



INTERVENTIONS TO REDUCE MENTAL HEALTH STIGMA

1. Health communication in general



- Health communication(HC) is defined as the use of communication strategies to inform and influence personal and community decisions to improve health.
- HC has two distinct areas -
 - Interpersonal and group communication in clinical settings
 - Mass media health messages (including the way in which we search for and use information) and how risk information is disseminated.
- WHO defines 'health' as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Historical background



- Reports of the first mass media health campaign came from America in 1721 with the smallpox epidemic. Thousands of pamphlets were issued at this time.
- Health care emerged in the US and Western Europe in the twentieth century and influenced the development of health communication as a discipline.
- In the 1950's scientific advances led to the development of the medical model which largely ignored the role of communication and the patient, the approach was more concerned with the treatment of disease as opposed to preventative education (Thomas, 2006).

Some questions...

1. What techniques are effective in raising public awareness and promoting engagement in general health issues?



2. What techniques are effective in raising public awareness of mental health issues and helping people talk to their families?



3. What are the best ways of raising awareness of MH stigma and what is the impact on the individual?



4. What are the key features of successful campaigns?



WHAT TECHNIQUES ARE EFFECTIVE
IN RAISING PUBLIC AWARENESS AND
PROMOTING ENGAGEMENT IN
GENERAL HEALTH ISSUES?



Social marketing or “mass media” campaigns

- Reviews of research on social marketing campaigns, including online campaigns, suggest that they can influence people to change their behaviour and can also influence policy-makers.
- Shorter interventions (in terms of time) have been shown to have larger impacts on voluntary behaviour change.
- An important condition for the success of any campaign is that individuals must feel able to trust the information given.
- In Canada, an evaluation of TV advertisements showed that recipients were generally distrustful of the information if they perceived that it had been provided by the “government.
- However professionals such as doctors or celebrities were seen as more trustworthy.

eHealth interventions and social media.

A representative survey in Australia found that people preferred to receive eHealth information through the device that they were most familiar with.

There is likely to be a range of inter-relating factors affecting how eHealth interventions work, including design features, social support, peer pressure, and information sharing practices.

Little is understood about these factors or to what extent any changes observed are sustained, although simple interventions that are easy and quick to use appear to be more effective at changing behaviour.

Social media has the potential to increase engagement and enable debate and discussion, as well as create virtual social networks.

However, there may be unintended consequences and risks - generally, challenges include evaluation of social media based interventions in diverse communities with different concerns and uncertainties about how to design features to sustain engagement and behaviour change.

Intergroup
contact and
mental health
stigma: A
comparative
effectiveness
meta-analysis.
Maunder and
White (2019)

The World Health Organization (2013) has recognised the vital importance of reducing mental health stigma in its Comprehensive Mental Health Action Plan 2013-2020, but many organizations call for more research to inform anti-stigma campaigns (e.g., beyondblue, 2015).

Clinicians must also stay abreast of advances in this research area. Clinicians can contribute to mental health stigma through the stigmatizing treatment of their patients, but they have also been recognised as powerful agents for change (Schulze, 2007).

According to past reviews, establishing contact between participants and PMI is one of the most effective ways of reducing stigma.



Contact interventions have their theoretical roots in Allport's (1954) intergroup contact hypothesis, which states that positive interaction between members of different social groups (e.g., White people and Black people) can reduce prejudice and animosity between those groups.



In relation to mental health stigma, contact has been found to be more effective than protest strategies that shame individuals for holding stigmatizing views, and more effective than education strategies in which presenters contrast myths about PMI (e.g., violence) with factual information in order to reduce reliance on stereotypes (Corrigan et al., 2012; Thornicroft et al., 2016).



- There is evidence that **traditional contact interventions**, in which participants experience **direct, face-to-face** contact with a PMI, significantly reduce mental health stigma (Martinez-Hidalgo et al., 2018).
- Additionally, contemporary **indirect contact interventions** also appear to be effective. These latter interventions **include vicarious contact**, where participants observe another individual interacting with a PMI (West and Turner, 2014); **imagined contact**, where participants visualise themselves interacting with a PMI (Na and Chasteen, 2016); **contact via video**, in which participants view a PMI on film (Penn, Chamberlin, and Mueser, 2003); and **E-contact**, where participants converse with a PMI in an online chatroom.



- Another indirect form of contact, called **extended contact**, which reminds participants that they have a friend who is friends with a PMI, has also been found to be effective at reducing prejudice against other stigmatized groups (Wright et al., 1997) and could be effective at reducing mental health stigma.

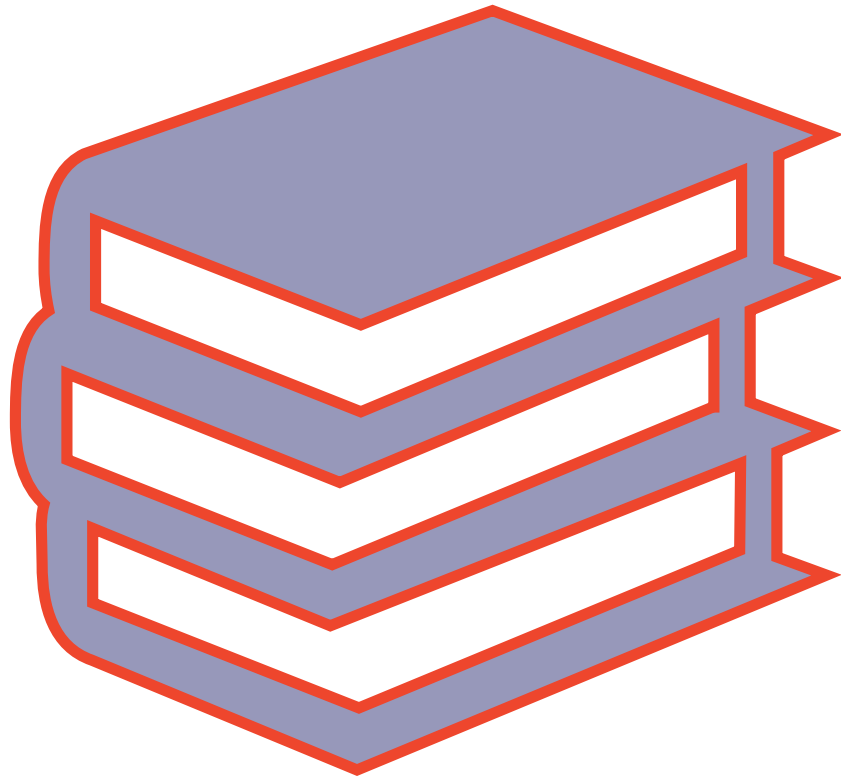
Contact-based education strategies



In contrast to these **pure contact** interventions, there are also **contact-based education** strategies which combine contact with education about mental health.



Contact-based education interventions provide participants with educational information about mental illness either during contact with a PMI (i.e., the PMI discusses their experience of mental illness) or before or after contact with a PMI (i.e., another individual provides educational information).



- Unlike education interventions which **explicitly correct pervasive myths** about PMI in order to reduce stigma, **contact-based education interventions educate participants** on the symptoms and treatment of mental illness as well as the impact of mental illness and stigma on life goals.
- **Contact-based education is also distinct from pure contact strategies, as the latter do not make mental illness the focus of the interaction between the participants and PMI.**
- However, **both** interventions **can be** delivered in **direct and indirect** formats. Contact-based education interventions have been found to be effective (O'Reilly, Bell, & Chen, 2010), but it is unclear whether the incorporation of educational information makes them more effective than pure contact strategies.

How stigma is measured

Other pertinent questions have also gone unanswered, such as whether contact improves stigma across **all stigma measures.**

Measures of stigma are typically categorised as being -

1. **cognitive**, referring to participants' beliefs, attitudes, and stereotypes about PMI;

2. **affective**, referring to participants' emotional responses towards PMI; or

3. **behavioural**, referring to participants' actions towards PMI.

However, due to the difficulty in measuring participants' **actual behaviour**, researchers often substitute this with measures of **behavioural intentions.**



- Previous meta-analyses have found some differences in the effectiveness of interventions on these different measures of stigma both when outcomes are measured immediately and in the long-term.
- For example, although Corrigan et al. (2012) found **contact to reduce stigma overall** (i.e., averaged across different measures), contact **did not** appear to significantly reduce **affective bias**, and the average effect size for behavioural intentions was smaller than that for attitudes. What does this mean?
- In contrast, Morgan et al. (2018) found the effect size for **social distance** to be larger than the effect size for **attitudes** for both pure contact interventions and contact-based education interventions. Again, what does this imply?
- Moreover, the cognitive, affective, and behavioural intentions outcomes identified above and included in previous meta-analyses all comprise explicit, self-report measures of stigma, in which participants indicate their responses on a questionnaire.



The problem with self-report measures...

- This is problematic for two reasons. First, explicit measures are vulnerable to biases, with individuals able to alter their responses to create a particular impression (e.g., being less stigmatizing; Teachman et al., 2006).
- This is not the case for implicit measures, which examine automatic associations between two categories which are not consciously held by individuals and thus less likely to be inaccurately reported (Neumann et al., 2004). Remember the IAT?
- Secondly, explicit and implicit measures appear to predict behaviour differently - explicit bias predict intentional behaviour while implicit bias predicts behaviour that occurs when individuals are not cognizant of the need to appear tolerant (Neumann et al., 2004).



- Another related question to consider is whether the effect of contact endures over time, and whether this differs between types of contact and stigma measures.
- The majority of researchers measure participants' mental health stigma immediately after the intervention, but organizations implementing these interventions likely intend for them to reduce stigma long-term.
- Mehta et al. (2015) found the effect of indirect contact on stigma to be significantly larger than that of face-to-face contact when outcomes were measured at least 1 month later.

So...in summary, interventions can be:

Contact based or
Educational

Direct contact or
Indirect contact

Short term or
Long term
focused

Measured on
Attitude
(Cognition)

Measured on
Emotions (Affect)

Measured on
Behaviour (Social
Distance)

Measured on
BEHAVIOURAL
INTENTION -
future intention

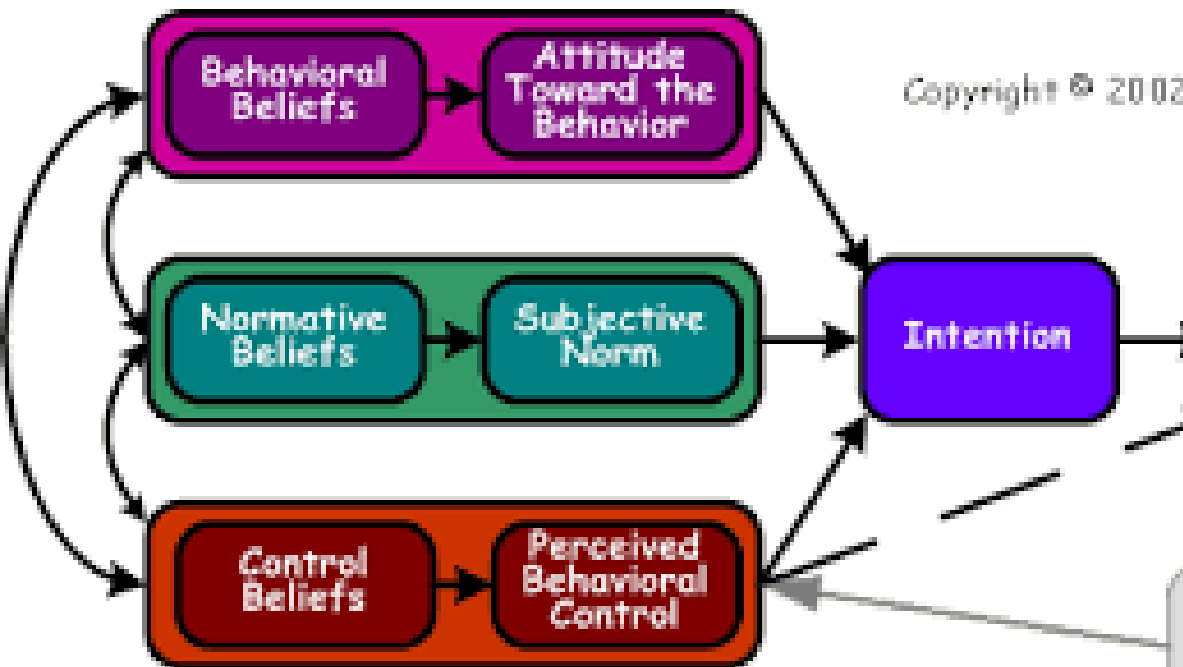
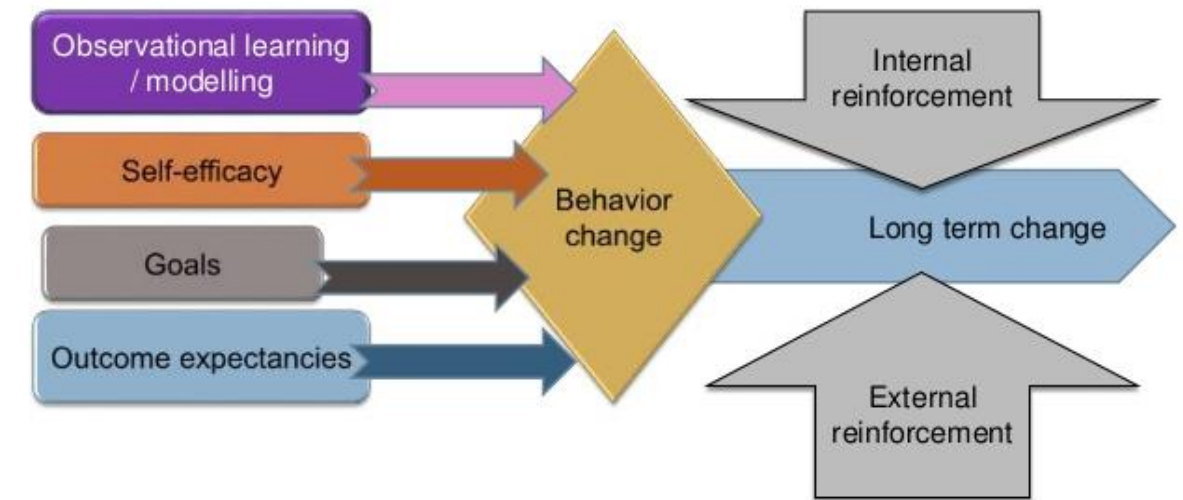
Measured
Explicitly (self-
report
questionnaires)

Measured
Implicitly (e.g.,
IAT test)

An overview: 7 main functions of Interventions

- **Mass health campaigns usually aim to do/have the following-**

1. Directly educate to bring about change or the adoption of new behaviours
2. Reach large audiences (heavily funded)
3. Use multi communicative approaches
4. Change awareness, attitudes, beliefs, actual or perceived social norms, improve self-efficacy to change behaviour
5. Government, professional or advocacy sponsored
6. Part of a broad social marketing campaign
7. Change public policy



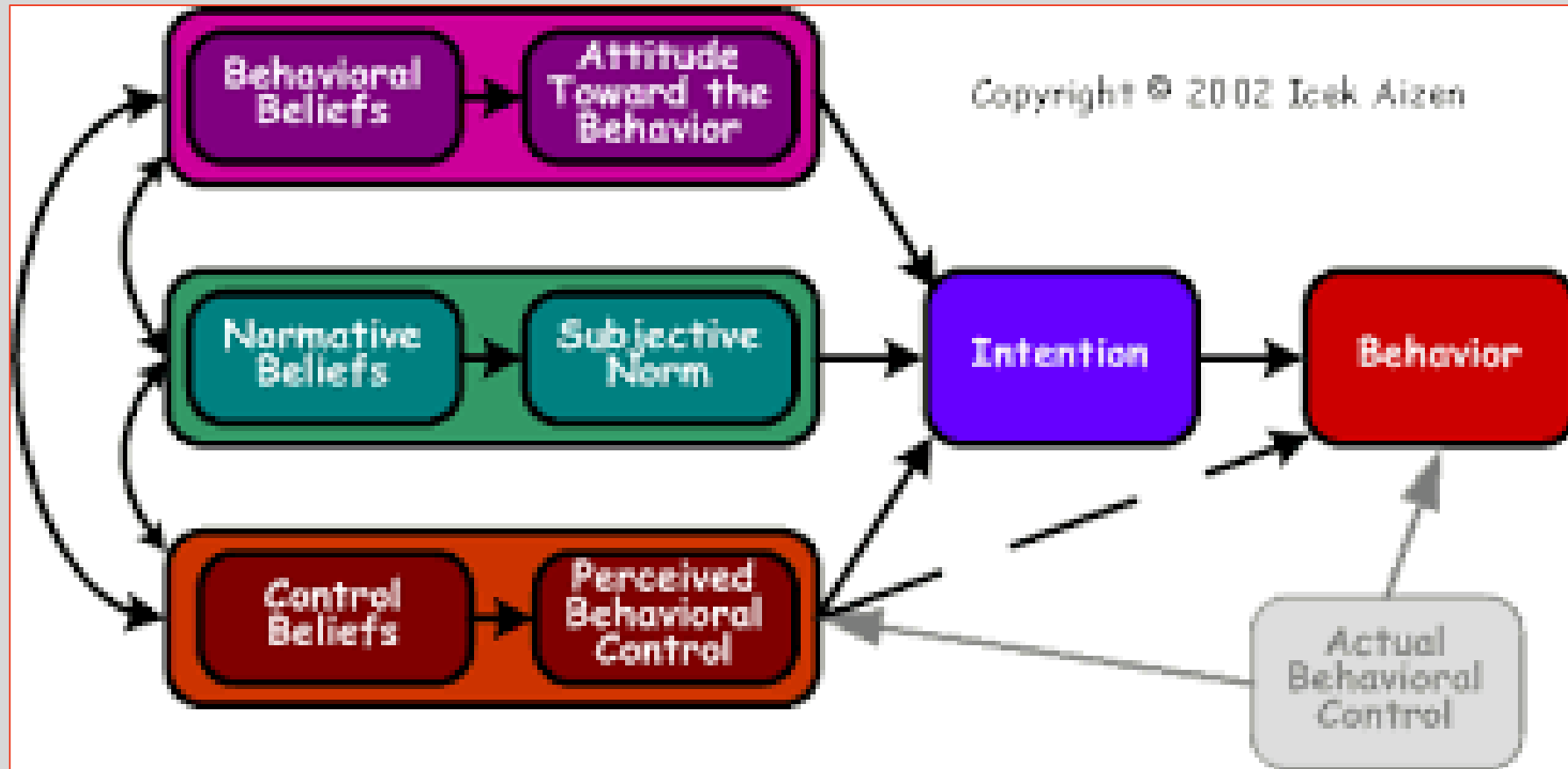
Role of Psychological theory

- The Theory of Planned Behaviour and the Theory of Reasoned Action – are behind changes in attitudinal beliefs, perceptions and social norms, as they propose that behavioural change comes from these.
- Self-efficacy is derived from Social Cognitive Theory, which states that people model their actions and self-efficacy from the observation of others.

Theory of Planned Behaviour/ Theory of Reasoned Action

- Deliberate processing of available information in the form of intention.
- Based on the concept that attitudes guide behaviour and the **intention to perform a particular** behaviour.
- The model also includes **perceived behavioural control** (PBC) which is taken as a **direct predictor of behaviour** and an indirect predictor of behaviour via intention.
- The other determinant of intention is **subjective norm** (SN). This relates to an individual's belief of how other persons think they should behave . This is a form of social pressure that individuals feel to perform or not perform an action/behaviour.
- The theory also allows for feedback loops from behaviour- i.e. unanticipated consequences or reactions can change beliefs, intentions or actions.

Theory of Planned Behaviour:





Objectives and expected outcomes

- For a successful campaign, there should be early agreement on the expected outcomes. There should be well defined objectives, communicated in a strategic manner to make this possible (Schiavo, 2007).
- Health campaigns aim to influence behaviour, but although this is the final goal, there are several stages recognised before an individual commits to new behaviour - it is essential that campaigns account for these stages in attitude, knowledge, social norms, perceptions of risk etc. It is important that these stages are part of the campaign objectives (Lederman et al., 2008).



Types of media

- The media selected should be the most effective way to reach the TA and offer the opportunity for individuals to notice and remember.
- Hornick (2002) argues that not enough emphasis is placed upon **HOW** the message is communicated and that this is crucial.
- You want to aim for **MAXIMUM SATURATION**.
- Whilst TV, radio, newspapers etc have been the traditional route, the emphasis is now on the internet and social media.
- The internet/social media is different for important reasons-

Effectiveness and evaluation



- According to Watson (2004), evaluation is the key to an effective campaign. Campaign evaluations have three main functions-
 1. To determine the degree of reached objectives.
 2. To help designers and researchers know how and why it worked (or didn't).
 3. Provide information to plan effective future campaigns (Valente, 2001).

Measuring behavioural change



- Salmon & Murray- Johnson, (2001):
- The time of measurement is crucial
- Why?
- Changing in social norms takes place at different rates dependent on campaign
- Also, what changes?
 - Knowledge
 - Attitude
 - Social norms
 - Behaviour