Evidence Compass

Summary Report

What strategies are effective for reducing the stigma associated with mental health disorder?

A Rapid Evidence Assessment

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Department of Veterans' Affairs

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Please forward any comments or queries about this report to at-ease@dva.gov.au

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Executive Summary

- Stigma towards mental health illnesses represents an important challenge to overcome and occurs at both the public (negative prejudice towards others) and self (applying the prejudice from others to oneself) level.
- Interventions designed to reduce public and self-stigma of mental illness can target large groups (e.g. society-wide) or smaller groups (e.g. persons with particular mental illnesses), but information as to what works best, for which group, and under what conditions remains elusive.
- Educational interventions focus on informing individuals about the stigmatised condition; Contact-based interventions emphasise interpersonal contact between the stigmatised individual and others; Imagined exposure interventions involve an individual imagining a hypothetical contact event with the stigmatised individual; therapeutic interventions focus on psychoeducation or psychotherapy; multi-model interventions incorporate a variety of elements.
- This aim of this rapid evidence assessment (REA) was to examine the efficacy of interventions designed to reduce the stigma associated with mental health disorders. As part of the REA methodology, a search was conducted for high quality treatment guidelines, meta-analyses and systematic reviews of interventions targeting stigma reduction.
- The search identified a meta-analysis addressing public stigma and a systematic review addressing self-stigma reduction interventions. Studies identified since the publication of both the meta-analysis and systematic review (2010 and 2011 respectively) were then assessed for quality and risk of bias, and consistency, applicability and generalisability to the population of interest.
- These assessments were used to determine an overall ranking of the level of support for the effectiveness of public and self-stigma interventions. The ranking categories were ‘Supported’ –clear, consistent evidence of beneficial effect; ‘Promising’ – evidence suggestive of beneficial effect but further research required; ‘Unknown’ – insufficient evidence of beneficial effect; ‘Not supported’ – Clear, consistent evidence of no effect or negative/harmful effect.
- The search identified 24 papers meeting the inclusion criteria, including the meta-analysis on public stigma, and the systematic review on self-stigma. Of the 22 empirical

studies, 21 examined public stigma interventions, and one examined a self-stigma intervention.

- For the interventions targeting public stigma, eight studies utilised education-based interventions, three utilised contact-based interventions, two utilised imagined exposure interventions, and eight utilised multi-modal interventions. The single study on self-stigma adopted a group therapy intervention.
- The evidence for education-based interventions for public stigma received a 'Promising' ranking. This should be interpreted with the caveat that the effect of education-based interventions appears only to be small.
- Contact interventions also received a 'Promising' ranking with the caveat that the effect again seems to be small (although larger than education-based interventions).
- The evidence for imagined exposure and multi-modal interventions received an 'Unknown' ranking.
- Interventions to target self-stigma suffered from significant methodological limitations. In this report the quality of studies were assessed but not ranked because of these limitations.
- Overall the evidence reflects the highly variable and often poorly defined interventions to reduce stigma. In order to move forward, efforts should be made to engage experts in the field to reach an appropriate consensus-based definition of stigma, and to provide a testable, meaningful theoretical framework on which to build an intervention.

Background

Individuals who live with mental illnesses are one of the most stigmatized groups in society[1]. Stigma occurs at both a public level (stigma towards another) and self-level (stigma towards oneself). Stigma has significant negative effects, and may influence how an individual with a mental illness engages in the community, in relationships, and whether or not they seek care or adhere to treatment recommendations[2]. Importantly, stigma has been regarded as pervasive, destructive and highly resistant to change[1]. Interventions designed to reduce public and self-stigma of mental illness have targeted large groups (e.g. society-wide) or smaller, targeted groups (e.g. persons with particular mental illnesses), but information as to what works best, and for which group under what conditions, remains elusive. In self-stigma research, the majority of interventions have focused on physical not mental illnesses[3]. Self-stigma reduction interventions targeting mental health are a relatively new line of research[2],

and less is known about their methods or overall efficacy. In comparison, many public campaigns have been launched across the UK, US and Australia to target public stigma towards mental health illness however, the effectiveness of these campaigns is an important issue to investigate.

The aim of this rapid evidence assessment was to identify effective interventions to reduce mental health stigma at the public and individual level. The significant variability within the stigma literature posed a challenge when categorising the evidence. Despite this challenge, an attempt was made to categorise the numerous interventions to provide some structure within which the evidence could be evaluated. The interventions for stigma were categorised as follows: education, contact, imagined exposure, therapy and multi-modal interventions (interventions that included multiple components, for example, education, contact, and role play). The multi-faceted approaches of stigma interventions require review to help determine appropriate avenues for future anti-stigma intervention strategies.

Types of stigma interventions

Education

An educational intervention is an initiative that focuses on informing individuals about the stigmatised condition. For example, if an intervention was targeting a reduction in public stigma of persons with schizophrenia using an educational component, it would include information about prevalence rates, causes, presentation, dangerousness, and typical treatment for schizophrenia. Educational interventions rest on the notion that the more an individual/society knows about a marginalised group, the less likely they are to fear, discriminate or stigmatise persons belonging to that group. Educational components may include public service announcements, books, videos, webpages, movies, flyers, and other media-based aids[4]. Educational intervention benefits include low cost and a broad reach audience[4-6].

Contact

Contact refers to interpersonal contact between the stigmatised individual and others[4]. Contact provides individuals with the opportunity to engage in discussion and the opportunity to learn about similar interests and goals. These interactions have been shown to reduce stereotypes in the broader social-psychological literature[7] and have the greatest effect in reducing the prejudice of the general public[4,8]. Contact can be face-to-face or via film, such as documentaries or interviews of people with mental illness.

Imagined Exposure

Imagined exposure is a form of mental simulation, where an individual imagines a hypothetical contact event with the stigmatised individual[9,10]. Imagined exposure interventions are useful for providing the benefits of a 'contact' intervention, without the limitations, such as cost and time associated with actual contact[10].

Multi-Modal

Multi-modal interventions represent those studies that used a variety of components in the intervention. For example, multi-modal interventions may combine education and contact activities. Often they can include additional components such as role-play, case studies or group activities. Multi-modal interventions are by nature multi-factorial, and therefore cannot be separated into component parts in order to determine effect of each component on the outcome reported.

Therapy

More often used in self-stigma reduction interventions than public stigma, therapeutic interventions consist of a wide variety of approaches, targets and methods of implementation. Therapies can be simple or complex, encompassing the full trajectory from psychoeducation to cognitive behavioural therapy, cognitive restructuring, or more advanced multimodal therapies[2]. Therapies tend to target the areas considered important to the overall conceptualisation of self-stigma and vary widely in the literature. Therapeutic interventions that aim to reduce self-stigma have included attempts to reduce the negative beliefs and attitudes of the individual while other interventions provide skill enhancement training, targeting areas like empowerment, help-seeking behaviour and self-esteem[2].

Assessment of the evidence

Assessment of the evidence was based on the following criteria:

- the **evidence base** which incorporated the quality (e.g. type of study, randomized controlled trial (RCT), case-study), quantity of evidence (such as the number of studies and the size of the samples), and the quality of studies
- the **consistency** across studies
- the **generalisability** of the studies to the target population
- the **applicability** to an Australian context.

Categorising the evidence

After the evidence was evaluated, and the studies were categorised as follows:

SUPPORTED	PROMISING	UNKNOWN	NOT SUPPORTED
	Education Based Interventions Contact Based Interventions	Imagined Exposure Based Interventions Multi-Modal Interventions	

'**Supported**' means there was clear and consistent evidence of a beneficial effect of the intervention; '**Promising**' means the evidence was suggestive of beneficial effect, but requires confirmation with additional evidence/research; '**Unknown**' is defined as insufficient evidence at present on whether or not to support the use of this intervention, or additional evidence is required to determine efficacy of intervention; **'Not supported'** is defined as evidence suggesting that the intervention does not have an effect, or produces a harmful effect when implemented.

The literature search was restricted to 2010 – 2013 as a result of a published meta-analysis and systematic reviews on public and self-stigma, respectively, with literature search end-dates in 2010. A total of 22 empirical papers met the inclusion criteria for this REA. This review found that for public stigma, education and contact-based interventions showed some efficacy and taken with the findings of the meta-analysis they both received a 'Promising' ranking. These findings need to be interpreted with caution as the effect of both appears to be small (with the effect for contact being larger than education). Both imagined exposure and multi-modal interventions received an 'Unknown' ranking based on a weak evidence base.

Interventions targeting self-stigma suffered from significant methodological limitations and as such, the quality of studies were assessed but could not be ranked. The systematic review identified two emerging trends within the literature: (1) interventions that aim to alter the stigmatising beliefs and attitudes of the individual; and (2) interventions that are designed to enhance coping skills through improvements in help-seeking behaviour, empowerment and or self-esteem. The authors noted that the second approach appears to be gaining traction amongst experts in the field. However, a substantial amount of research is required before the degree to which these approaches lead to change is known.

Implications for policy makers and service delivery

There is a clear need to target public and self-stigma interventions towards the current and ex-serving personnel. Recent Australian Defense Force (ADF) findings reported that 22% of the ADF population, or one in five members, experienced a mental disorder in the preceding 12 months[11]. An investigation into mental health problems and barriers to care in US military personnel involved in combat operations in Iraq and Afghanistan reported that for those personnel whose responses were positive for a mental disorder, only 23 to 40 precent sought mental health care[12]. Taken together, these data suggest that efforts to reduce stigmas related to mental health are an important area of investigation.

However, despite the importance of overcoming stigma, there is currently no consistent evidence supporting the efficacy of implementing an intervention to reduce stigma. In order to move forward, efforts should be made to engage experts in the field to reach an appropriate consensus-based definition of stigma, and to provide a testable, meaningful theoretical framework on which to build an intervention. A clear decision as to which type of stigma to target (i.e., public or self-stigma) is imperative, as is a clear idea of what/who the target will be (e.g., decreasing stigma towards veterans seeking care for PTSD). It is important to understand that an intervention that is designed to reduce public stigma may not reduce self-stigma at the same time, and vice versa. Interventions to reduce stigma must have a directed target and focus; a one-size fits all strategy to stigma does not appear to work. A clear and rigorous method, paired with outcome assessment that makes sense of the available data is essential.

Once these fundamental components are established, efforts to begin developing and then assessing an intervention are warranted. Efforts should be directed at pilot studies, in order to identify and monitor variable success. Use of informed processes will clarify what elements are and are not effective, allowing for redesign and retesting processes in methodological rigorous randomised control trials. The end product of this rigorous process is a strong and effective intervention. This process provides a unique opportunity to advance the current knowledge in relationship to the reduction of mental health stigma.

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