Literature Review: Effectiveness of Mental Health Awareness Campaigns

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Definition: The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 2016)." The Department of Mental Health and Substance Dependence in WHO, Geneva, has the goal of reducing the burden associated with mental and neurological disorders and to promote mental health worldwide.

Target Population: The general public in Bernalillo County. In addition to the general public demographic, campaign messages should be further tailored for young adults, older adults, adults who are homeless and their families, persons with serious mental illness, and persons with substance-use disorder. According to the U.S. Census Bureau 2015 population estimates, Bernalillo County has 676,685 people of which 22.7% (148,870) are persons under the age of eighteen. In 2015, according to a point-in-time count conducted by the New Mexico Coalition to End Homelessness, 1,287 individuals experienced homelessness in Albuquerque. According to New Mexico's Indicator-Based Information System (NM-IBIS) from the Department of Health, Bernalillo county-level Behavior Risk Factor Surveillance System (BRFSS) data collected between 2012 and 2014 showed that 18.2% of adults in New Mexico and 12% (national rate is 10.7%) of adults in Bernalillo County self-reported frequent mental distress (NM-IBIS, 2016). In contrast, 32.4% of youth (adolescents aged 12 to 17 years old) reported feelings of sadness or hopelessness; both risk factors for clinical depression (NM-IBIS, 2016). The National Institute on Drug Abuse (NIDA) reported that in 2010 New Mexico had the second highest drug overdose death rate in the nation (NIDA, 2013). The number of drug overdose deaths increased by 66.3% in Bernalillo County in 2011 over the previous year. Of the 521 drug overdose deaths statewide in 2011, nearly 40% occurred among Bernalillo County residents (NIDA, 2013).

Description: The purpose of a mental health awareness campaign is to increase the nature, magnitude, and treatment of mental health issues in the population by informing the public about the nature and treatment of mental disorders, which will facilitate early identification and treatment of such problems (WHO, 2004). The campaign would also aim to reduce the stigma attached to mental health problems that may cause further emotional and social distress or prevent an individual from seeking treatment. Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves (Thornicroft et al., 2015). Finally, these types of campaigns often seek to begin a dialogue between different stakeholder groups so people may begin to work together to promote mental health awareness.

Research Summary: This research summary focuses on information regarding the necessary components needed in order to facilitate an effective mental health awareness campaign. Evaluations of mental health and suicide-related educational campaigns are relatively rare and generally methodologically weak, which limits definitive conclusions. Recent reviews have concluded that suicide prevention and so-called "mental health literacy" campaigns can make short-term improvements in mental health and suicide related knowledge and attitudes, for example, increased recognition of depression. However, most studies show limited effects on behaviors when communications are used alone (Goldney et al., 2008). A review of different stigma reduction efforts used since the 1990s has shown how the field has evolved with research, and how different approaches have been taken, including an emphasis on communicating that, (1) mental illness is a disease like any other, (2) mental health is an integral part of our overall health, (3) mental illness is common, impacting large numbers of the general population, and (4) social inclusion is effective (Sczersputowski et al., 2013). A campaign driven by this type of approach shows people with mental illness as responsible, able to recover, and able to live productive lives. A proven theoretical base on which to build the campaign is essential to the most effective mental health awareness campaign (Kelly et al., 2007). The Suicide Intervention Project used the Theory of Planned Behavior Model, and the Compass Strategy employed the Transtheoretical/Stages of Change Model, the Health Belief Model, and the Diffusions of Innovation Model, which are all informed by the evidence-based "Precede-Proceed" Model (Kelly et al., 2007).

Other evaluation research of mental health awareness campaigns has shown that prominent sports figures or other popular role models have been successful in raising awareness and improving attitudes of youth and young adults towards mental health issues. Livingston et al., (2013) evaluated the effectiveness of the *In One Voice* campaign for raising mental health awareness and improving attitudes of youth and young adults towards mental health issues and found that those who were exposed to the campaign were significantly more likely to talk about and seek information relating to mental health issues. Training interventions targeted at specific youth have yielded some limited evidence of positive effects of stigma and discrimination reduction initiatives. For example, trainings targeting students have yielded some short-term positive changes in attitudes towards mental illness (Boysen and Vogel, 2008). Some studies also suggest that trainings aimed at police officers may reduce the use of force and unnecessary arrests and increase referrals to psychiatric facilities (Bower and Pettit, 2001). There are three types of stigma associated with mental health issues: Public or societal stigma, individual stigma, and institutional stigma (Tanielian and Jaycox, 2008). Public or societal stigma refers to public misconceptions towards individuals with psychological problems. Individual stigma results from a person's internalization of the public's negative perceptions, while institutional stigma occurs when policies regarding mental health unreasonably limit the opportunities of an individual (Tanielian and Jaycox, 2008). Together these types of stigma form a barrier to treatment. Sociological theories consider public stigma as a wider societal force affecting both the individual and society as a whole. Using labelling theory to describe how stigma is created, sociological theories are based fundamentally on the idea that interpersonal interactions are socially constructed, so that stigma is present when labelling, stereotyping, separation, status loss, and discrimination occur (Thornicroft et al., 2015). The behavioral consequences of stigma can compound the disabilities related to the primary symptoms of mental illness, and lead to disadvantages in many aspects of life, such as personal relationships, education, and work. Such discrimination can limit opportunities through, for example, loss of income, unemployment, reduced access to housing or health care (Thornicroft et al., 2015). The studies that assessed the short-term effectiveness of intervention in high-income countries had substantial methodological and clinical heterogeneity, which lead to meta-analysis' rarely being conducted. What the data from the studies show is that interventions are usually able to produce short-term to medium-term knowledge and, though less often, attitudinal improvements (Thornicroft et al., 2015).

The variation in results might be due to differences in the intensity of interventions that aim to increase knowledge compared with those campaigns that aim to change attitude, or might reflect the use of different methodological approaches. Despite the lack of agreement between studies, the most distinct consensus was from interventions with social contact or first person narratives were more effective than others (such as factual data about the occurrence of mental illness). Some interventions have the potential to cause harm such as an increase in stigma (e.g., using a biological explanation of the cause of the mental illness)(Holzinger et al.,2008). Most reviews of studies that have assessed the effectiveness of mental health awareness campaigns were critical of the methodological quality, which places an emphasis on the need for more randomized trials and robust methods, the use of invalidated measures, and the absence of follow-up beyond the immediate post-intervention period in many studies (Thornicroft et al., 2015). A meta-analysis of 79 intervention studies intended to reduce stigma among the general populous by Corrigan et al., (2012) showed that both education and social contact were effective in reducing stigmatizing attitudes and intended behavior. Corrigan et al., 2012 concluded that live contact was superior to filmed contact, and for adults, contact was more effective than education. In interventions efforts to reduce stigma for people with mental illness, there is evidence to suggest that such interventions are effective. Mittal et al., 2012 showed that of the 14 studies assessed, eight provided benefits in terms of self-stigma reduction, usually with small to moderate effect sizes. Most self-stigma reduction strategies consist of group-level psychoeducational sessions some of which might include cognitive-behavioral elements (Mittal et al., 2012).

Anti-stigma interventions for school and college students have been studied in several countries. These interventions have primarily involved either mental health education, or education combined with direct contact with someone who has a mental health problem (e.g., peer support worker). A systematic review of anti-stigma interventions for those at school, reported that overall the methodological quality of the studies is mixed, with only two randomized trials, leading one reviewer to find it difficult to draw overall conclusions (Schachter et al., 2008). Corrigan et al., 2012 showed that although direct contact was the most effective approach for adults, this was not the case for adolescents and education approaches were probably more

beneficial for this group. The mental health professionals that provide services with these various populations can be an important source of stigma and discrimination. Mental health professionals could be the ones that perpetrate stigma, recipients of stigma themselves, and also can be agents of de-stigmatization. Interventions to reduce stigmatization among health-care staff are uncommon (Thornicroft et al., 2015). With all of the work done to assess the effectiveness of mental health awareness campaigns, the most widely used intervention types tested as promising practices were education or information, and variants of social contact between people with and without mental illness (Corrigan et al., 2012). Results from the systematic reviews supported social contact as the most effective intervention for adults in short-term outcome studies, but is not consistently effective for those with longer-term follow up. At the general population level, there is a consistent pattern of short-term benefits for positive attitude change, and weaker evidence for knowledge improvement. For people with mental illness, some group-level anti-stigma campaigns show promise. For specific target groups, such as students, social contact based interventions usually achieve short-term attitudinal improvements and less often knowledge gains. There is a clear need for studies with longer-term follow up to assess whether initial gains are sustained or attenuated, and whether continuing or intermittent doses of the intervention are needed to maintain progress (Thornicroft et al., 2015).

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