity. The web-based program delivered to working parents described in Section 3.3.1.1.3 also led to improvements in mental health literacy (Deitz, Cook et al. 2009). Other interventions targeted towards health professionals have shown benefits (See Section 3.3.1.1.7).

Conclusion: There is limited evidence to suggest that workplace-based interventions improve mental health literacy.

3.3.1.1.7 Improving mental health literacy in health professionals

Description: Interventions targeted to health professionals that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help, as well as how to assist someone with a mental illness.

Quality of evidence: Limited evidence of effectiveness

Review of effectiveness: Computer-based education has been shown to be effective in improving mental health literacy in nursing home staff. Rosen and colleagues (2002) compared the effects of a monthly computer-based training program, a lecture and a no-intervention control administered at different nursing home sites. Improvements in knowledge were greatest in the computer-based training group. In an RCT, Irvine and colleagues (2012) assessed the effectiveness of a web-based training program for 70 nursing home staff. The results showed that the intervention was effective in improving knowledge and attitudes about mental illness.

Education has also been shown to improve knowledge and attitudes to depression in Chinese medical students (Rong, Glozier et al. 2011). In a controlled trial, 205 medical students were allocated to one of two groups: a teaching group or a combined teaching and self-directed learning group. The latter group took part in a series of learning activities after both groups had a lecture on depression together. The results showed that combined teaching and self-directed learning group showed substantially greater improvements in recognition of depression as a major health issue and identifying helpful treatments than the teaching group. This improvement was sustained over six months.

Conclusion: There is limited evidence to suggest that interventions targeted to health professionals improve mental health literacy.
3.3.2 Reducing stigma

Anti-stigma initiatives typically take three main approaches: education to challenge inaccurate stereotypes, interpersonal contact with a person with a mental illness, and social activism or protest (Corrigan, Morris et al. 2012).

3.3.2.1 Whole-of-community campaigns

**Description:** Whole-of-community campaigns use various means to achieve their aims, including mass media campaigns, educating journalists, enlisting prominent people to speak about mental illness, sponsoring artistic and sporting events, and free information through printed materials, telephone services and the internet.

**Strength of evidence:** May be effective

**Review of effectiveness:** The effects of whole-of-community campaigns designed to reduce mental illness stigma have been evaluated in a number of countries. These include the UK Defeat Depression (Paykel, Hart et al. 1998) and Changing Minds campaigns (Crisp, Gelder et al. 2005), the New Zealand Like Minds, Like Mine campaign (Vaughan and Hansen 2004; Wylie, Cameron et al. 2008). Evaluation of these campaigns involved repeated cross-sectional population surveys. Defeat Depression appeared to reduce stigmatizing beliefs about depression, and Changing Minds was associated with modest positive shifts in attitudes and beliefs to a broader range of mental illnesses. For each of these initiatives, however, the evidence of effectiveness is weakened by the lack of a comparison group.

The German evaluation of the World Psychiatric Association's global anti-stigma-program ‘Fighting stigma and discrimination because of schizophrenia--Open the Doors’ also showed reductions in stigmatising attitudes (Gaebel, Zaske et al. 2008). The program involved 4 years of public events such as lectures, art exhibitions, cinema events, readings, theatre events and charity concerts in two cities, a schizophrenia awareness program aimed at teachers and GPs in two cities and no intervention in two other cities. Effectiveness was assessed by baseline and follow-up population surveys. The results showed significant decreases in stigmatising attitudes in the intervention cities. However the decrease was primarily in relation to ‘transient’ rather than ‘close’ social relations.

Evaluation of the Scottish See Me campaign used an attitude survey in England as a comparison against which to benchmark campaign effects (Mehta, Kassam et al. 2009). The researchers used the Department of Health Attitudes to Mental Illness Surveys 1994-2003 and analysed trends in attitudes for 2000 respondents in each survey year using quota sampling methods. The results showed that comparing 2000 and 2003, there was significant deterioration for 17/25 items in England and for 4/25 items in Scotland. Neither country showed significant improvements in items between 2000 and 2003. Thus, public attitudes towards people with mental illness in England and Scotland became less positive during
1994-2003, especially in 2000-2003, and to a greater extent in England. The authors concluded that the See Me campaign may have been effective in minimising the negative effects of media coverage of mental health issues that occurred in this period, as the increases in stigmatising attitudes were evident in England after the end of the Changing Minds campaign, but not in Scotland where the See Me campaign continued.

Evaluation reports from largest national campaign ever undertaken, the Time to Change (TTC) campaign have recently made a significant contribution to the literature on whole-of-community interventions. Time to Change is the largest-ever programme in England designed to reduce stigma and discrimination against people with mental disorders [http://www.time-to-change.org.uk/] and was aimed both at the general population and at specific target groups (including employers, teachers, medical students and social inclusion officers), as well as at people with mental health problems themselves. It involved a mass media strategy, a one-day event designed to facilitate social contact with people with a mental illness and sports-related programmes. Changes in public attitudes were measured every year from 2008 to 2012 using the Department of Health’s national Attitudes to Mental Illness general population survey in England (Evans-Lacko, Henderson et al. 2013). Analysis of longitudinal trends in public knowledge, attitudes and behaviour between 2009 and 2012 among a nationally representative sample of English adults revealed a mixed picture. There were improvements in intended behaviour and a non-significant trend for improvement in attitudes, but no significant improvements in knowledge or reported behaviour. Encouragingly, one of the most marked changes between 2008 and 2011 was the significant overall reduction in the levels of experienced discrimination reported by people using mental health services (Corker, Hamilton et al. 2013).

However, as with the other studies discussed above, the lack of a control population limited the ability to determine the exact contribution of the campaign to the changes reported in annual survey results. In support of the campaign impact, online interviews carried out before and after each burst of mass media social marketing showed that campaign awareness was positively associated with greater knowledge and more favourable attitudes (Evans-Lacko, Malcolm et al. 2013). In addition, social contact at events had a positive impact on attitude change, and contact quality predicted more positive attitude changes and greater confidence to challenge stigma. Further studies showed beneficial effects of the campaign on employer attitudes, knowledge and practices (Henderson, Williams et al. 2013) and on media reporting (Thornicroft, Goulden et al. 2013).

**Conclusion:** Evidence suggests that short-term (e.g. 3-week) campaigns are not likely to be effective, while longer-term campaigns may be effective in reducing stigmatising attitudes and reducing experiences of discrimination.

### 3.3.2.2 In-person psycho-education
In-person psycho-education interventions, which may be delivered by a trained individual, provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help, as well as how to assist someone with a mental illness. Stigma-reduction interventions often incorporate a presentation by, or interaction with, a person with a history of mental illness. This may be in-person or, more commonly, by video.

**Strength of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** Couture and Penn (2003) reviewed 22 studies that evaluated the links between contact with a person with mental illness and stigma. Studies were then grouped into two types: retrospective (reporting the effects of previous contact) and prospective (the effects of planned contact in which an advocate interacts with a group). The authors concluded that both retrospective and prospective contact had robust stigma-reduction effects. Dalky (2012) reviewed the literature relating to stigma-reduction interventions and also concluded that educational and contact-based strategies resulted in the most durable gains in attitudinal and behavioural changes.

In a recent meta-analysis, Corrigan and colleagues (2012) examined the effects of stigma-reduction approaches that included protest or social activism, education and contact with people with a mental illness. Searches yielded 72 articles and reports with sufficient data and statistics to complete analyses (to October 2010). Studies represented 38,364 research participants from 14 countries. Only one of the included studies was from Australia (Griffiths, Christensen et al. 2004). 27% of the interventions targeted college students, 24% targeted adolescents, 27% targeted adults and 9% targeted students in professional programs. Outcome measures included those relating to attitudes (most commonly dangerousness) and behavioural intentions (most commonly avoidance). Studies focusing on adolescents were analysed separately and studies involving in-person contact were compared with those involving contact by video. The authors concluded that both education and contact had positive effects on reducing stigma for adults and adolescents with a mental illness. However, contact was better than education at reducing stigma for adults, while, for adolescents, the opposite pattern was found. Overall, face-to-face contact was more effective than contact by video.

Psycho-education interventions have also been used to address stigma in carers of people with mental illness. Perlick and colleagues (2011) carried out a study of a family peer-based intervention designed to reduce self-stigma among 158 primary caregivers of patients with schizophrenia who reported they perceived at least a moderate level of mental illness-related stigma. Participants were randomly assigned to participate in one of two, one-session group interventions: a peer-led intervention (In Our Own Voice-Family Companion (IOOV-FC), which consisted of playing a videotape of family members who describe their
experiences coping with stigma, which was followed by a discussion led by two family peers who modelled sharing their own experiences and facilitated group sharing or a clinician-led family education session. The results showed that carers receiving IOOV-FC reported a substantial reduction in self-stigma relative to those receiving clinician-led family education as well as significant reductions in secrecy.

**Conclusion:** There is sufficient evidence to suggest that psycho-education interventions reduce stigmatising attitudes, with face-to-face contact more effective than contact by video.

### 3.3.2.3 Web-based interventions

No international studies of web-based interventions were located, other than those aimed at health professionals which are discussed in section 3.3.2.7.

### 3.3.2.4 School-based interventions

**Description:** Interventions delivered in schools that provide education about mental illness. They may incorporate videos and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help.

**Strength of evidence:** Limited evidence of effectiveness

**Review of effectiveness:** Schachter and colleagues (2008) conducted a systematic review of school-based stigma-reduction interventions. Interventions fell into three types: education, contact or interventions involving both. Most of the interventions were short-term evaluations of brief, single-opportunity interventions conducted in classrooms. While they considered the studies to be of poor quality, they concluded that contact with a person with a mental illness may be beneficial in reducing stigmatising attitudes in older children and adolescents.

In a later systematic review, Wei and colleagues (2013) evaluated the effectiveness of school mental health literacy programs in reducing stigmatising attitudes to mental illness. Their review included 11 secondary school-based studies which reported improvements. However, only one of these was an RCT (Chan, Mak et al. 2009). In a subsequent Greek study, Economou and colleagues (2012) compared the effectiveness of an intervention that aimed to reduce stigma to people with schizophrenia with a control intervention in 616 high school students. Results showed reductions in stereotypical beliefs about people with schizophrenia, stigmatising attitudes and desire for social distance. Only changes in beliefs and attitudes were maintained at one-year follow-up.

**Conclusion:** There is limited evidence to suggest that school-based interventions reduce stigma. However, evidence for long-term effects is inconclusive.
3.3.2.5 Tertiary education interventions

Just over one quarter of the studies in the meta-analysis by Corrigan and colleagues discussed in section 3.3.2.2 were aimed at tertiary students. Many of these studies involved psychology students participating for course credit and the evidence of effectiveness is likely to be similar to that described for the whole sample (Corrigan, Morris et al. 2012). Studies assessing the effects of interventions in health professional students other than psychology are discussed in section 3.3.2.7.

3.3.2.6 Workplace-based interventions

**Description:** Interventions delivered in workplaces that provide education about mental illness. They may incorporate videos, seminars and written material and typically cover information on signs and symptoms of mental illness, treatments, self-help behaviours and where to seek help. They may also incorporate education to challenge inaccurate stereotypes about mental illness.

**Strength of evidence:** Limited evidence of effectiveness in police

**Review of effectiveness:** A recent scoping study of workplace anti-stigma initiatives identified 22 programs, four of which were from Australia (Malachowski and Kirsh 2013). However, only 10 of these had conducted evaluations (five of these targeted armed forces and are not further discussed here). Three studies have assessed the effects of interventions to reduce stigmatising attitudes in police, including a pre-post UK study that showed the effectiveness of an educational intervention (Pinfold, Huxley et al. 2003) and two US studies of crisis intervention team training (Compton, Esterberg et al. 2006; Bahora, Hanafi et al. 2008). All showed reductions in stigmatising attitudes, with the latter two studies reporting reductions in the desire for social distance. Knifton and colleagues (2008) conducted a pre-post evaluation of a 6-hour anti-stigma workshop targeted to staff in benefits, housing, employment and voluntary-sector agencies. The intervention improved attitudes relating to unpredictability and recovery. In a study of a similar intervention, Quinn and colleagues (2011) assessed the impact of a 1-day training course on housing association and telecommunications workers and found positive impacts on personal and perceived stigma. Anti-stigma interventions targeted to health professionals are discussed in Section 3.3.2.7.

**Conclusion:** There is limited evidence to suggest that workplace-based interventions can reduce stigmatising attitudes in police

3.3.2.7 Reducing stigma in health professionals

**Description:** Interventions targeted to health professionals that provide education about mental illness. They may incorporate videos, seminars and written material and typically
cover information on signs and symptoms of mental illness, treatments, self-help behaviours, where to seek help, as well as how to assist someone with a mental illness.

**Quality of evidence:** Sufficient evidence of effectiveness

**Review of effectiveness:** Studies in a number of countries have assessed the effects of interventions aiming to reduce stigmatising attitudes in health professionals. Those that have shown positive effects include studies of direct social contact interventions with US nurses (Clement, van Nieuwenhuizen et al. 2012), an education and contact intervention with Turkish medical students (Altindag, Yanik et al. 2006), a contact intervention with UK medical students (Friedrich, Evans-Lacko et al. 2013), an education intervention with Turkish GPs (Ucok, Soygur et al. 2006), an internet intervention with Israeli psychiatry specialist or residents (Bayar, Poyraz et al. 2009), print and web-based interventions with Russian special education students (Finkelstein, Lapshin et al. 2007), an educational intervention with Chinese medical students (Rong, Glozier et al. 2011), an educational intervention with Japanese medical students (Mino, Yasuda et al. 2001), an educational intervention in German medical students (Lincoln, Arens et al. 2008), a contact intervention with Canadian pharmacy students (Patten, Remillard et al. 2012), and a contact intervention with graduate-level helping professionals (Pittman, Noh et al. 2010). However, whether the effects are maintained in the longer term is unknown and there is evidence from the recent Time to Change campaign that they may not be (Friedrich, Evans-Lacko et al. 2013).

**Conclusion:** Educational and contact interventions are effective in reducing stigmatising attitudes in many types of health professionals in the short term. Evidence for long-term effects is inconclusive.

### 3.4 Summary

- There is sufficient international evidence to suggest that whole-of-community campaigns improve mental health literacy and may also lead to increases in professional help seeking.
- There is sufficient international evidence to suggest that in-person psycho-education interventions improve mental health literacy, although there is no evidence that such interventions increase help-seeking behaviour.
- There is limited international evidence to suggest that web-based, school-based and workplace-based interventions improve mental health literacy.
- There is limited international evidence to suggest that interventions targeted to health professionals improve mental health literacy.
- There is inconclusive international evidence of the effectiveness of interventions to improve mental health literacy in staff and students of tertiary education institutions.
• International evidence suggests that long-term campaigns may be effective in reducing stigmatising attitudes and reducing experiences of discrimination.

• There is sufficient international evidence to suggest that psycho-education interventions reduce stigmatising attitudes, with face-to-face contact more effective than contact by video.

• There is limited international evidence to suggest that school-based and workplace-based interventions (in police) reduce stigma. However, evidence for long-term effects is inconclusive.

• There is international evidence that educational and contact interventions are effective in reducing stigmatising attitudes in many types of health professionals in the short term. Evidence for long-term effects is inconclusive.
4 Assessment of current policy and practice against the evidence

The aims of this section of the literature review are to:

- Provide an assessment of current policy and practice against evidence or international good practice
- Identify gaps in knowledge, research or practice as these apply to the Australian situation
- Review data relating to different cultural groups, particularly Aboriginal and Torres Strait Islander peoples, where this possible.
- Make recommendations for future policy and practice changes or areas of research

4.1 Introduction

Improving community understanding of mental illness is a feature of federal and state mental health policies in Australia, and many mental health NGOs play a valuable role in raising public awareness and health education to improve community understanding of mental illness. However, as very few of these interventions have been the subject of good quality evaluations, documenting their impact remains a challenge.

There is evidence from population surveys in Australia and other countries that the mental health literacy of the general population is increasing (Goldney, Dunn et al. 2009; Reavley and Jorm 2012; Schomerus, Schwahn et al. 2012), and it is likely that whole-of-community campaigns and individual-level interventions have contributed to this increase. The situation in relation to stigmatising attitudes is less encouraging.

4.2 Whole-of-community campaigns

4.2.1 Mental health literacy

Whole-of-community campaigns have been carried out in Australia and many other countries, with evaluations conducted in a number of these, including Germany, Scotland, England and Norway. International studies suggest that there is sufficient evidence that such campaigns are effective in improving mental health literacy and that they may be effective in increasing professional help seeking.

The whole-of-community campaign run by beyondblue, which has been in operation since 2000 is the largest of its type in Australia. beyondblue has been very successful in gaining brand recognition. The 2011 National Survey of Mental Health Literacy and Stigma included questions about exposure to media organisations related to mental health. The results showed that 66.6% of respondents said that they had heard of such organisations, with
*beyondblue* being the most commonly recalled (by 51% of respondents) (Reavley and Jorm 2011). The next most commonly mentioned organisation was Lifeline at 23%. When asked specifically about *beyondblue*, 77.7% said they had heard of it, up from 22.5% in 2003-4.

Moreover, the Australian government’s decision to invest in population mental health literacy surveys has allowed for evaluation in changes in knowledge of and attitudes to mental illness. Differences in *beyondblue* activity according to state allowed for the levels of mental health literacy and treatment-seeking behaviour in high exposure states to be compared with those in low exposure states. Results showed that the recognition of depression improved greatly at a national level, the increase was slightly greater in the high-exposure states (Jorm, Christensen et al. 2005). Moreover, treatment seeking in the high-exposure states increased by 14.6% while, in the low-exposure states, the increase was 6.0% (Jorm, Christensen et al. 2006). In terms of evaluation, given that whole-of-community campaigns do not lend themselves to evaluation in randomised trials, this level of evidence of effectiveness is of relatively high quality.

With its high level of brand recognition and relatively high quality evaluation, *beyondblue* is internationally regarded as an example of best practice in the area of whole-of-community campaigns designed to improve mental health literacy regarding depression. However, until very recently there has been little focus on mental health literacy relating to other disorders, particularly anxiety disorders. In recent months, beyondblue has extended its brief to cover anxiety disorders. The relatively high prevalence of these disorders (12-month prevalence rates of 14.4%) suggests that this is an important area for future campaigns, which should also be evaluated as rigorously as possible. The inclusion of PTSD and social phobia in the 2011 National Survey of Mental Health Literacy and Stigma offers the opportunity to assess population level changes in mental health literacy relating to these disorders (Reavley and Jorm 2011).

### 4.2.2 Stigmatising attitudes

In contrast to the improvements seen in mental health literacy, population studies in Australia and other countries have not typically demonstrated equivalent reductions in stigmatising attitudes (Reavley and Jorm 2012; Schomerus, Schwahn et al. 2012), and some aspects of stigma, notably those relating to dangerousness and unpredictability, may be increasing in prevalence (Reavley and Jorm 2012). While comparisons of the 2003/4 and 2011 National Mental Health Literacy surveys showed a reduction in desire for social distance from someone with depression and suicidal thoughts, reductions in the desire for social distance from those with other disorders were not seen (Reavley and Jorm 2012). Thus, it appears that knowledge of mental disorders is not necessarily linked to a reduction in stigmatising attitudes.
The evidence of the effects of whole-of-community campaigns on the reduction of stigmatising attitudes in Australia is inconclusive, with little evidence that the activities of beyondblue have impacted on stigmatising attitudes, which were not assessed in the initial mental health literacy survey conducted in 1995. However, the international evidence suggests that whole-of-community campaigns to reduce stigma may be effective. A very recent Cochrane review concluded that mass media interventions may reduce stigmatising attitudes in the immediate, short and medium term, and that there is justification for continuing to use mass media as one strategy for countering the stigma associated with mental illness (Clement, Lassman et al. 2013).

Potential areas for activity may be usefully informed by the results of the evaluation of the Time to Change campaign, the largest ever program in England designed to reduce stigma and discrimination against people with mental illness. While the funding for anti-stigma programmes in many countries tends to be sporadic, short-lasting and generally insufficient (Beldie, den Boer et al. 2012), the Time to Change campaign was well funded (approximately £21 million (AUD 34.8 million) for the 4 years to 2011), led by major mental health charities, had clear objectives, and was subject to relatively rigorous and comprehensive evaluation. A particularly innovative aspect of the Time to Change programme is its annual measurement of discriminatory experiences on the part of those using mental health services, rather than evaluating only public attitudes. As such, it represents an aspect of good practice that may be emulated in future campaign evaluations.

The evaluation of the programme covered public knowledge, attitudes and behaviour, service users’ experience, newspaper coverage of mental illness, attitudes of employers, a social marketing campaign, attitudes of medical students and an economic evaluation. However, despite the emphasis on best practice, the results were mixed (Henderson and Thornicroft 2013). There were improvements in intended behaviour and a non-significant trend for improvement in attitudes as well as a significant overall reduction in the levels of experienced discrimination reported by people using mental health services. However, there were no significant improvements in knowledge or reported behaviour, or in user reports of discrimination by mental health professionals. Disappointingly, initial improvements in medical student attitudes were not maintained at 6-month follow up (Friedrich, Evans-Lacko et al. 2013).

Analysis of the influence of the social marketing interventions, which were carried out in bursts of activity, showed that levels of unprompted awareness of the campaign following each burst of activity ranged between 16 and 24%, and levels of prompted awareness ranged from 38 to 59% (Evans-Lacko, Malcolm et al. 2013). Encouragingly, prompted awareness of the campaign was consistently associated with better knowledge, attitudes and intended behaviour. These results point to the potential of adequately-funded campaigns run by organisations with a high level of community recognition. Moreover,
Henderson and colleagues (2013) found greater realism in employers’ views about mental illness, greater appreciation of employees’ struggles and improved tendencies to grant reasonable accommodations, pointing to the potential of workplace-based programs to target stigma.

However, the limited impacts of Time to Change underline the enormous challenges involved in this area of research. Bringing about population-level changes in mental illness-related knowledge, attitudes and behaviours in the general public is an ambitious goal and one that is difficult to rigorously evaluate. However, in an editorial accompanying the reports of the evaluation of the Time to Change campaign, Link (2013, p S106) notes that “Without change at this level, even apparently effective individual-level interventions, ones with tight designs, robust effect sizes and tiny P-values, are subject to a sharp erosion of effects due to the influence of a broader cultural context that remains unchanged.”

Other commentators have called for a rethink of the way anti-stigma campaigns are conducted. Smith (2013) notes the need to resist the temptation to presume that “‘more of the same’ might work in future” and points to the need to better understand the nature of the events that are reported as stigmatising and to hear from both sides of the complex relationships in which stigma arises. It is also likely that future campaigns to address stigma should consider addressing specific mental disorders rather than mental illness more generally, a term which the public tends to associate with schizophrenia (Jorm and Reavley 2012). There is evidence that stigma is a multidimensional construct and that different aspects of stigma are more prominent in certain disorders, e.g. people are more likely to believe that social phobia is a sign of personal weakness, while beliefs in dangerousness and unpredictability are generally higher for schizophrenia (Reavley and Jorm 2011; Yap, Mackinnon et al. in press). Future anti-stigma campaigns should take account of these differences. The eminent US stigma researcher, Patrick Corrigan has noted the need for stigma reduction interventions to involve contact with people with a mental illness; to target key groups, typically those in positions of power; to consider local context; to ensure that the contact involves people with mental illness who are credible to the target audience; and to ensure that contact is ongoing, as one-off interventions as less likely to be effective (Corrigan 2011).

In recent years there has been some debate about the impact of the biomedical model of mental illness on stigmatising attitudes. The majority of education campaigns have an emphasis on mental illnesses as ‘real’ illnesses that are no different to other types of diseases, for which effective medical treatment is available (Pescosolido, Martin et al. 2010). There have also been increases in the mental health literacy of people in a number of countries, with greater numbers of people correctly identifying the symptoms of mental illnesses and increases in the beliefs that mental illness requires professional help (Schomerus, Schwahn et al. 2012). However, these changes have not been accompanied by
reductions in stigmatising attitudes, with Australian studies suggesting minimal changes in social acceptance of people with mental illness and even an increase in beliefs about dangerousness and unpredictability. Some commentators have drawn attention to the potentially negative effects of the biomedical model of mental illness, that is, an enhancement of the notion of ‘otherness’, reduced optimism about the effects of treatment and greater concerns about the lack of ability to control behaviour (Dietrich, Beck et al. 2004; Read, Haslam et al. 2006). Further studies are needed to explore this.

4.3 In-person psycho-education

In-person psycho-education has been shown, both nationally and internationally, to be effective in improving mental health literacy and reducing stigma.

One of the best known psycho-education interventions is MHFA, which was started in Australia and has now reached 1% of the Australian population and spread to 15 countries worldwide (Jorm and Kitchener 2011). MHFA is an example of a best-practice intervention, as it has been rigorously evaluated in RCTs in different populations and settings, including CALD communities, workplaces and in health professionals (Kitchener and Jorm 2004; Lam, Jorm et al. 2010; O’Reilly, Bell et al. 2011). Given the relatively intensive nature of MHFA, it is likely to be most appropriate for those who have more contact with people with mental illness.

The results of a 2012 meta-analysis showed that both education and contact had positive effects on reducing stigma for adults and adolescents with a mental illness (Corrigan, Morris et al. 2012). However, contact was better than education at reducing stigma for adults, while, for adolescents, the opposite pattern was found. Overall, face-to-face contact was more effective than contact by video. It has also been noted that contact with people who are in recovery rather than acutely unwell is important, as the latter may in fact, increase stigma (Reinke, Corrigan et al. 2004).

4.3.1 Stigmatisation by health professionals

Psycho-education interventions may be particularly appropriate for health professionals, as this literature review revealed that, despite stigma from health professionals being an area of significant concern to consumers, interventions to combat this are relatively uncommon, particularly in Australia. Given the importance of the area, health professionals were included as a target group in the UK Time to Change campaign, with UK medical students participating in a contact-based anti-stigma intervention (Friedrich, Evans-Lacko et al. 2013). While the intervention had beneficial effects, these were no longer present at 6-month follow-up. Further work is needed to explore longer-term effects and the types of interventions necessary for sustainability. Evidence from the Time to Change campaign
suggests that population-level interventions alone may not lead to changes in discrimination by health professionals (Corker, Hamilton et al. 2013).

### 4.4 Web-based interventions

Web-based interventions to improve mental health literacy and reduce stigma have been the subject of a considerable amount of research in Australia. There is sufficient evidence from Australian studies that some improve mental health literacy and limited evidence that they reduce stigma. However, the literature from international studies is relatively uncommon, with limited evidence that web-based interventions improve mental health literacy and no evidence that such interventions can reduce stigma.

The results of this literature review support the contention that Australia is a world leader in e-mental health (Christensen and Petrie 2013; Jorm, Morgan et al. 2013). Australian mental health researchers have developed and evaluated a number of pioneering e-treatment programs and psycho-education websites, including MoodGYM and BluePages, which have been the subject of a number of studies included in this review. In a recent review of the e-mental health field in Australia, Christensen and Petrie (2013) reported that Australia has been responsible for around half of the world’s e-mental health programs and has produced more publications on the topic over the last decade than the rest of the world put together. It is likely that technological developments will continue transform mental health care and present many opportunities for improving community understanding of mental illness. It is also likely that the role of social media will increase in importance.

Given the relative ease of dissemination once developed, web-based interventions may play an important role in mental health literacy and anti-stigma interventions in settings such as school and workplaces. However, there is also a need for more evaluation, as much of what is currently available has not been evaluated. In their review Christensen and Petrie (2013) noted that over half of the web interventions have never been evaluated in a trial. New funding models and adequate ethical regulatory frameworks may be needed. It is also likely that e-health interventions cannot entirely do away with the need for human contact. One of the significant findings of the meta-analysis of the effectiveness of anti-stigma interventions conducted by Corrigan and colleagues (2012) was that video contact intervention are less effective than in-person interventions.

The issue of health inequalities also needs to be considered. In order to reduce the risk of increasing health inequalities, web-based interventions may need to be publicly funded, available in a wide range of languages and in formats that do not require literacy (Munoz 2010).
4.5 Mental health literacy and anti-stigma interventions in schools, tertiary institutions and workplaces

Relatively few evaluations of Australian interventions addressing mental health literacy and stigma in schools and tertiary institutions were identified. An international systematic review of the effectiveness of school mental health literacy and anti-stigma programs showed that, while studies tend to be of relatively poor quality, there is some evidence that they may be effective (Wei, Hayden et al. 2013).

Similarly, work in tertiary institutions in Australia has been relatively limited, with the exception of the use of psychology students as convenience samples in studies of anti-stigma interventions. Given the importance of earlier life stages in forming attitudes to mental illness and the high prevalence of mental illness in adolescents and young adults, further work exploring the potential of Australian school and tertiary-institution based interventions is recommended.

Given the relatively high rates of unemployment in people with a mental illness and the importance of work for recovery, workplace attitudes to mental illness are an area of key importance. However, there have been relatively few studies of workplace-based mental health literacy and stigma interventions, with a 2010 review of workplace-based stigma reduction programs reporting that none had published evaluation reports (Szeto and Dobson 2010). In Australia, two trials of MHFA conducted in workplace settings have shown benefits (Kitchener and Jorm 2004; Jorm, Kitchener et al. 2010) and international studies have shown benefits of web-based interventions. Given the great diversity and time constraints faced by many workplaces, it is recommended that further studies assess the potential of interventions that involve flexible delivery methods that can be adapted to different workplace contexts. Studies should also include workplace-related outcomes including mental health policy, absenteeism and return-to-work outcomes.

4.6 Mental health literacy and anti-stigma interventions in Aboriginal and Torres Strait Islander groups

A notable feature of this literature review was the lack of studies addressing these issues in Aboriginal and Torres Strait Islander peoples. This is despite the high rates of mental illness in Aboriginal and Torres Strait Islander populations and discussion of the need to address stigma as a barrier to accessing services and community participation. The MHFA program has developed mental first aid guidelines for indigenous Australians (Hart, Jorm et al. 2009) and an Aboriginal and Torres Strait Islander MHFA course has been developed and its initial uptake and acceptability evaluated (Kanowski, Jorm et al. 2009). Further work is needed to refine the course and to evaluate its impact on help provided to Aboriginal people with mental health problems.
<table>
<thead>
<tr>
<th>Interventions to improve mental health literacy</th>
<th>Australian studies</th>
<th>Level of evidence</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole-of community campaigns</td>
<td>++</td>
<td>+++</td>
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<tr>
<td>In-person psycho-education</td>
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<td>Web-based interventions</td>
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<td>School-based interventions</td>
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<td>Workplace-based interventions</td>
<td>+++ (in relation to the workplace as an intervention setting)</td>
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</tbody>
</table>

| Interventions targeted to CALD groups          | +++                | -                | +++    |
| Interventions targeted to health professionals | +++                | +++              | +++    |

| Interventions to reduce stigma                  |                      |                  |        |
| Whole-of community campaigns                  | +                   | ++               | ++     |
| In-person psycho-education                    | +++                | +++              | +++    |
| Web-based interventions                        | +++                | -                | +++    |
| School-based interventions                     | +                  | +++              | +++    |
| Tertiary education-based interventions         | -                  | +++              | +++    |
| Workplace-based interventions                  | +++ (in relation to the workplace as an intervention setting) | +++ (in police) | +++ (in relation to the workplace as an intervention setting) |

| Interventions targeted to CALD groups          | +++                | -                | +++    |
| Interventions targeted to health professionals | +++                | +++              | +++    |

Note: ++++ Sufficient evidence of effectiveness, +++ Limited evidence of effectiveness, ++ May be effective, + Inconclusive evidence of effectiveness, - no evidence of effectiveness
4.7 Conclusions

Any social change, including the improvement of community understanding of mental illness is likely to require action at multiple levels. Population interventions may be appropriate for most members of the community, whereas more intensive interventions will be justified for those in higher risk groups or who are more likely to have contact with people with mental disorders.

In summary, in the area of improving community understanding of mental illness, Australia demonstrates a number of strengths when compared to other countries. With its high level of brand recognition and relatively high quality evaluation, beyondblue is internationally regarded as an example of best practice in the area of whole-of-community campaigns designed to improve mental health literacy regarding depression.

In-person psycho-education has been shown, both nationally and internationally to be effective in improving mental health literacy and reducing stigma. In this area, MHFA, with its evidence of effectiveness supported by high quality evaluations and its international impact, is another example of world’s best practice. As stigma from health professionals is an area of significant concern to consumers and is a relatively under-researched area in Australia, further consideration should be given to the role of psycho-education interventions such as MHFA in addressing this.

Australia is also a world leader in the use of web-based interventions for improving mental health literacy and reducing stigma. Given the relative ease of dissemination once developed, web-based interventions may play an important role in mental health literacy and anti-stigma interventions in settings such as schools, tertiary education institutions and workplaces. Further work should address these relatively under-researched areas.

There is also a clear need for interventions to address mental health literacy and stigma in Aboriginal and Torres Strait Islander populations.

In the area of whole-of-community campaigns to improve mental health literacy, further work should address mental health literacy relating to anxiety disorders. Australian efforts in the area of whole-of-community campaigns to address stigma and discrimination, which have not shown evidence of effectiveness, may need to better understand the nature of events that are regarded as stigmatising, further explore the impacts of the biomedical model of mental illness on stigma and incorporate an understanding of stigma as a multidimensional construct that varies according to disorder. In order to move towards best practice, evaluation of anti-stigma interventions should include the measurement of discrimination experienced by those with mental illness as well as assessment of stigmatising attitudes.
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5 Appendix A

5.1 State and Federal policy documents that incorporate the aim of improving community understanding of mental illness

5.1.1 ACT Health: Building a Strong Foundation – A Framework for Promoting Mental Health and Wellbeing in the ACT, 2009-2014 (no date)

The Framework aims to address improving mental health literacy in the following ways: guide and strengthen activities that improve mental health literacy through combined government and community sector efforts; increase access to services that educate vulnerable and disadvantaged groups about mental health literacy (e.g. CALD and Aboriginal and Torres Strait Islander communities); provide mental health literacy skills training to government departments and community service organisations; provide information about mental health literacy; and develop and implement psycho-education programs to increase mental health literacy. To address stigma, the Framework aims to: improve community understanding about the effects of stigma on consumers and carers and engage these people to help educate the community; increase people’s understanding of the roles and responsibilities associated with reducing stigma; conduct education campaigns and improve access to services that reduce stigma, especially in CALD communities; and providing training to government departments and community service organisations, especially Housing ACT and ACT Correctional Services, that focuses on improving knowledge about the factors influencing stigma and reducing stigmatising attitudes.

5.1.2 ACT Health: Managing the Risk of Suicide – A Suicide Prevention Strategy for the ACT 2009-2014 (no date)

The Strategy aims to improve individual mental health literacy and reduce stigma related to suicide prevention and intervention and provide mental health literacy and stigma reduction training to ACT corrections staff. The Strategy lists programs that aim to increase mental health literacy in their participants that have been delivered in the ACT (see next section).

5.1.3 ACT Health: ACT Mental Health Services Plan 2009-2014 (2009)

The Plan aims to encourage recovery oriented mental health services to be active in mental health awareness activities, and promote stigma reduction. The Plan also suggests that
consumers and carers can be engaged in promotion, prevention and early intervention work by educating the wider community about stigma.


The Response outlines a new plan for suicide prevention in Australia. It aims to maintain a focus on promotion, prevention and early intervention activities related to community education about suicide and aims to provide funding for activities specifically targeting males at risk of suicide and build on current initiatives targeting Aboriginal and Torres Strait Islander peoples. The Response indicates its support for sustained awareness and education programs that aim to reduce stigma, including MindMatters, SANE’s StigmaWatch and Mindframe.


The Plan details goals to improve community mental health literacy to prevent or intervene early in the onset of mental illnesses by, for example, working with schools, communities and workplaces. The document also states an aim to reduce stigmatising attitudes by facilitating social inclusion and recovery, implementing a national stigma reduction strategy, enacting anti-stigma legislation and introducing anti-stigma programs in the community and the mental health workforce. The Plan also includes suggestions for monitoring the outcomes of these activities and suggests that indicators of change will include the reduction of stigmatising and discriminatory attitudes in the community.


The Initiative contains a section detailing investments into mental health by each Australian state. It states that Western Australia is developing several anti-stigma campaigns aimed at improving help seeking rates for perinatal depression as part of their state investment plan.

5.1.7 Council of Australian Governments: The Roadmap for National Mental Health Reform 2012-2022 (no date)

The Roadmap states it will “improve the ‘mental health literacy’ of Australians so that people can better understand and recognise their own and other people’s mental health needs; identify the early signs and symptoms of mental health issues; and know the appropriate action to take in these situations” (p. 23) It also states it will aim to “reduce
stigma about mental health issues among service and support providers, improve integration of clinical and non-clinical mental health services, and strengthen coordination with broader community services” (p.25).

5.1.8 Department of Health and Ageing: e-Mental Health Strategy for Australia (2012)

This document suggests that e-mental health initiatives can play a role in reducing the stigma associated with help seeking for a mental illness, thus providing rationale for investing in e-mental health initiatives. The document does not contain aims as such.

5.1.9 Department of Health and Ageing: Quality Framework for Telephone Counselling and Internet Based Support Services (2009)

This document states that “Organisations will engage in activities that promote acceptance of its client group within the broader community, to help reduce stigma associated with mental illness and improve mental health and well being” (p. 16).

5.1.10 Living is For Everyone (LiFE): A Framework for Prevention of Suicide in Australia (2007)

This framework lists aims to reduce stigma associated with suicidal thoughts and behaviours through creating supportive environments and also increasing community education about suicide prevention.


The Strategy states it will develop a comprehensive stigma reduction strategy aimed at communities and services to improve attitudes towards drug dependence, help seeking and related problems.

5.1.12 NSW Department of Health: NSW Community Mental Health Strategy 2007-2012 (2008)

This Strategy aims to further develop and disseminate community awareness programs aimed at increasing mental health literacy and reducing stigma as part of promotion, prevention and early intervention initiatives. Reduction of stigma towards people with mental illness is also stated as an aim, with an anticipated benefit being improved community participation for these people. The Strategy also states its intention to "provide community emergency and acute mental health services that are consumer-sensitive, responsive and provide timely, effective and high quality care," thus aiming to minimise the stigma associated with assessing and transporting people with mental health problems.
from community locations to inpatient services. The Strategy also specifically states that it will aim to reduce the stigma of mental health problems for the CALD population.


This Strategy contains a number of aims targeting the improvement of mental health literacy and/or reducing stigmatising attitudes. It will:

- Consider the influence and impact on suicidal behaviours of new technologies/multimedia communication (e.g. media, internet, MySpace, YouTube, chat rooms, instant messaging)
- Review the use of innovative technology as a means to enhance linkages between services, promote help seeking, reduce stigma and enhance existing service delivery to at risk groups, where appropriate.
- Foster environments where it is acceptable to express emotions (anxiety, stress, sadness, grief) without a fear of stigmatisation.
- Connect to and align with other frameworks and initiatives that work to enhance social and emotional wellbeing, and equip people with the skills to express and understand emotions.
- Continue to develop and implement programs that raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.
- Develop whole of government, whole of community guidelines for dealing with and discussing suicide and attempted suicide within families, schools, workplaces and communities.
- Work to destigmatise conditions that contribute to suicide risk with a view to encouraging help seeking behaviour.
- Improve links across government agencies and community groups to improve awareness of and understanding about risk factors for suicide, including mental illness, homelessness, and financial hardship, and provide pathways to appropriate services.
- Educate communities to identify and respond to warning signs, tipping points and imminent risk factors associated with suicide.
- Continue to develop and implement programs that raise awareness of suicide prevention and at risk people, encourage help seeking behaviour and challenge stigma associated with suicide.
- Conduct a social marketing campaign to raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.
• Reduce the stigma and myths surrounding suicide by actively communicating the range and complexity of factors that contribute to suicidal behaviours.
• Develop and build partnerships across government agencies, the education system, and community and business groups to encourage active communication of factors that contribute to suicidal behaviour through mental health education.
• Enable locally based networks and cooperative partnerships to respond effectively to traumatic incidents or significant changes in local circumstances (e.g. drought, industry closures).
• Continue to implement initiatives that enhance community awareness of and capacity to respond to traumatic incidents and significant changes in local circumstances, including identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.
• Include media focused initiatives
• Develop new guidelines for discussing suicide and a social marketing campaign to raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.
• Conduct a social marketing campaign to raise awareness of suicide prevention and people at risk, encourage help seeking behaviour and challenge the stigma associated with suicide.
• Continue to implement initiatives to enhance community awareness of and capacity to respond to traumatic incidents and significant changes in local circumstances, including identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.
• Strengthen local capacity, particularly in rural, remote and regional areas by supporting and sharing of practice and experience across agencies involved in community and emergency services.
• Continue to implement initiatives to enhance local community capacity in rural areas, including by using existing suicide prevention networks, community networks and new e-technologies, and identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.
• Identify communities in which suicide and suicidal behaviour is prevalent, and proactively develop strategies and services that address the underlying causes and contributing factors.
• Continue to implement initiatives to enhance local community capacity in at risk areas, including rural areas and Aboriginal communities, identifying emerging needs, improving early intervention strategies and pathways to care, reducing stigma and strengthening the role of General Practitioners in networks and services.
5.1.14 Queensland Department of Communities: Supporting Recovery – Mental Health Community Services Plan 2011-2017 (no date)

The Plan indicates its goal of providing mental health literacy and mental health first aid training to service delivery staff. It also aims to make this training available to mental health community support services that specifically work with CALD and Aboriginal and Torres Strait Islander communities. The Plan aims to create a Queensland Mental Health Commission, whose core functions will include promoting mental health awareness and inclusion, and combating stigma and discrimination on a population level. The Plan also states it will support the mental health community sector’s efforts to reduce stigma and discrimination, which incorporates strategies that target Aboriginal and Torres Strait Islander peoples.


The Plan aims to improve community understanding of mental illnesses and reduce stigma by: developing partnerships across government and non-government sectors; improving access to mental health literacy and mental health first aid training for non-clinical workers; raising community awareness of mental health literacy and stigma in CALD communities and improving their access to resources; and allocating $0.8 million to improve community and stakeholder understanding of the forensic mental health system (as part of the recommendations from the Review of the Mental Health Act 2000) by developing mental health literacy materials, culturally targeted resources and a media professionals’ package.

5.1.16 South Australian Government: South Australia’s Mental Health and Wellbeing Policy 2010-2015 (no date)

This Policy states three main aims related to reducing stigma and increasing community mental health literacy:

- Promoting positive mental health in the community and increasing mental health literacy in South Australia
- Support community awareness campaigns to improve mental health literacy, promote positive mental health and increase help-seeking behaviours.
- Engage a range of community settings, including schools and workplaces, in mental health promotion activities to increase awareness and organisational capacity, build resilience, reduce risk factors and increase protective factors.
- Support the provision of training to give people the skills to better recognise mental health conditions.
- Increase awareness of the signs and symptoms of depression and anxiety and options for help and illness management.
- Protect the human rights of people with a mental illness and support people who experience mental ill-health to live fulfilling lives in our community, without stigma or discrimination.
- Support policies that promote the fullest possible social and economic participation in the life of the community by people with a mental illness, without stigma or discrimination.
- Reduce stigma and discrimination
- Promote and support programs and initiatives that actively address stigma and discrimination in the community.
- Support training and education initiatives in the health and non-health sectors that address specific issues related to mental health to reduce stigma and discrimination.
- Support media campaigns and initiatives that aim to reduce stigma and discrimination in the community.
- Cross-sectoral workforce training in mental health
- Improve the knowledge and skills of workers in non-health care sectors such as community services, education, justice, housing and employment about mental health to reduce stigma and strengthen their capacity to assist people experiencing a mental illness.

5.1.17 South Australian Government: South Australia Suicide Prevention Strategy 2012-2016 (no date)

This Strategy intends to invest in mental health awareness programs that increase mental health literacy and stigma reduction; improve mental health literacy for community, nursing staff, consumers and carers to enable early identification of suicidal thoughts and behaviours; improve the mental health literacy of farmers, youth and men; undertake further research into the benefits of reporting suicide in relation to reducing the suicide rate and improving mental health literacy; "reduce stigma and enhance responsiveness in places where people in distress may seek assistance" (p. 29); report irresponsible journalism to SANE's Stigmawatch; challenge stigma associated with depression and coping mechanisms in farmers (e.g. by encouraging rural counsellors to make home visits) and people who have experienced childhood trauma and are presenting as adults; develop and implement responses to social stigma in regional communities and service stigma (e.g. within medical and emergency services) towards people who present frequently and people who have attempted suicide; and developing and implementing strategies targeting health professionals to de-stigmatise people affected by suicidal behaviours.
5.1.18 Standing Council on Health: Mental Health Statement of Rights and Responsibilities (2012)

This document does not contain aims as such. Rather it is a series of statements regarding rights and responsibilities that are applicable to particular domains of mental health. For example, it states that programs promoting mental health should include strategies to reduce stigma and discrimination, that consumers and carers should be able to participate in their communities without experiencing stigma and that service providers are responsible for providing best practice assessment, care and support without stigmatisation or discrimination against people who require these services.

5.1.19 Tasmanian Department of Health and Human Services: Tasmania's Suicide Prevention Strategy 2010-2014 (2010)

The Strategy outlines aims to develop guidelines for community action plans by promoting mental health literacy and help seeking. It also aims to maintain dissemination of the Mental Health First Aid program, which increases community mental health literacy and helping responses. In relation to stigma, the Strategy intends to "de-stigmatise those affected by suicidal behaviours and promote an improved understanding of the suicidal state by health professionals" and utilises programs such as Suicide TALK and Mental Health First Aid to do this. Its ultimate aim is that the community is able to destigmatise suicide and talk openly and sensitively about it.


This Strategy aims to increase community mental health literacy across all population groups, as well as "bring together a coordinated rolling program of training for staff in health, justice, education, housing, homelessness and other community service sectors to improve mental health literacy, effective early identification, referral and follow up" (p. 17) and "explore ways to provide mental health literacy training to multicultural, ethno-specific and refugee agencies to improve their understanding of mental illness... Additionally, we will help refugees and asylum seekers to recognise the signs of poor mental health and seek help earlier by working to improve the mental health literacy of these communities and de-stigmatise mental illness" (p. 122, 123). Another consideration outlined in the Strategy is to initiate a rolling program of training for staff across community sectors to improve their mental health literacy and early identification, referral and followup. The Strategy also aims to destigmatise mental illness and promote social inclusion of people with mental illness, counter stigma from employers (thereby encouraging them to employ people with a mental illness) and utilise collaborations between government and non-government organisations to target sustained approaches to reducing stigma.
5.1.21 Western Australia Department of Health: Western Australian Suicide Prevention Strategy 2009-2013 (no date)

The Strategy specifies as part of its coordinated approach to suicide prevention the development of community action plans that promote mental health literacy. It also aims to foster community environments free of stigma, encourage open discussion of mental health problems and help seeking and destigmatise conditions that increase risk of suicide and encourage help seeking behaviour.

5.1.22 Western Australia Mental Health Commission: Mental Health 2020 - Making it Personal and Everyone's Business - Reforming Australia's Mental Health System (no date)

The document aims to implement strategies that focus on stigma reduction as a form of mental health promotion and prevention, destigmatising mental illness and creating culturally sensitive mental health services. It also aims to decrease the stigma associated with mental illness in CALD communities.

*Note: Tasmania's Mental Health Strategy expired in 2011. The Northern Territory's Suicide Prevention Strategy expired in 2011 and Queensland's expired in 2008. Victoria has no explicit Suicide Prevention Strategy except for one specifically related to the Aboriginal and Torres Strait Islander population; this contains no references to mental health literacy or stigma. The Northern Territory uses the Federal Government Mental Health Strategy framework and thus has no Northern Territory-specific mental health strategy documents.
5.2 State and Federal government activities with the stated aim of improving community understanding of mental illness


Both documents aim to have mental health literacy training included in all ACT Government Department OH&S training, continue to provide mental health literacy training to frontline Government and community agencies (including correctional services staff and Housing ACT staff), develop and implement psycho-education programs to promote individual mental health literacy, increase accessibility to mental health literacy training programs for CALD and Aboriginal and Torres Strait Islander populations and provide information about mental health literacy and culturally appropriate mental health services. Aims related to reducing stigma include: continuing to deliver mental illness education sessions to educate target communities about the signs and symptoms of mental illness and the effects of stigma on people experiencing mental illness, Mental Health Justice Health Alcohol and Drug Services providing stigma reduction skills training to correctional services staff.

5.2.2 ACT Health: Managing the Risk of Suicide – A Suicide Prevention Strategy for the ACT 2009-2014

The Strategy lists programs that aim to increase mental health literacy in their participants that have been delivered in the ACT, including the BluePages (which has evidence supporting its role in stigma reduction), the Belconnen Bungee Program (which aims to reduce stigmatising attitudes towards people with a mental illness) and Mental Illness Education ACT (MIEACT; which aims to improve community mental health literacy). These programs are not necessarily government programs.

5.2.3 ACT Department of Health: Managing the Risk of Suicide Evaluation Report 2009-10 and ACT Department of Health: Managing the Risk of Suicide 2009-10 – 2010-11 Implementation and Evaluation Report

Both documents aim to evaluate the effectiveness of suicide prevention and mental health literacy training currently delivered in the ACT, provide mental health literacy and stigma reduction training to correctional staff in relation to suicidal thoughts and behaviours and explore ways to provide mental health literacy and stigma reduction training to detainees.
of ACT corrections facilities. The report also mentions the launch of the Let’s Talk suicide prevention campaign, which has the aim of reducing the stigma associated with suicide.

5.2.4 Commonwealth of Australia: The Contribution of the Australian Government to Mental Health in Australia – Submission to Senate Inquiry into the Provision of Mental Health Services in Australia

This document states that a key outcome of mental health promotion initiatives is to increase mental health literacy and decrease stigma associated with mental illness across the community. It also states that Centrelink psychologists aim to promote mental health literacy amongst their clients to assist them in understanding and managing their illness. The Report notes that the Australian Government had funded some research projects that aimed to improve community mental health literacy, such as the Beyond Ageing Research Project for the Prevention of Depression and assists in the development and distribution of publications and pamphlets (e.g. the What is? series) related to mental health and mental illness, with the aim of decreasing community stigma around mental illness.

5.2.5 Department of Health and Ageing: LiFE Promoting Good Practice in Suicide Prevention - Activities Targeting Men

This report identifies some local community programs that are focused on suicide prevention and early intervention in men. One project that is mentioned is the Central Coast and Sutherland Shire Suicide Safety Network, which provided information and education to increase community mental health literacy. There is no further information about an evaluation of this project (a reference is provided, but the original document is not available online).

5.2.6 Department of Health and Ageing: Review of the Multicultural Mental Health Australia (MMHA) Project

This review contained an assessment of the role of the MMHA project from the perspective of stakeholders, one of whom stated that the role of MMHA was ‘To educate CALD communities about mental health issues, reduce the stigma surrounding mental health, influence public policy on issues to do with CALD mental health and develop and distribute resources for sectoral capacity development.’ (Roberts, Scorsonelli et al. 2009, p.39). This view was not explicitly stated as an aim of the project and the review did not state whether or what actions were taken to reduce stigma in CALD communities.

5.2.7 Fremantle Multicultural Centre – Mental Health Access Service

The Service aims to reduce the stigma associated with help seeking for mental illnesses among CALD communities by having consumers initially engage with non-healthcare-
professional staff who provide them with information about accessing professional help and assist in addressing the stigma associated with this.

5.2.8 NSW Health: NSW Community Mental Health Strategy 2007-2012

The Strategy states that the NSW Government will aim to develop and disseminate promotion and intervention initiatives to increase community mental health literacy and reduce stigma associated with mental illnesses, thereby eliciting benefits for consumers and carers. It does not detail what programs will be used or how these benefits will be evaluated.

5.2.9 NSW Health: Rural Advisory Mental Health Program

The Program aims to work with local service networks to plan and deliver activities that reduce stigma and improve mental health literacy.

5.2.10 Social Policy Research Centre: Housing and Associated Support for People with Mental Illness or Psychiatric Disability

The Report cites the National Standards for Mental Health Services (1996) which aim to promote the reduction of stigma for people affected by mental health problems.

5.2.11 Social Policy Research Centre: Independent Evaluation of Headspace

The evaluation explains that headspace contains a Community Awareness branch designed to create awareness of headspace services, reduce the stigma associated with help seeking and encourage early help seeking. No further mentions of progress towards this goal are made.

5.2.12 VicHealth: Promoting the Mental Health and Wellbeing of New Arrival Communities: Learnings and Promising Practices

This document states that a focus on first-contact organisations should be a priority when engaging new arrivals, as they can deliver mental health promotion resources in a non-stigmatising way. The document cites the Connect Project, a mental health promotion initiative introduced in schools as a way of reaching children and their families. The evaluation was not specifically aimed at reducing stigma or improving mental health literacy, but many of the principles and practices employed to achieve the aims were related to minimising stigma, e.g. using teachers to link children and their families with external mental health agencies, as teachers are a source of accessible, non-stigmatising support for newly arrived children. The evaluation did not state whether increases in mental health literacy or reductions in stigma were achieved by this program (VicHealth no date).
5.3 State and Federal government activities which state that they have improved community understanding of mental illness

5.3.1 Department of Families, Housing, Community Services and Indigenous Affairs: Evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives

The Report states that interviews with clients and stakeholders suggest that mental health literacy is increasing among family members, schools and community members as a result of the program. The Report also mentions data collected from the MHFA course run through the Connecting Communities program of the Brisbane South Division of General Practice, which indicates that course participants report less stigmatising attitudes towards people with a mental illness. More specific data was not provided. Lastly, the Report states that collaborations between mental health community based services improved access to services for clients; previously these services would not have been approached due to fear of stigmatisation. This finding was based on a survey of mental health community based service providers (Courage Partners 2011).

5.3.2 Department of Health and Ageing: Day to Day Living (D2DL) Program Final Report

This report explained that the D2DL program facilitated the reduction of stigmatising attitudes from organisations through exposure to people with a mental illness, which may have had flow-on effects into the community (Healthcare Planning and Evaluation 2010). The report did not clearly state how this result was measured.

5.3.3 Family Law Courts: Integrated Client Service Delivery Program Final Report

This Report states that an independent evaluation of the project found that “the availability of basic mental health literacy (a mental health brochure and key information in all relevant brochures and pamphlets of the Courts) increased client and staff awareness of mental health issues” (Family Law Courts 2009). This Report does not give specific details about how this outcome was measured.

5.3.4 Family Court of Australia: Mental Health Support Pilot Project

One of the broad aims of this project was to initiate a mental health literacy program with staff and clients to improve awareness of mental health and emotional wellbeing issues during separation. This involved developing and distributing related literature (e.g. flyers) and a research program that identified where in the court process clients became most
stressed so as to develop targeted mental health support strategies. This report stated that all the aims of this project were met, but did not specifically explain how this was assessed in relation to the mental health literacy component. The project also included an aim to provide a mental health skilling program to the Family Court staff which contained an element focused on destigmatising mental health problems. This was achieved through a modified version of the Mental Health First Aid program. The results of the skilling program do not include an assessment of changes to participants’ stigmatising attitudes.

5.3.5 Training delivered by the ACT Mental Health Policy Unit and Mental Illness Education ACT

“Three agencies provided evaluation information on their programs. Feedback from participants attending OzHelp’s ASIST and safeTALK programs indicates that, following completion of the program, the majority of participants feel ‘mostly prepared’ to talk directly and openly to people about their suicidal thoughts and that they found the course ‘very helpful’. Those participating in training delivered by the Mental Health Policy Unit (MHPU) reported increased knowledge of mental illness; improvements in stigmatising attitudes and that hearing about the 'lived experience' of mental health consumers was beneficial. It should be noted that the MHPU and MIEACT frequently delivered joint training. Carers ACT indicated that individuals participating in Keeping Families Connected felt the program was useful.” (ACT Department of Health 2011, p.12)

5.3.6 NSW Family and Community Services: Active Linking Initiative Report

The Report states that the Initiative “has helped to promote community acceptance and address social isolation and stigma, through its program of active linking, for example through visits to local shopping centres, cafes, parks and restaurants,” (Edwards and Fisher 2010, p.17), but does not explain how this outcome was measured.

5.3.7 Victorian Government Department of Human Services: Improving Services for People from a Non–English Speaking Background.

This report contains a brief summary of the Clarendon Community Mental Health Centre’s Vietnamese Family and Carer Project, which aimed to address the mental health information needs of Vietnamese families by providing an information afternoon at a local community health centre. The location of the session was chosen so as to reduce the stigma associated with mental illness by this population and the implication from the evaluation was that this was important in improving the integrity of the mental health service and increasing access to information about mental health in the community (Victorian Government Department of Human Services no date). More specific information on this project was not provided.