



**A life without
stigma**

A SANE Report

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A life without stigma



Stigma against mental illness is common.

Its impact is serious.

Action is urgently needed to eliminate stigma so that people affected by mental illness are included and valued as equal members of our society.

Stigma stops people asking for help and getting the treatment and support they need. It makes it more difficult to find somewhere decent to live, a job, a mortgage, or insurance. It can make it more difficult to get help to look after children, make friends, feel good about yourself, or even to feel that life is worth living. Stigma is a major barrier to recovery. If people with mental illness are to be included as equal members of our society, then stigma and its associated discrimination must be eliminated.

This report examines the impact stigma has on the lives of people affected by mental illness, including an overview of associated issues from the growing body of research in this area. It describes some of the major stigma-reduction initiatives carried out in Australia and overseas, looks at the evidence base to identify what works, and makes recommendations for future action in Australia to create a life without stigma.



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What is

stigma?

What is stigma?

Stigma was for me the most agonising part of my disorder. It cost friendships, career opportunities, and – most importantly – my self-esteem.

When the word 'stigma' is used, it generally focuses on the uninformed and negative attitudes held by many in the general community towards people with mental illness. While critically important, this tells only part of the story. Stigma comes in many shapes and forms.

Stigma has been described as an overarching concept that contains three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination) (Thornicroft et al 2007).

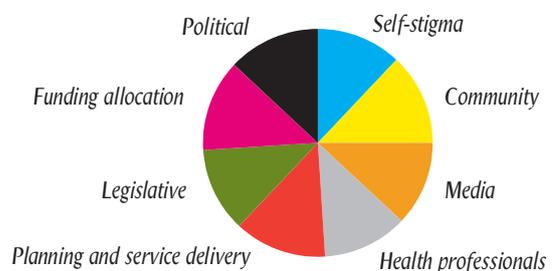
A life without stigma takes a broad approach, getting to the heart of the devastating impact stigma can have on the lives of people with mental illness and their families, friends and other carers. It challenges the hurtful and inaccurate views that people with mental illness are of less value to society or to themselves. Drawing from social theory and public health, this definition of stigma incorporates the importance of the environment in which people live, as well as the structural, political and power imbalances that are so integral to the process of stigmatising.

Stigma is therefore a complex social process that has a number of interconnected and mutually reinforcing parts which work together to exclude and take away the rights of people with a mental illness. The person is treated differently or discriminated against solely because they have a mental illness.

Link and Phelan (2001), have conceptualised stigma as involving several interrelated elements:

- Identification and labeling of difference.
- Cultural beliefs that link the label and the labeled person to negative stereotypes.
- Labeled people are then categorised in a way that creates a clear distinction between 'us' and 'them'.
- Stigmatisation is seen as contingent on social structures that provide unequal access to social, economic and political power. Only powerful social groups have the ability to create and maintain discriminatory practices.

Supporting this approach, SANE Australia has identified a range of levels at which stigma operates (SANE Australia 2004).



Understanding and misunderstanding

An Australian survey of the general community found that awareness, knowledge and attitudes differed depending on the mental illness in question:

- Depression is widely known and understood, and community attitudes are relatively benign
- Anxiety is recognised much less than depression; community attitudes are relatively benign
- Schizophrenia is widely known but poorly understood. Attitudes toward people with schizophrenia are less positive than towards other conditions, particularly in the workplace and in private spaces
- Bipolar disorder is neither well known nor understood. Attitudes towards those with bipolar disorder are less positive than those towards people with depression or anxiety.

This research (Wesley Mission 2007) highlighted a crucial need to raise community awareness about anxiety and bipolar disorder, as well as to debunk myths surrounding schizophrenia and bipolar disorder.

Stigma does not affect everyone with a mental illness in the same way therefore. It can vary from person to person and some groups appear affected more than others. There are, for example, 'degrees' of stigma and discrimination experienced by people with different diagnoses and for people within different social, age, cultural, or religious groups.

The most recent large-scale Australian community survey investigated views on depression, schizophrenia, social phobia and post-traumatic stress disorder (PTSD). Perceptions of discrimination, social distance, dangerousness and unpredictability were generally highest for schizophrenia, while beliefs in the condition as a sign of personal weakness or 'not a real medical illness' were generally higher for social phobia than for other disorders (Reavley and Jorm 2011).

Reinforcing the differences between illnesses, an international study by Indiana University, which involved 16 countries, found that when compared to depression, stigma against schizophrenia is significantly higher across the world. This study also looked at cultural barriers and community beliefs, which provide an important context. For example, if people believe that mental illness is caused by bad deeds in one's ancestry or by evil spirits, or that simply talking about mental illness can make it worse, then any stigma reduction activity has to start there (Rooney et al 1997; Pescolido et al 2013).



What is stigma's

impact?

What is stigma's impact?

My mental illness is no longer the problem for me. It's how other people view me that's the difficulty. Without knowing it, or even meaning to, I get a feeling that somehow I'm of less value than they are, that my illness is my fault or that I cannot be trusted, which is what really causes me pain and embarrassment.

Stigma against mental illness is common. Its impact is serious.

Studies in Australia and overseas show that stigma is a very common experience. A SANE Australia survey (2006) found that almost three-quarters of respondents living with a mental illness (74%) had experienced stigma. They said a reduction in stigma would help them to: feel better about themselves; manage their illness better; get back to work or study, and, join in social activities.

Australian research among people living with a psychotic illness, such as schizophrenia, found that almost 40% reported experiencing stigma or discrimination in the past year alone. The proportion was higher in females, with almost a half reporting stigma or discrimination in the past year compared with a third of males. Many reported that the fear of stigma or discrimination had stopped them doing some of the things they had wanted to do, and overall stigma and discrimination was one of the main challenges reported for the coming year. (Morgan et al 2011).

Stigma can be experienced directly, as when someone is avoided due to a diagnosis of schizophrenia, or is passed over for promotion solely because a manager knows they have had depression. It can also be seen in public perceptions – for example, in the common association of schizophrenia with violence. It is stigma towards oneself, however, which can do the most harm.

People living with mental illness want the same basic things as everyone else:

- A home – somewhere decent to live
- A job or something meaningful to do – a reason to get up in the morning
- A life worth living – friends to share your life with and give you hope.

Stigma can stop people with mental illness from achieving these basic needs and manifests itself in many ways, in many different settings. The outcome is that people may live less satisfying and

contributing lives than they would like, and are able to make. The community is much poorer as a result too.

A Wesley Mission study (2007) found that their clients felt they were stigmatised and discriminated against in a number of different areas, including:

- Insurance companies – making it difficult for people with a mental illness to get health or life insurance
- Employers/potential employers – not being offered employment or taken advantage of in the workplace
- School – denied opportunities or labelled as 'kids with problem behaviours'
- Police – being perceived as trouble-makers
- Hospitals – being perceived as a nuisance after repeat admissions
- Media – misrepresented in the media, for example, mental illness is often associated with violence
- Community – being shunned, experiencing verbal and physical abuse
- Mental health professionals – staff can burn out and blame the clients for their behavioural problems
- Families – rejecting and blaming them for their condition
- Discrimination by decision-makers in general.

A New Zealand survey conducted as part of the *Like Minds, Like Mine* anti-discrimination campaign reported that:

- People report discrimination in all aspects of their lives from employment and housing to discrimination from friends and family and the community. This results in people feeling excluded from many activities. Few formal complaints about discrimination are made.
- Discrimination, even when it occurred several years ago, makes a lasting impression and still affects people's lives today. Due to past experiences, many people attribute any poor service they receive as discrimination because they have a mental illness.

- The fear of discrimination (often based on past experience) is as crippling as discrimination itself. Fear of discrimination inhibits people from undertaking many activities in their lives such as employment and interacting with others.
- Disclosure is an issue across all the areas of discrimination. When people disclose that they have experience of mental illness they are treated differently (often negatively) to when they do not.
- People tend to believe and act on the common stereotypes of people with experience of mental illness as being incompetent or dangerous.

Corrigan (2002) identifies the compounding and reinforcing impacts of public and self-stigma on the everyday lives of people with mental illness.

Public stigma

<i>Stereotype</i>	Negative belief about a group (dangerousness, incompetence, character weakness)
<i>Prejudice</i>	Agreement with belief and/or negative emotional reaction (anger, fear)
<i>Discrimination</i>	Behavior response to prejudice (avoidance, withholding employment and housing opportunities, withhold help)

Self-stigma

<i>Stereotype</i>	Negative belief about the self (character weakness, incompetence)
<i>Prejudice</i>	Agreement with others' stigma, negative emotional reaction (low self-esteem, low self-efficacy)
<i>Discrimination</i>	Behavior response to prejudice fails to pursue work and housing opportunities)

The impact of stigma can be organised into seven 'real world' domains which affect people living with a mental illness and those who are close to them:

- 1 General community
- 2 Health and other services
- 3 Education
- 4 Workplace
- 5 Mass media
- 6 Government
- 7 Self-stigma.

The following sections look at each of the seven areas of impact in more detail.

1 General community

I have a dream that one day I won't hold my breath every time I tell a person that I suffer from bipolar disorder, that I won't feel shameful in confessing my mental illness.

Feeling that you belong is an important human need. Having friends, local connections and activities you enjoy, as well as making a contribution to your own or to others' wellbeing – all help make life worthwhile.

While there have been some improvements in knowledge about mental illness and understanding of its impact on day-to-day lives, there is still widespread misunderstanding and ignorance, particularly about some diagnoses. Myths – such as that people with depression are weak and should just pull their socks up, or that all people with psychotic illnesses such as schizophrenia are unpredictable and to be feared – are hurtful and harmful as well as being inaccurate. Dispelling these myths is important if people with mental illness are to be fully accepted into families, workplaces and communities.

Australian and overseas surveys support the need for community education and have identified a wide range of particular misunderstandings that need to be tackled.

The 2013 National Mental Health Commission report, *Can we talk . . . about mental health and suicide*, based on informal group discussions around Australia, set out to recreate the conversations Australians are having about mental health and suicide at home, at work and with their friends. National Mental Health Commissioner, Janet Meagher, says the study reinforces that we are still struggling to make sense of mental illness and suicide, and that the stigma associated with accessing the mental health system is one of the biggest barriers to treatment.

The Wesley Mission study (2007) found that one in three (32%) would not feel comfortable working with a colleague who has mental illness. Two-thirds (66%) would not be comfortable with their child sharing a unit with someone who had a mental illness, and 71% did not believe people with mental illness could be trusted in positions of high responsibility.

Negative attitudes were more common among respondents 60 years and older, without a university education, or from a household with an income less than \$50,000 a year.

The Australian *National Survey of Mental Health Literacy and Stigma* found that statements with which respondents were most likely to agree or strongly agree involved a perception of other people's beliefs: that people with mental illness were unpredictable, that those affected would not tell anyone about their diagnosis, and that most other people would not employ someone with the problem (Reavley and Jorm 2011).

In relation to depression, the findings of a series of beyondblue community surveys indicate that change is happening although there is still a long way to go. The percentage of people who agreed that 'people with severe depression are unreliable' reduced from 66% in 2002 to 52% in 2008. Those who agreed with the statement that 'people with severe depression

are unpredictable' reduced from 78% to 68%. Agreement that 'people with severe depression should pull themselves together' reduced from 36% to 24% in 2008 (beyondblue 2011).

These findings are echoed in overseas studies, such as a recent survey of attitudes to mental illness in the UK which reported that direct social contact with people with mental health problems is the most effective way to challenge stigma and change public attitudes (Dept of Health 2010).

2 Health and other services

Sometimes nurses . . . don't encourage you to do something new or tell you not to go for a job. They sow the seeds of doubt.

When we are unwell, we expect to be treated with understanding and respect by people working in health and community services. Unfortunately this is not always the case for people with mental illness, who frequently report that they feel stigmatised.

Health and mental health services

A Mental Health Council of Australia study (2011) found that people with mental illness reported similar levels of stigma from health professionals as from the general community.

Some of the study's key findings are that:

- 1 Almost 29% reported that a health professional had 'shunned' them. These figures rose to over 50% for people with post-traumatic stress disorder and borderline personality disorder.
- 2 Over 34% had been advised by a health professional to lower their expectations for accomplishment in life.
- 3 Over 44% agreed that health professionals treating them for a physical disorder behaved differently when they discovered their history of a mental illness.

As Kathleen Griffiths of the ANU Centre for Mental Health Research writes in the study's foreword:

It is unthinkable that health professionals would stigmatise Australians with a physical condition such as cancer or a heart condition. However, there is a widespread belief that mental health consumers encounter stigmatising attitudes from health professionals. Such stigma poses a substantial risk to the wellbeing of consumers with a mental illness. It is a potential barrier to vital help-seeking from health professionals, it can further exacerbate a consumer's psychological distress, and it may reduce career opportunities.

Other health services are not always better. Some people report dismissive attitudes from general practitioners, for example, whereby presentations of physical symptoms were assumed to be 'all in the mind' as one UK study reports (Lyons et al, 2009). This is especially concerning, as evidence suggests people with mental illness are at greater risk from physical health problems, including cardiovascular disease, diabetes, obesity and respiratory disease; they also have a higher risk of premature death (Coghlan et al 2001).

The opinions of support workers about treatment and recovery were found similar to those held by the general public in another UK study (Crisp et al 2000). However, their opinions about dangerousness were different – fewer believed that people with mental illness were violent. Many support workers (86.5%) had prior personal knowledge of mental illness. While spending time with people with mental illness can work to change attitudes, the authors also note that some support workers do not always find it easy to talk to people with mental illness, and that lack of acknowledgement of these difficulties could lead to feelings of personal inadequacy, perhaps resulting in avoidance.

It is important to acknowledge that health and community support workers may also experience stigmatising attitudes and discriminatory behaviour. This may result in lower recruitment and retention rates in these jobs. As well as being targets for stigma-reduction work therefore, these groups and settings will also be beneficiaries of it.

Housing

People with mental illness may be stigmatised and discriminated against by neighbours: they may ' . . . at best be given the "cold shoulder" and at worst be victimised by other tenants' (Mental Health Community Coalition ACT 2005).

Decent, secure and affordable housing, with support as needed, is fundamental to recovery from mental illness, yet this is in short supply and often not always available to people with mental illness.

The Australian Bureau of Statistics reports that people who are living with a mental health problem find it harder to get and keep their own home compared to the general population; fewer own their own home or are paying off a mortgage, more rent their homes and their need for housing support is growing. (Australian Bureau of Statistics, 2009).

A 2008 survey of people living with mental illness found that nearly 90% believed they had been discriminated against at some time in regard to housing, particularly private rental accommodation, forcing them to accept unsafe or substandard housing options. Around a third (34%) had concerns about becoming homeless in the future, and 47% were looking for somewhere else to live. Difficulty finding suitable housing was an ongoing concern (SANE Australia 2008).

Attitudes of landlords, agents and accommodation workers undoubtedly influence housing outcomes. A study in the US examined what effect hearing that someone has a mental illness has on obtaining community accommodation. In a sample of 160 people advertising rental property, telephone calls for half the sample made simple enquiries as to availability; for the other half, similar enquiries were made by someone ostensibly receiving psychiatric treatment but soon to require accommodation. For people thought to have a mental illness, rooms were significantly more likely to be described as unavailable (Page 1993).

3 Education

I was diagnosed with OCD when I was 13 and have faced all types of stigma over the years. Mainly classmates making fun of me and the symptoms of my illness. It had a huge effect on my confidence and can be one of the hardest parts of dealing with a mental health problem.

Three-quarters of people who develop mental illness do so between the ages of 16 and 25 years. Reducing stigma in schools, TAFE and other colleges, and universities is an integral part of stigma reduction work if we are to encourage more young people to feel OK about asking for help and, when necessary, accepting ongoing treatment. It is also critical if we want friends, fellow students, teachers and others to provide them with understanding and support. This is a growing issue. In *Young Australians: Their Health and Wellbeing*, the Australian Institute of Health and Welfare (2007) reported that psychological distress was increasing, with over 25% of people aged 18-24 having a mental disorder. Of special concern is that only around one in four (22%) of young people experiencing a mental health problem sought professional help.

It's easy to see why stigma may be associated with this low rate of help-seeking. Research carried out in the UK found that nearly one in 10 young people think that classmates with a mental health problem should not be at their school, while the same proportion said they would stop being friends with a peer who had a mental health problem (Time to change 2008).

The research found that nine out of 10 young people who have a mental health problem reported experiencing negative treatment as a result of their mental illness. Often, much of the discrimination they face comes from those they might need to turn to first including friends (66%), parents (54%) and, shockingly, teachers and lecturers (49%). It is clear, therefore that the attitudes of parents, peers and teachers often need to be addressed. Similar rates were reported in the US.

In Australia, schools have long been a setting for attitude and behaviour change towards mental illness in students. The Mind Matters program has been in operation for over 10 years and, as part of its whole-of-school approach to mental health promotion, looks at stigma reduction in a variety of ways, including curriculum materials as well as teacher education and resources. A similar program, Kidsmatter, operates for primary schools.

The education workforce is also vulnerable to stigma. One study found that just 490 professional and support staff out of 200,605 education employees (0.002%) had reported a mental illness in the UK. As one in six Britons (17%) experiences some form of depression or anxiety at any one time, according to Department of Health figures, the disclosure rates suggest a clear case of under-reporting (Equality Challenge Unit 2012).

I suspect individuals do not want to show weakness or vulnerability. There are very few occupations where people feel safe enough to report something because there is a stigma associated with mental health – and it is clearly something we have not overcome in academia. People

feel it might affect their promotion chances or the credibility of the scientific work they do. Cary Cooper, Professor of Organisational Psychology and Health, Lancaster University.

4 Workplace

If someone at a job interview explains a two year gap in their resume by mentioning chemotherapy, they will likely be heralded as a survivor and their chances at the job typically would not be affected. But if the same person, with the exact same qualifications and manner of interacting explains a gap and mentions a psychiatric hospitalization, things may be a little different.

Having a job is more than a source of revenue. It helps define who you are as a person, provides friendships and gives you status in the community. Australia, along with many other countries, now has employment equity legislation in place to protect the rights of people with disabilities and to remove barriers to their economic participation. Yet despite this legislation, disabled employees in general are more likely to be paid by the hour, less likely to be a member of a union, less likely to receive benefits such as employer provided health insurance and pension plans, and less likely to be in professional, technical, or managerial jobs (Schur et al 2009). Despite the efforts of Disability Employment Services and other specialised agencies, unemployment rates remain very high among people seriously affected by mental illness.

Large-scale population surveys have consistently estimated the unemployment rate among people with mental illness to be three to five times higher than their non-disabled counterparts. The UK National Labour Force Survey found that the proportion of the adult population who were employed was about 75%; for people with physical health problems the figure was about 65%, yet for people with more severe mental health problems only about 20% were employed. Even for people with more common forms of mental illness, such as depression, only about half are competitively employed (Office for National Statistics 2012). When in employment, having a mental illness may also limit career advancement as employers are less likely to offer promotion (Stuart 2006). In the US, one in three people with mental illness reported being turned down for a job once their psychiatric status became known. In some cases, job offers were withdrawn when a psychiatric history was revealed (Wahl 1999).

Yet employing a person who has a mental illness can benefit both the job seeker and employer. With appropriate treatment and support, people who have a mental illness can be loyal and productive staff members, offer much-needed skills and valuable contributions in the workplace. Employer attitudes play an important role and these seem to be improving modestly in Australia. Research commissioned by WISE Employment (2012), found that of the 254 small and medium-sized enterprises (SMEs) surveyed:

- ▶ 32% of employers would consider hiring a person who has a mental illness.
- ▶ 68% of employers who had employed someone who has a mental illness still do.
- ▶ 74% of employers described their experience as positive.
- ▶ 45% of all hiring managers had a friend, family member or someone close to them who has a mental illness.

Deciding whether or not to tell employers about a mental illness is also a major issue. An Australian survey found that over a third (38%) had not done so. More than half (53%) of all respondents had also experienced stigma at some time at work (SANE Australia 2011). The main reasons given for non-disclosure were embarrassment and fear of discrimination by employers or others at work – not wanting to risk losing their job or to be treated differently simply because they told someone they had a mental illness.

The introduction of a number of workplace mental health programs in Australia is encouraging as one of their main objectives is to improve understanding and reduce stigma associated with mental illness among employers, managers and co-workers (beyondblue 2013; Mindful Employer 2013).

Employees with mental health problems may also experience stigma and discrimination from co-workers once their mental illness becomes known. Some report being targets for unpleasant or negative comments from workmates who had previously been supportive and friendly. Half of the competitive jobs acquired by people with a serious mental illness will end unsatisfactorily as a result of problems that occur once the job is in progress, largely as a result of interpersonal difficulties (Curr 2006).

Equal opportunity legislation in Australia is rarely used by people with mental illness in relation to employment, and when it is used, there are mixed results. Some reasons why few people make a complaint of workplace discrimination in Australia have been identified by SANE Australia (2011). The majority of respondents to the survey on social inclusion reported experiencing discrimination at some time because they have a mental illness (69%). Despite this, a similar proportion (71%) did not know where to make a complaint, and were unable to name a single human rights agency. Of the few (6%) who did approach a body such as the Australian Human Rights Commission (AHRC), the majority (81%) did not proceed with a complaint as the process was too complex and stressful, or they did not find the agency helpful.

Some complaints have however been upheld and, encouragingly, a conciliation process is now bringing about some positive outcomes. One AHRC case report concerns a woman with anxiety disorder who complained that applications for public service promotion had been rejected because she had experienced anxiety attacks. The matter was resolved when the employer agreed to assist her in drafting a new application for advancement; to provide her with project work which would strengthen her application; arrange for an independent

committee to consider her application; accept the application if this was recommended by the independent committee; and arrange training for relevant staff on mental health issues in the workplace (Australian Human Rights Commission 2006).

Many more people lodge complaints in the USA; mental disorders are the second most common basis for charges of discrimination and workplace harassment under the Americans with Disabilities Act. The success rate, however, is low. Of 263 disability cases brought to trial in 2004, only 2% of the decisions favoured the employee, 74% favoured the employer, and 24% were unresolved (Scheid 1999).

5 Mass media

I was diagnosed with schizophrenia a decade ago and in my search to understand my new illness, the media offered me a skewed vantage point where it appeared schizophrenia was simply a licence for bad behaviour. Now, on the inside looking out, I recognise what an inaccurate portrayal this is, the exception rather than the rule. Like many living with schizophrenia, I was a victim of violence and abuse rather than the perpetrator.

Australians are avid media users via the Internet as well as television, cinema, video, and print. Media professionals are important allies in helping to reduce stigma. Community attitudes and opinions are shaped by what people consume in the media (including advertising). The media is also a primary source of knowledge about mental illness.

The language used and images traditionally presented, however, are often inaccurate, sensational, unbalanced and stereotypical. These stigmatising representations have a real and profound effect on people living with a mental illness, causing great distress and distorting community attitudes. Violent or disturbed behaviours are too often linked exclusively to mental illness. A recent study found that new stories about mass shootings involving a shooter with mental illness heighten readers' negative attitudes toward persons with serious mental illness in general (McGinty et al 2013).

Whenever I see a mass murder reported in the media my first thought is to make a silent prayer: please don't let the person have a mental illness. I'm sick and tired of living with the shame of the label I carry with me like the mark of Cain on my forehead.

Children are particularly exposed to these messages. For example, a UK study which sampled one week of children's television, found that almost half (46%) of 128 programs contained one or more references to mental illness. Terms such as 'crazy', 'mad' and 'losing your mind' were commonly used to denote losing control. Six characters were identified as being consistently portrayed as mentally ill. These were almost totally devoid of positive characteristics. Wilson et al 2000).

People living with mental illness are acutely aware of the influence of the media on community attitudes as a whole. A survey of 357 Australians with mental illness found that

respondents were optimistic that stigma could be reduced and regarded tackling stigma in the media as an urgent need (SANE Australia 2007).

In recent years there have been improvements in Australian media representation of mental illness. We still have a long way to go, however. A University of Melbourne study prepared for the Mindframe Media Initiative, concluded that there is a tendency for news media to present mental illnesses in a way that promotes stigma (for example, by conflating it with violence and crime) or perpetuates myths about mental illness (for example, by presenting information that is inaccurate about treatment and prognosis). This study also found differences depending on the type of disorder presented.

Undifferentiated mental disorders (where the illness or illnesses is not specified) and schizophrenia appeared to receive the poorest treatment in the media. News stories citing 'schizophrenia' over a 12-month period were coded for the presence of stigmatising coverage and for story attributes that might contribute to it. Violence featured in 47% of stories and 46% were judged to be stigmatising. People identified as 'schizophrenic' were overwhelmingly reported as male and as perpetrators rather than victims of violence. Analysis indicated that more stigmatising stories tended to appear in tabloid sources, to refer to foreign events and substance use, and to represent people diagnosed with schizophrenia as young and male. There is, nevertheless, some evidence that reporting practices have improved over time. (Pirkis and Francis 2012).

Analysis of reports to SANE Australia's StigmaWatch program support these findings, with schizophrenia often represented in an inaccurate, sensationalised way, and associated with violence. Depression is far more likely to be reported responsibly and positively, while other conditions receive little coverage (SANE Australia 2010).

A study conducted for the Scottish anti-stigma campaign, Shift, found that media representations of mental illness were strongly associated with violence and danger (Shift 2010). Of 74 programs with storylines on mental health issues, there were instances of:

▶	violence to others	33
▶	other types of harm	48
▶	self-harm	53
▶	sympathetic portrayal	33

It is also being recognised that the media can play a positive role in reaching out to many different audiences to improve attitudes and promote mental health literacy. Mass media stigma reduction campaigns, web-based mental health literacy programs and documentary films have all contributed to helping reduce stigma and discrimination, and promote community understanding and acceptance. This is particularly the case if they include personalised stories (as opposed to education alone).

Irresponsible media reporting of suicide has been shown to trigger suicidal behaviour, but the influence of suicide reporting may not be restricted to harmful effects; coverage of positive coping in adverse circumstances, such as items about coping with suicidal ideation, may have protective effects. (Niederkroenthaler, T et al 2010).

6 Government

Funding

The level of funding provided for mental health directly affects the availability and quality of services that are available to provide treatment and support for people with mental illness. As well as improving outcomes and quality of life, effective treatment for mental illness is also important to reduce stigma associated with symptoms of illness.

Policy-makers have unenviable decisions to make about where limited resources are allocated. Their attitudes are likely to affect these decisions, along with government priorities and perceptions of what voters want. Internationally, mental illness is rarely seen as a high priority, so it is welcome that recent governments in Australia have allocated some additional funding in this area. The Better Access and Personal Helpers and Mentors programs, headspace, and early intervention centres are all welcome initiatives.

The 2012 *Report Card* from the National Mental Health Commission concludes there is little or no accountability for the \$6.3 billion Australia spends on mental health annually. The report also notes that mental health spending has increased by 4.5% per annum between 2005-06 and 2009-10. In a response to the *Report Card*, however, it was noted that overall health expenditure has increased by around 8.5% per annum over the same period, meaning that mental health's share of the health budget is shrinking not growing (Rosenberg 2012).

Funding inequities between physical and mental illnesses are international. A UK report, *How Mental Illness Loses Out in the NHS*, found that a disproportionately small amount of funding was allocated to treatment of mental illness compared with physical illness. Despite accounting for 23% of the total burden of disease and the existence of cost-effective treatments, mental illness receives only 13% of NHS health expenditure (LSE 2012). The under-treatment of people severely affected by mental illnesses is a glaring case of health inequality.

Legislation

In most parts of Australia it is unlawful under anti-discrimination legislation to vilify people on the grounds of race, religion, sexuality or gender identity. However under current Australian legislation (apart from Tasmania), people with a mental illness or other disability do not enjoy this protection.

Insurance industry

The *Disability Discrimination Act 1992* provides an exception for insurance companies to discriminate against people with mental illness or other disability on the grounds of actuarial or statistical data or where it is 'reasonable, having regard to other relevant factors'. There are reasons to believe this legal exception is being exploited however. Research conducted by beyondblue and the Mental Health Council of Australia (MHCA) and has found that people with a mental illness are regularly discriminated against unreasonably when they apply for insurance.

Their report (beyondblue and MHCA 2011) describes many disturbing cases of unfair treatment by insurers, who often reject people with mental illness when they try to purchase life insurance, income protection insurance, total and permanent disability insurance, or travel insurance. Claims associated with mental illness are often explicitly excluded in many insurance policies.

'Insurers don't seem to possess even a basic knowledge of mental health issues,' comments Frank Quinlan CEO of the Mental Health Council in the report. 'Just seeing a counsellor is apparently regarded by insurance companies as a major risk – even if someone has never been diagnosed with a mental illness.'

7 Self-stigma

Self-stigma is a burden. My mental illness diagnosis and treatment left me with a very difficult feeling of failure.

Just because someone has a mental illness doesn't mean they don't share common community attitudes to mental illness. Self-stigma can be the most harmful form of stigma. When someone self-stigmatises, they take on negative and inaccurate stereotypes and accept that 'people with mental illness are of less value to society or to themselves'. The fear of being rejected can then stop someone from going out, socialising, looking for a job, or taking part in their local community.

People then start to see what they believe – their perception becomes reality in a very vicious cycle. Goffman comments that the difference between a stigmatised person and someone who isn't is a question of perspective, not reality. Stigma (like beauty) can be in the eye of the beholder (Goffman, E 1963).

Self-stigma is common. An international study of 732 people living with schizophrenia found that over one third anticipated discrimination in job-seeking. Another 14-country study of people with schizophrenia who were members of mental health organisations found that almost half (42%) reported moderate or high levels of self-stigma. Almost 70% reported moderate to high levels of perceived discrimination and this was significantly associated with higher reported self-stigma (Brohan et al 2010).

Self-stigma causes harm. Many studies have shown that people with mental illness who self-stigmatise are more isolated, alienated, and socially withdrawn than those who are not self-stigmatising. Social isolation often involves withdrawal from, and problems with, friends and family. It also includes avoiding employment-seeking for fear of rejection and 'failure'. Having fewer social support networks then means that people who self-stigmatise are less likely than others to receive support just when they need it.

After being told what you have, you begin to feel shame, fear, confusion. You have a sense of loss. You don't know how this is going to impact on your life, afraid other people might find out. You start to isolate yourself from others and eventually from society.

Another consequence for people with mental illness and self-stigma is that they are less likely to seek treatment for symptoms than are people without self-stigma, less likely to cooperate with treatment, are more likely to have worsening of symptoms and have problems with recovery (Peterson et al 2008).

Research on self-stigma in the US found that stigma aroused strong emotions, ranging from hurt to anger, which people seldom voiced for fear they would be ignored or that it would be taken as evidence of mental instability. The majority (71%) reported not disclosing mental illness on job applications for fear of discrimination. This often left people feeling worried in case they were 'found out'. This additional fear and anxiety can then worsen existing illness and slow recovery (Wahl 1999).

Not everyone with mental illness experiences self-stigma. Being male, older, having less education, being born overseas, and poorer knowledge about depression are all independently associated with greater personal depression stigma (Griffiths et al 2008).

The landmark New Zealand report on self-stigma, *Fighting Shadows* (Peterson et al 2008), identified eight recommendations to disrupt the cycle of stigma and discrimination at a community as well as personal level:

- recognise the contribution of [people with] mental illness and foster leadership
- celebrate and accept difference
- affirm human rights
- encourage disclosure
- encourage recovery-oriented practices
- encourage empowerment
- support peer support services
- challenge attitudes and behaviour.



Stigma and
policy

Stigma and policy

Mental health policies in Australia and comparable countries have acknowledged the need to tackle stigma, but the challenge remains to translate these policies into effective action.

Australia

Australia has long recognised the importance of stigma reduction, and this is acknowledged in many government plans and strategies. Carrying these good intentions through into practice has been a challenge however.

One of the four aims of the *National Mental Health Policy* is to 'reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community' (Commonwealth of Australia 2008).

The *Fourth National Mental Health Plan* lists 'Social inclusion and recovery' as a priority, with a main action area to 'improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy' (Commonwealth of Australia 2009).

The need for ongoing stigma reduction campaign work was further emphasised in *Work Wanted: Mental Health and Workforce Participation*, a report of the House of Representatives Standing Committee on Education and Employment (Commonwealth of Australia, 2012). A principle recommendation of the report was that the Australian government coordinate a comprehensive and multi-faceted national education campaign to target stigma and reduce discrimination against people with a mental illness in Australian schools, workplaces and communities. It concluded that the campaign should:

- include involvement from the public, private and community sectors, educational institutions, employers and a range of other stakeholders, including individuals with mental illnesses, families and carers, and
- complement existing government-funded education and awareness campaigns on depression and mood disorders, with an inclusion of psychotic illnesses.

Australia's first report card on mental health, *A Contributing Life*, also noted stigma reduction as a key priority for action (National Mental Health Commission 2012):

The role of stigma or discrimination experienced or perceived by people living with a mental health difficulty in trying to access services or when using services, also has an impact upon how they connect with the services they need and therefore upon the opportunities for their recovery.

There is also a demonstrable impact from mental health-based discrimination. These are issues of self-stigma and discrimination experienced from a person's community and health professionals, which affect a willingness to seek health support.

Increasing access to support for depression has been shown to reduce suicides and this must be a primary focus of our efforts by ensuring care is available by better understanding how to remove barriers and reduce the stigma and discrimination that prevents people from seeking help.

The Commission's forward work program includes 'examining how Australians really think and feel about mental health, mental illness and suicide, including stigma and discrimination'.

New Zealand

There has been strong commitment to mental health in New Zealand, including funding to reducing stigma. *Te Tahuu – Improving Mental Health 2005-2015* (Ministry of Health 2005), New Zealand's mental health and addiction plan, states that:

- mental health and addiction problems, such as depression, anxiety disorders, and substance misuse can reduce an individual's sense of belonging and participation in society;
- stigma and discrimination can be both a consequence and a cause of social exclusion, and a major barrier to successful participation in society for excluded groups and individuals; and that risk factors and promoting protective factors that strengthen communities – such as enhanced cultural awareness, sensitivity, and promoting access to the resources of mainstream society to encourage full participation in society – are important for mental health.

Canada

As a consequence of a landmark report from the Canadian Senate, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Government of Canada 2008), the federal government provided funding for an independent mental health commission with a mandate to develop a national mental health strategy, a 10-year anti-stigma strategy and a knowledge exchange centre. Leaders and organisations from across the country are brought together to accelerate these changes. In 2009 the Commission launched *Opening Minds*, the largest systematic effort to reduce the stigma of mental illness in Canadian history.

United Kingdom

The British government document *No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages*, has six shared objectives to improve mental health outcomes for individuals and the population as a whole. One objective is that 'fewer people will experience stigma and discrimination' (Department of Health 2011). A clear commitment is made to challenge stigma by supporting and working actively with the *Time to Change* program and others.

The *Time to Change* campaign is a comprehensive anti-stigma campaign run by mental health charities, Mind and Rethink Mental Illness. This is the biggest attempt yet in the country to end the discrimination that surrounds mental health. The first phase ran from 2007-2011 with funding from the Big Lottery Fund and Comic Relief. The second phase, funded by the Department of Health, will run until March 2015 (*Time to Change* 2013).

Scotland led the way in the UK when it launched the campaign *see me* in 2002. Established to end stigma and discrimination against people experiencing mental health problems, *see me* is fully funded by the Scottish Government and conducted by an alliance of five mental health organisations. The *Mental Health Strategy for Scotland 2012-15* includes as one of its seven themes, 'Extending the anti-stigma agenda to include further work on discrimination. It makes a commitment to work with the management group of *see me* and the Scottish Association for Mental Health . . . and other partners to develop the strategic direction for *see me* for the period from 2013 onwards.' (Scottish Government 2012)

United States of America

In 2007 a public awareness advertising campaign, *What a Difference a Friend Makes* was launched by the Substance Abuse and Mental Health Services Administration in partnership with the Ad Council. This was designed to decrease negative attitudes to mental illness and encourage young people to support friends who have a mental health problem. This campaign is no longer active, and there is no current comprehensive national campaign in the US.

Following recent tragic school shootings, President Obama issued a directive to launch a national conversation to increase understanding about mental health. Stressing that the vast majority of people with mental health conditions are not violent, the President committed his Administration to coordinating action to reduce stigma and encourage early intervention. As part of this initiative, a White House conference on mental health was held in June 2013, to which SANE Australia CEO, Jack Heath, was invited to contribute.



What is being

done?

What is being done?

A selection of programs from around the world provide hope for effective action to combat stigma and discrimination against people affected by mental illness.

Australia

Mindframe National Media Initiative

Mindframe encourages responsible, accurate and sensitive representation of mental illness and suicide in the Australian mass media. The initiative involves building a collaborative relationship with the media and other sectors that influence the media (such as key sources for news stories) and is funded by the Australian Government, National Suicide Prevention Program.

The Mindframe Education and Training program is managed by the Hunter Institute of Mental Health, and works with the following sectors:

- ▶ News media
- ▶ Mental health and suicide prevention sector
- ▶ Universities
- ▶ Australian film, television, and theatre
- ▶ Police.

Mindframe provides access to up-to-date, evidence-based information to support the reporting, portrayal and communication about suicide and mental illness.

The SANE Media Centre is managed by SANE Australia, and provides the media and the mental health sector with day-to-day guidance about reporting and portrayal of mental illness and suicide-related issues. The SANE Media Centre achieves this by providing a 'one-stop' service of information, expert comment, advice and referral.

The StigmaWatch program, an integral part of the SANE Media Centre, voices community feedback about representations within the media that stigmatise mental illness or inadvertently promote self-harm and suicide. StigmaWatch also provides positive feedback to the media about accurate and responsible portrayals of mental illness and suicide which help break down stigma and increase understanding of mental illness.

The Media Monitoring project involves two large-scale media monitoring projects conducted by the University of Melbourne and the University of Canberra. These have shown that when compared to reporting in the 2000-2001 period, reporting in 2006-2007 showed considerable improvement. Across all media, both suicide and mental health items increased in volume, with approximately a two-and-a-half-fold increase of responsible reports, increasing from 57% to 75% (Pirkis et al 2008).

beyondblue

The national depression and anxiety initiative beyondblue, is an independent, not-for-profit organisation working to increase awareness and understanding of these conditions in Australia and to reduce the associated stigma. Established in 2000, beyondblue is an initiative of the Federal, State and Territory governments, also supported by the generosity of individuals, corporate Australia and Movember. Reducing stigma and discrimination is a key aim of beyondblue. Specific objectives are to:

- ▶ reduce stigmatising attitudes surrounding depression and anxiety within the community through promoting personal experiences and education
- ▶ reduce the levels of self-stigma
- ▶ reduce the discrimination experienced by people with depression and anxiety through leadership and support for changes in attitudes, policies, practices and systems
- ▶ increase awareness of discrimination as a risk-factor for depression and anxiety through campaigns, programs, policy and advocacy.

For over 11 years, beyondblue has conducted a *Depression Monitor* survey every two years to measure changes in community awareness, knowledge and understanding of depression and anxiety in the community.

The 2012 beyondblue annual report notes that ‘while there have been significant improvements in awareness, knowledge and attitudes surrounding depression over time, there is still room for improvement on some issues – including increasing awareness and understanding about anxiety disorders and some attitudes including stigma’ (beyondblue 2012).

There is a range of activities for young people in Australia.

Mind Matters (secondary schools)

Kids Matter (primary schools)

These school-based programs are designed to promote inclusion, mental health, and raise awareness of when and how to seek help for mental health difficulties. While not specifically listing stigma reduction as a major focus of their programs, these are all important pre-requisites to stigma reduction.

Mind Matters and KidsMatter are funded by the Australian Government, Department of Health and Ageing.

Inspire Foundation

Inspire’s reachout.com flagship service, increases young people’s knowledge of mental health and wellbeing, increases their help-seeking skills and ensures that they feel less alone. Reachout can be accessed anonymously, offers help and support 24 hours a day, and is accessible to young Australians in remote regions, allowing thousands of young people to be helped at any one time.

Mental Health First Aid (MHFA)

MHFA is the help provided to someone who is developing a mental health problem, or who is in a mental health crisis, until appropriate professional treatment is received or the crisis resolves. The MHFA course teaches members of the community how to assist when someone needs help in this way. Mental health first aid strategies are taught in evidence-based training programs and conducted by MHFA Instructors across Australia.

The MHFA training and research program is growing in popularity in Australia and has now been adapted for use with specific communities and in many countries overseas. Partnerships are vital to MHFA and courses are delivered by a wide variety of organisations. It has been well evaluated in several trials from the program’s inception in 2001. These have shown consistently that participants are:

- better able to identify mental illness
- more confident in offering help
- more likely to recommend professional help
- more knowledgeable about the evidence-based treatments for mental illness
- more realistic and less stigmatising attitudes towards people with mental health problems
- sustaining the benefits of the program over time.

Two States in Australia, Queensland and South Australia, have established media campaigns specifically to reduce stigma associated with mental illness. Launched in a blaze of publicity, both have since ceased due to funding constraints and change in government priorities.

Change Our Minds

Change Our Minds was a 2011 Queensland Government initiative to address the stigma and discrimination associated with mental illness. It aimed to make the community aware of how negative attitudes and behaviours affect the lives of people living with mental illness, including their families and carers. It also promoted positive attitudes, acceptance and social inclusion of people living with mental illness (Queensland Government 2011).

Let’s Think Positive

The landmark report, *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform* (South Australian Government, 2007), recommended a media campaign specifically to address the issue of stigma within the community. Launched in February 2012, the South Australian *Let’s Think Positive* campaign comprised a series of thought-provoking television and radio commercials, as well as online and outdoor ads and brochures.

New Zealand

Like Mind, Like Mine

The *Like Minds, Like Mine* public education program aims to reduce the stigma and discrimination faced by people with experience of mental illness in New Zealand. The program started in 1997 as a five-year public health project for both national and community-level activities, funded by the Ministry of Health and guided by the Like Minds National Plan. Since 2001, the Government has funded the project as a core public health activity.

The campaign combines national media messaging with local activities to change discriminatory attitudes and behaviours. The aim is to have a community which values and includes people living with mental illness; for all organisations to have policies and practices to ensure that people with mental illness do not experience discrimination; and for individuals to have the same opportunities in everyday life as people who do not have a mental illness. *Like Minds, Like Mine* provides opportunities for contact and direct interactions with people living with mental illness, and delivers education and training programs to challenge and change stigmatising and discriminatory attitudes and behaviours.

As knowledge about what is needed and what works has deepened, the focus has changed from raising awareness and promoting attitude change to bringing about changes in behaviour, practices and policies.

United Kingdom

Time to Change

Launched in 2007, *Time to Change* is a comprehensive initiative to engage people in all sectors and communities to reduce the stigma and discrimination experienced by people with mental health problems.

Time to Change is operated by three mental health organisations and has an academic evaluation partner from the Institute of Psychiatry at King's College London. The national campaign uses bursts of mass media advertising and public relations exercises to convey the message that mental illnesses are common, that people with mental illness can lead a meaningful life, that discrimination experienced is often worse than mental illness itself, and that we can all do something to help. Media activities are supported by local projects.

Evaluation has found no large-scale shift in attitudes as yet, however there have been some significant impacts, particularly where there has been personal contact with someone with mental illness: knowing someone who is open about having a mental health problem has a clear and positive impact on attitude and behaviour. The evidence suggests a modest reduction in discrimination towards people with mental health problems, as well as some improvement in public attitudes as follows:

Changing behaviour and reducing discrimination

A 3% increase in the numbers of people reporting no discrimination in their lives was noted, and a significant 11.5% reduction in the average levels of discrimination reported in 2011 compared to 2008.

Improving public attitudes

Since the launch of *Time to Change*, there has been a 2.4% improvement in public attitudes towards people with mental health problems

The link between the campaign and improved attitudes and behaviour

Evaluation suggests a clear and consistent link between awareness of the *Time to Change* campaign and improved knowledge, attitudes and behaviour around mental health.

Starting conversations about mental health

A key principle of *Time to Change* is 'social contact'. This means knowing someone with a mental health problem. Research shows that this is one of the most powerful indicators of improved attitudes and behaviours, so a lot of *Time to Change* is about creating opportunities for more members of the public to come into contact with people who are open about their mental health problems. Since *Time to Change* launched there has been a significant increase in the number of people who say they know someone with a mental health problem.

Scotland

see me

Scotland's national campaign to end the stigma and discrimination of mental ill-health, *see me*, is operated by an alliance of five Scottish mental health organisations.

Fully funded by the Scottish Government, *see me* was launched in 2002 as a response to long-standing concerns within the mental health community that action was needed to address prejudice and discrimination.

With strong involvement of people with direct experience of stigma, the emphasis is on publicity campaigns to raise public awareness of the impact of stigma on people with mental illness and to improve understanding of mental illness. These campaigns target specific groups, such as youth, and environments such as workplaces, as well as the general public. Local activity is encouraged and partners are supported to conduct activities providing resources, advice and guidance. The campaign also works closely with the media in challenging negative portrayals of people with mental health problems.

It is accepted by the *see me* partners that ending stigma and discrimination towards people with mental illness may take many years to achieve. Their National Action Plan for years 8-11 of the campaign builds on the earlier work, tackling some of the more complex areas of stigma and discrimination, including a focus on health and social care settings. Built on the existing evidence base, campaign activities are tested and evaluated to make sure they are appropriate and effective.

Canada

Opening Minds

The *Opening Minds* initiative was established by the Mental Health Commission of Canada in 2009 with the aim of changing Canadians' behaviours and attitudes toward people living with mental illness, to ensure they are treated fairly and as full citizens with opportunities to contribute to society.

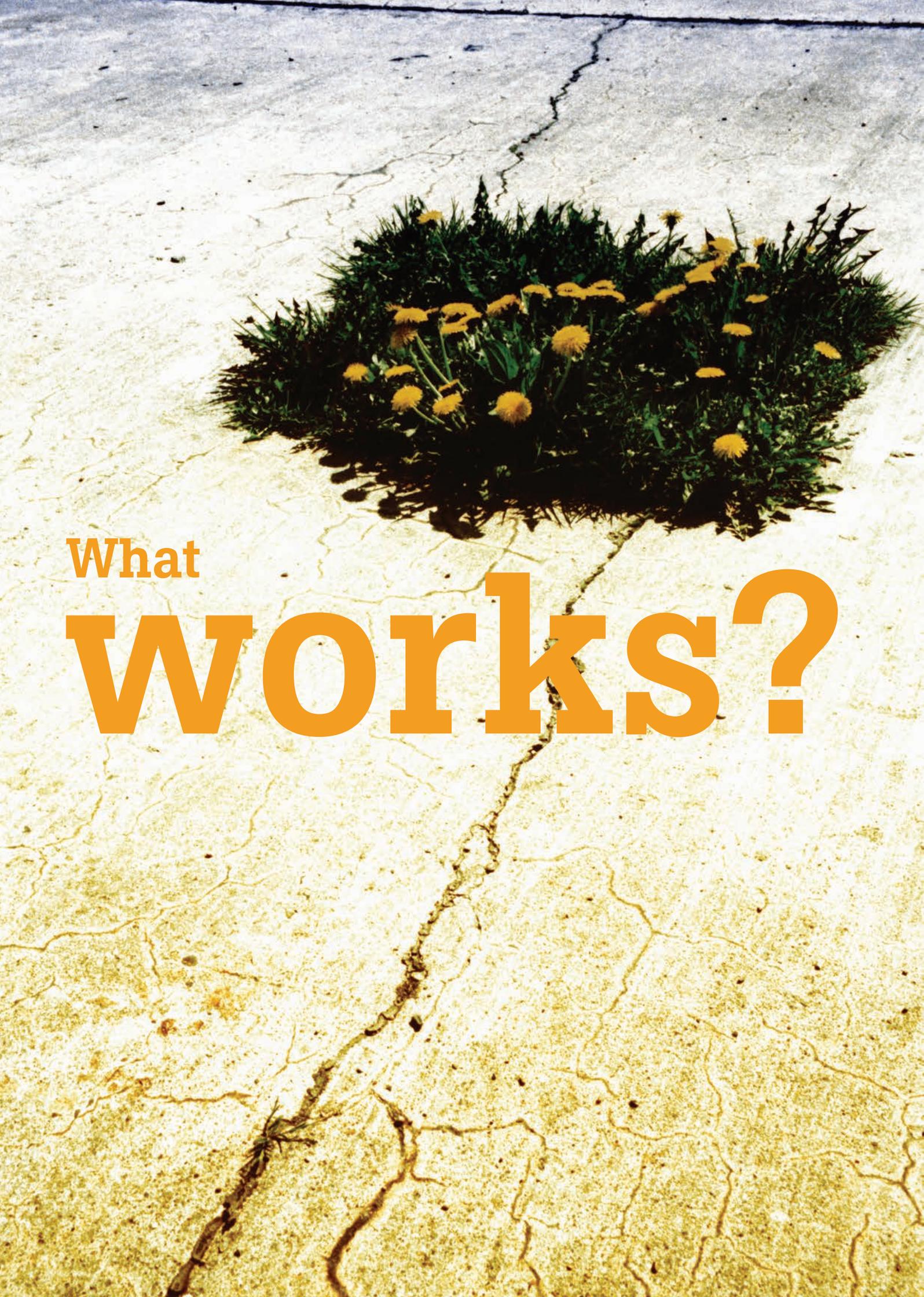
Opening Minds is addressing stigma within four main target groups: healthcare providers, youth, the workforce and the media. As such, the initiative has multiple goals, ranging from improving healthcare providers' understanding of the needs of people with mental health problems to encouraging youth to talk openly and positively about mental illness.

The ultimate goal of *Opening Minds* is to cultivate an environment in which people living with mental illness feel comfortable seeking help, treatment and support on their journey toward recovery.

A number of programs across Canada are now working on reducing stigma. *Opening Minds* has been evaluating more than 70 of these projects to identify those which are most effective, so they can be replicated across Canada. Evidence gathered through these evaluations will reveal best practices which will contribute to the development of anti-stigma toolkits and other resources.

At the same time, the *Opening Minds* evaluation process is forging ties throughout Canada's mental health field, creating a valuable network for sharing best practices and programs designed to reduce stigma.

The Australian National Mental Health Commission and the Mental Health Commission of Canada have signed a formal Memorandum of Understanding to share knowledge and successful practices in mental health research. This outlines how the two Commissions will seek opportunities to work together in areas such as mental health and the workplace, international knowledge exchange and stigma, with cross-promotion of work informed by the lived experience of those experiencing mental health issues, their families and support people, and the mental health sector.



What

works?

What works?

Evidence suggests there are strategies which are effective in reducing stigma and discrimination to improve the lives of people affected by mental illness.

There have been many stigma-reduction programs and campaigns in Australia and internationally over the past ten years. These have not always been rigorously evaluated however.

There is a general consensus that effective stigma-reduction strategies acknowledge different forms of stigma, and that actions need to be well coordinated, comprehensive, long-term, at national and local levels, with a range of groups and, most importantly, involving people with lived experience of mental illness.

There is also clear recognition that behaviour change must be measured as well as attitudes and beliefs. It is not good enough to have well-informed community members, employers, policy makers and health workers for example, if they continue to treat people unfairly just because they have a mental illness.

Experts have identified areas where there have been changes in stigma over time (Carter Centre 2009).

Positive	Negative
Increase in willingness to discuss mental illness	Increase in association with violence
Increase in willingness to seek help from non-medical mental health professionals	Permanence implied with genetic explanation
Belief that normal lives are possible	Belief that the general public is uncaring and unsympathetic.

Systematic academic reviews show that there are two evidence-based approaches demonstrated to reduce stigma.

Contact with people affected by mental illness

Spending time with people with mental illness is a powerful tool for changing attitudes, influencing fear, social distance, and hence stigma.

People can also 'get to know' someone affected by mental illness through television or film portrayals, when these are accurate and responsible portrayals. This can also help reduce self-stigma.

The recent evaluation of the first phase of the *Time to Change* campaign in the UK has also demonstrated that knowing someone who is open about having a mental health problem has a clear and positive impact on attitude and behaviour. (Time to Change, 2013).

Education

Educational interventions can reduce stigma by providing information about mental illness and improving mental health literacy – knowledge and beliefs about mental illnesses, which aid their recognition, management or prevention. These have been shown to be effective with many target audiences and extend to online interventions, with evidence that Internet-based educational programs can reduce the stigma associated with depression, including people with high psychological distress (Griffiths et al 2004), and in older people from Greek and Italian backgrounds (Kirropoulous et al 2011).

Research shows that interventions to improve public knowledge about depression have been successful in reducing the effects of stigma. A beyondblue campaign to increase knowledge about depression and its treatment ran an intensive, coordinated program in some States and Territories and not in others. People exposed to the program more often recognised the features of depression, and were more likely to support help-seeking for depression or to accept treatment with counselling and medication (Jorm et al 2005).

An educational approach to reduce the stigma associated with schizophrenia has also been shown to be effective with young people in a study conducted in Greece. A randomised control trial showed that following intervention, positive changes in students' beliefs, attitudes and desired social distance were recorded, although only changes in attitudes and beliefs were maintained after one year. The authors' recommendations are for anti-stigma interventions to be delivered continuously throughout the school years and to allow for interactions with people who live with mental illness (Economou et al 2012).

Five essential principles of strategic stigma change are described by Corrigan (2011) using theTLC3 acronym. These are centred on contact with people with mental illness as a fundamental part of the campaign, requiring that messages be:

- **targeted**
Messages must speak to people in positions of power such as employers, landlords, healthcare professionals, teachers and media in order to change behaviour.
- **local**
Designed for and acknowledge differences in geographic, socioeconomic, religious or cultural groups.
- **credible, continuous contact**
The contact person needs to be credible and be identifiable by the target group. For example, a health worker or employer with a mental illness who is in recovery talking to other health workers or employers. People who are acutely unwell or who have not started their recovery may have no positive influence and may even make things worse. Contact should also be continuous; one contact may be positive but the effect is usually short-term.

While existing research does not yet provide meaningful evidence about the impact of advertising campaigns, such as change in stigma, prejudicial attitudes and discriminatory behaviours, evaluation of these is now an integral part of current national campaigns in England, Scotland and Canada for example.

In Australia, as part of the National Mental Health Strategy, a four-year Australian National Community Awareness Program (CAP) comprising national public advertising and education resources started in 1995. While there was strong support for the campaign and demand for its education materials, outcome effects were small with little evidence of behaviour change, of whether people with mental illness were actually treated differently. This highlights the importance of a multi-faceted campaign incorporating local and targeted activities, and with involvement of people with mental illness as an integral part of the campaign.

What works best

A literature review conducted by the Queensland Alliance (Queensland Alliance 2009) summarised recommendations for what works best in stigma reduction. Drawing on the research, international anti-stigma programs, and advice from research and program experts, the following principles for best practice were identified:

- **Direct personal contact with people who experience mental illness is the best approach.**
Direct contact is the best approach to changing attitudes and behaviours, particularly when there is: a relationship of equal status; a context of cooperation, an opportunity for discussion; and credible presenters who disabuse myths of dangerousness, incompetence, and incapacity.
- **Information alone does not change attitudes.**
The goal of education is to increase understanding of the challenges real people face (including discrimination), how difficulties are overcome, what helps, how others can be supportive and include messages of equality, hope and recovery. Use of creative arts and multi-media increases impact.
- **Mental health problems are best framed as part of our shared humanity.**
Mental health problems are an understandable response to a unique set of circumstances and not purely as biomedical, genetically based, illnesses, or a diseased state of brain.
- **Create a simple and enduring national vision.**
A vision that promotes human rights, social inclusion, full citizenship, and a shared responsibility for change will be most effective, using multi-media, and social marketing tools to create clear program outcomes and benchmarks.
- **Support grass-roots, local programming.**
A national campaign that still increases contact, education, and builds consumer leadership from the grass-roots up is important. Change happens at the local level. Encourage bold, creative programming and evaluate carefully.
- **Plan strategically at the national level.**
Develop a national strategic plan that works in partnership with government and stakeholders to develop and deliver a multi-level national plan targeting transformative systemic change at a service system, legislative, policy and practice level.
- **Support people living with mental health issues in active leadership.**
Consumer leadership should be encouraged to define issues, design programs, undertake research, and evaluate program success. Protest, disclosure and group identification are cornerstones of empowerment. Support consumer leadership and empowerment through the national program.

- **Target programs at influential groups.**
Influential groups could include emergency response, policing and corrections, social service providers, employers, educators, friends, family, religious leaders.
- **Assist media to play a significant role.**
Require media to have a special focus on increasing depictions of people as competent, capable and productive citizens and utilise 'first person' narratives. Challenge inaccurate or discriminatory portrayals of people with mental health issues.
- **Utilise evidence.**
Programs must use evidence-informed approaches. Informed programming should also be evaluated to allow for course correction. Build knowledge through research and findings shared through program networks.

Improvement of access to effective treatment support for people with mental illness is also an integral aspect of reducing stigma.

There is no doubt that untreated mental illness contributes to stigmatising attitudes. There can be a 'credibility gap' between what is said by people working in stigma reduction and what the general public may see around them every day. Misunderstanding and fear of someone with psychotic symptoms or with the unwanted side-effects of treatment, provide fertile ground for stigma and discrimination.

For example, seeing someone in a shopping mall who is dirty and unkept, talking to their voices, and going through rubbish bins will create understandable anxiety and avoidance in passers-by who have no understanding of the effects of conditions such as schizophrenia and symptoms such as auditory hallucinations. News reports of aggressive or violent behaviour by someone with mental illness too often miss the contextual information about the person not receiving treatment, so the exaggerated association of mental illness with violence persists.

Dr Fuller-Torrey, a US psychiatrist and long-term advocate for people with severe and enduring mental illness, has outlined the association between violence resulting from untreated illness and stigma (Fuller-Torrey 2011):

- The perception of violent behaviour by mentally ill persons is an important cause of stigma. It is clearly established that viewing mentally ill persons as dangerous leads to stigmatisation.
- Most episodes of violence committed by mentally ill persons are associated with a failure to treat them. This has been demonstrated in many studies.
- Treating people with serious mental illnesses significantly decreases episodes of violence. Multiple studies have demonstrated that the treatment of individuals with serious mental illnesses with antipsychotic medication . . . is effective in reducing arrests rates and violent behaviour.

- Reducing violent behaviour among individuals with mental illnesses will reduce stigma. If violent behaviour by mentally ill persons is an important cause of stigma, then reducing violent behaviour should logically reduce the stigma.

The need for improved access to treatment in order to bring about a reduction in stigma is also acknowledged in *No Health without Mental Health*, the British government's mental health strategy document (Dept of Health 2011):

Although serious incidents involving a person with severe mental illness are extremely rare, we recognise the public's concerns about safety. However, we also recognise that such serious incidents can add significantly to the stigma surrounding mental health. Mental health services must play their part in reducing and managing risks of harm, through their own interventions where they are best placed to intervene, or by helping other agencies to do what they are best placed to do.



Summary and **recommendations**

Summary and recommendations

Stigma is a major issue for people affected by mental illness, influencing how they are viewed, and how they view themselves. It can appear at home, at school, at work, in hospitals, clinics, clubs, in the media, and in the offices of decision-makers. It is destructive, hurtful and excluding.

If we are to work towards a society where every person is valued, respected, and belongs, we must address stigma. Most of us will be affected by mental illness somehow at some time in our lives, so it is important for everyone in our community to feel comfortable talking about mental illness, and not to fear disclosing their own experience.

A strategy to tackle stigma and discrimination associated with mental illness is vital, and should be a non-negotiable component of mental health policies and plans. It should be as non-negotiable as treatment and support programs. It is essential if we are to help people with mental illness live a contributing life. This strategy will also benefit recruitment of people to work in mental health services in both clinical and non-clinical roles.

Significant progress has been made in the last ten years to reduce the stigma associated with depression. Ongoing government and community support for organisations such as beyondblue and the Black Dog Institute will help ensure progress continues and extends to anxiety.

Australia now needs a national, long-term strategy and campaign to reduce the stigma and discrimination associated with mental illness, with a particular focus on psychotic illness. The strategy must be consistent with national and state mental health plans and strategies, the social inclusion agenda and the forward workplan of the National Mental Health Commission.

Recommendations

Australia needs a national strategy to address stigma which:

- ▶ is comprehensive, targeted, well-coordinated and robustly funded
- ▶ includes people with lived experience of mental illness as integral to the campaign – including at a leadership level
- ▶ has a clear digital and social marketing strategy which incorporates a range of mass media initiatives
- ▶ learns from the best available evidence from similar campaigns in other parts of the world
- ▶ works closely with and supports community stakeholders to ensure local initiatives reinforce campaign messages
- ▶ works with and builds upon current effective stigma reduction strategies in Australia, such as Mindframe’s work with mass media professionals to improve the portrayal of mental illness and suicide
- ▶ works with a range of government departments such as employment, housing, education, and justice for example, to ensure their programs and messages are supportive of the campaign
- ▶ works with a range of stakeholder professional bodies in the clinical, education and employment areas for example, who are both targets and beneficiaries of campaign messages
- ▶ has ongoing monitoring and evaluation of the campaign and its components to gather evidence of effectiveness, add to public knowledge about the issues, and for accountability. Evaluation measures to include measures of discriminatory behaviour
- ▶ complements and supports existing stigma-reduction campaign strategies for depression and anxiety disorders
- ▶ works with media professionals
- ▶ ensures that any mass media campaign work, such as television and cinema advertising is embedded in and integral to the overall campaign, rather than being its main focus.

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SANE Australia
PO Box 226
South Melbourne VIC 3205

T 03 9682 5933

F 03 9682 5944

E info@sane.org

www.sane.org



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