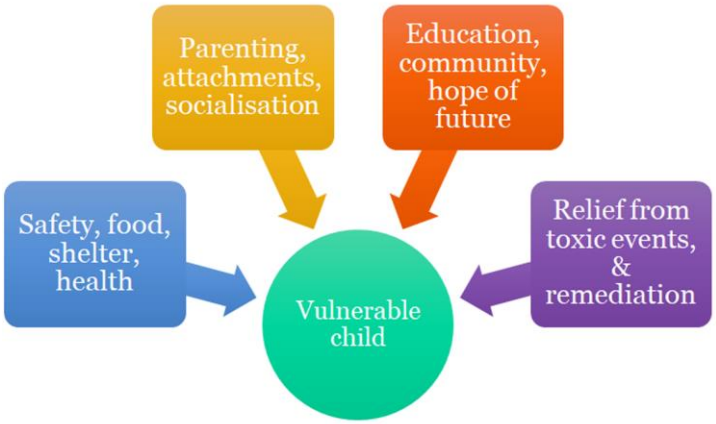
PROJECT EVIDENCE

PROJECT EVIDENCE for Prevention of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[1] Universal Programs. Universal programs are desirable because they have the potential to reduce the community prevalence of mental disorders whereas Selective and Targeted interventions only focus on small sub-populations. A discussion of this can be found in the 2018 Winston Rickards Memorial Oration. [Link] The Oration put forward the hierarchy a,b,c,d below, based on the World Health Organisation literature on Prevention of Mental Disorders.



These aspects of prevention form a kind of hierarchy of significance, somewhat similar to Maslow's *Hierarchy of Needs.* If you are in a war zone, unsafe, with no reliable food and water, no shelter and no support services, there is a high level of stress and not much else matters. Once those basic needs are met there is time to look at family functioning and parenting. Enhancement of attachment and pro-social behaviours then become feasible, paving the way for processes to reach one's potential and to respond to individual therapeutic interventions.

[1 d] Reduction of toxic factors: Introductory comments

This final section of the consideration of the hierarchy of causal factors and interventions looks at the identification and dealing with toxic events impacting on the mental health of children. The earlier sections (a, b and c) were predominantly about universal interventions based upon the World Health Organization literature on prevention of mental health disorders. This final section is more about risk factors that are mostly dealt with in sections below on selective or targeted preventions, but some factors are so widespread that universal programs are appropriate. It uses the approach described in the 2001 report of the USA Surgeon General on mental health. This referred to many biological factors, psychological factors and the interaction between these that we would refer to as social factors.

[1 d i] Biological factors

These include not only the genetic and chromosomal disorders but exogenous causes such as very low birth weight, poor nutrition, lead and similar poisonings, brain injuries from trauma and infections like measles, rubella, syphilis and HIV, and pre-natal toxicity such as foetal alcohol syndrome and effects of other drugs including cigarette smoke. Many of these are avoidable and preventive measures are included in general health and welfare.

Public Health universal measures to prevent these disorders include regulations regarding poisons, immunizations, food quality, and education regarding toxicities such as drugs and alcohol.

[1 d ii] The psychological and social factors

These are in two broad groups –

- dysfunctional family life with its attendant attachment difficulties, and
- stressful life events.

The dysfunctional family factors include discord, parenting deficiencies and antisocial conduct. Appraisal of family and child mental health is universally indicated for cases of maternal depressive disorders and other mental illness, domestic violence and parental substance abuse. Related preventive measures about these are included in earlier sections about promoting family functioning and pro-social behaviour. Additional public health measures include education such as Positive Parenting Programs and countervailing domestic violence.

Stressful life events such as natural disasters or witnessing of homicides warrant preventive interventions. The universal intervention is the formulation of a State Disaster Plan that includes training of responders and provision of response services in disaster situations. Selective and targeted services can then be directed as required.

Project Evidence [1d ii]

School-based programs for pro-social behaviour (anti-bullying) are also warranted universally. Selective and targeted services can then be directed as required.

Stigma is a stressful factor requiring universal interventions.

Stigma is a term originating with the ancient Greeks, denoting a visible mark placed or branded on members of tainted groups such as traitors or slaves. All members of society therefore knew instantly of the degraded status of the stigmatised individual. Currently the term has more of a psychological meaning, signalling an invisible, internal mark of shame related to membership in a castigated subgroup. The insidiousness of stigmatisation is that virtually all of the individual's attributes come to be interpreted in light of the mark or flaw. [1,2]

Human tendencies to form in-groups and to castigate out-groups are universal. In the case of the out-group of persons with mental illness this involves stereotyping all members as having undesirable characteristics, prejudging their acceptability, and discriminating against them by limiting their power and rights. Stigma also frequently results in the victim internalising the degradation and experiencing low self-esteem and despair. Pervasive social messages convey the negative attributes. Such imagery is learned at early ages, overlearned and automatic. However, some individuals have been able to overcome prejudice by self-control, understanding and empathy, giving hope that this can be achieved more widely in society.

The extent of stigma

The SANE Stigma Survey [3] conducted in 2004 asked consumers and carers to report on their experience of stigma in the previous two years. "Analysis of over 300 responses suggests that being treated unfairly and disrespectfully, by health professionals as well as the general community, is a regular occurrence for many Australians whose lives are affected by mental illness." 80% of respondents reported experiences of stigma, including 54% by the community and an alarmingly high 57% by health professionals. [3]

SANE Australia identified seven levels of discrimination against persons with mental illness, which form a useful framework for considering the extent of stigma and the points at which interventions might be directed. These are:

- **Political** Australians affected by mental illness are almost ignored by politicians. The crisis in mental health services is only rarely mentioned in Parliament.

- **Funding allocation** Less than 8% of the Australian health budget is spent on mental health whereas the OECD average is about 12%. The economic burden is high, with nearly a quarter of lost productive days being due to mental illness.

- **Planning and service delivery** Low priority is given to mental health services and limited availability results in rationing of treatments.

- **Professionals** Focus on acute crisis care often neglects rehabilitation and family support, sometimes being disrespectful and contributing to stigma.

- **Legislative** In disability discrimination legislation, vilification of people suffering mental illness is not unlawful in any State or Territory except Tasmania.

- **Media** Inaccurate and insulting stereotypes of violence and unpredictability are frequently portrayed in TV and news media for dramatic effect.

- **Community** Most, if not all, people affected by mental illness experience stigma in their day to day lives. This is the level requiring the most intensive intervention.

The Impact of Stigma

Barbara Hocking[4] (2003) reports more than forty negative consequences of stigma, including discrimination in housing, education and employment and increased feelings of hopelessness. This in turn means that people are reluctant to seek help, are less likely to co-operate with treatment and slower to recover self-esteem and confidence. This may be a contributor to suicidal behaviour.

The subjective suffering through stigma is rated as worse than the objective problems of families coping with mental illness. In addition, there is often a message of faulty parenting and blame from professionals which promotes secrecy and avoidance.[1] The person with mental illness is likely to go to great lengths to conceal the mental illness due to the perceived fear of others' reactions. Many relatives also fear others' disapproval and conceal family members' mental illness and hospitalisation.[6] Peter Byrne (2000) writes: "Secrecy acts as an obstacle to the presentation and treatment of mental illness at all stages. So, unlike physical illness, when social resources are mobilised, people with mental disorders are removed from potential supports. Poorer outcomes in chronic mental disorders are likely when patients' social networks are reduced."[7]

There is no doubt that stigma towards the mentally ill has severe consequences on their quality of life and treatment. The respondents to the *SANE Phone-In Survey* claimed that reducing stigma was the number one factor that would improve their lives.[5]

Steps to counteract stigma

There are a number of steps that can be taken to reduce the stigma suffered by people with mental disorders. These are predominantly educational, but also involve active monitoring and affirmative action. They can be summarised as:

- Improving the public understanding of mental disorders and reducing fear
- Improving public awareness of stigma causing harm
- Reducing the harassment of victims through hurtful comments
    - By media
    - By professionals
    - By the public
- Strengthening coping
- Improving access to helping services
- Improving the quality of services

The MHYFVic Stigma Initiative supports intervention at all six of these levels so that collectively the burden of stigma will be reduced.

Improving the public understanding of mental disorders and reducing fear is an essential step in changing the status from castigated out-group to assisted in-group. Public education programs have been shown to have a transient effect unless the message is maintained and given massive public authority support. Even well-funded campaigns, such as the ethnic diversity "We are Australians" program, have found considerable inertia before much change in public attitude. Nevertheless, increasing awareness is an essential prerequisite to change. Perhaps the most promising approach is in raising these issues with young people before attitudes are as fixed as in adulthood. The "Mind Matters" Program made available through the Education Department has three important components that directly counteract stigma. These are "Understanding mental illnesses", "Dealing with bullying and harassment" and "Enhancing resilience". MHYFVic advocates the participation of all Victorian school children in such programs.[8]

Improving public awareness of stigma causing harm is also a difficult task. The over-learned out-group rejections run directly counter to the empathic responses required for avoiding hurtful remarks and discrimination. Positive personal experience of relating to a victim may assist individuals to be more empathic but is not sufficiently widespread to influence general public attitudes. There is one significant area, however, where gains have been made. This is in the adoption of a journalists' code of practice in reporting stories with a mental health component.

The *Mindframe National Media Initiative* has produced extensive guidelines for media professionals. "The resource is designed to inform responsible and appropriate reporting of suicide and mental illness in order to reduce harm and copycat behaviour, and reduce the stigma experienced by people who experience mental illness".[9] Awareness of copycat suicides and other harm has led to an editorial policy of avoiding explicit descriptions and for including "where to get help" messages in articles. It has not, however, reduced the prurient interest of linking most incidents of bizarre behaviour with attributions of mental illness.

Reducing the harassment of victims through hurtful comments by media remains a challenge despite the journalist's code of practice. Complaints about drama programs constituted the great majority of reports relating to television: "The persistent presentation in these dramata of people affected by mental illness as violent, frightening or ludicrous is especially concerning, as young people especially derive so many of their attitudes and day-to-day information about the world from watching television." The most important mechanism to reinforce adherence to the code is by active monitoring and feedback. SANE StigmaWatch offers such a program. When examples occur of negative or inappropriate stereotyping, the program contacts the media and the journalist involved to make them aware of the potentially harmful consequences of their story. They report that on many occasions the media acknowledge the transgression with an apologetic explanation that they had not been aware of the hazard. StigmaWatch reports, however, that the incidence of such reporting does not appear to have diminished greatly, and there is still a long way to go.[4]

Possibly the most troubling of the quoted statistics is the high prevalence of hurtful comments that have originated from mental health professionals, whom one would have thought would be the most sensitive to patients' feelings. Whether this finding is due to misguided attempts at reality-testing or lack of awareness of the effect or some other cause is not yet known, although it is a topic that invites further research. On the assumption that mental health professionals would wish to reduce the impact of stigma on their clients, a self-testing, education and self-monitoring program is being undertaken with mental health professional groups, based on the fourteen questions raised by Peter Byrne.[7] (See Appendix One in 'Best Practice Model')

The reduction of hurtful comments by members of the public remains the most difficult of the tasks. A campaign of the first *National Mental Health Strategy, The Australian National Community Awareness Program* (CAP) was developed to increase community awareness regarding all mental illnesses through a national advertising campaign.

CAP was followed by some increase in awareness and improved attitudes to mental health disorders suggesting that the campaign was effective. Unfortunately, there was only a slight increase in the awareness of helping services and there was no clear evidence of behaviour change towards people with mental illness. CAP also had no practical impact on community attitudes towards people with mental illness.[10] Overseas there have been a number of similar campaigns to change attitudes to mental illness. In 1996, the *World Psychiatric Association* embarked on an *International Programme to Fight the Stigma and Discrimination because of Schizophrenia* which has been given the name *Open the Doors*. The program has extensive programme materials and is being implemented in a number of countries including Australia.[11]

Huge anti-smoking public education campaigns have shown modest impact when sustained for prolonged periods. Smaller scale campaigns such as those sponsored by the Commonwealth Government against domestic violence and sexual assault have shown only marginal changes in manifested public behaviour despite widespread awareness of the information. Nevertheless, awareness is a crucial element in creating the public climate of unacceptability of abuse and bullying. Another necessary element is the confrontation of perpetrators with the unacceptability of their behaviour. For victims who are not necessarily very articulate and who may already be experiencing lowered self-esteem and feelings of inferiority this is a feared task. There are also concerns about safety in such confrontations. However, the preparedness and skills to make such responses are part of the general issue of strengthening individual coping with stigma.

Studies indicate that cognitive-behavioural therapy is effective in assisting people to cope with demeaning comments. Alongside therapeutic approaches to assist in coping with positive and negative symptoms of the mental disorder, it is reasonable to expect that there should be components assisting with strengthening capacity to cope with stigma. A major element of this is empowerment of the individual to assert himself or herself appropriately in social situations. This should be part of any effective mental health therapeutic process.

Despite evidence of the usefulness of these measures it is clear that constraints on mental health funding mean that many clients do not receive such help. Improving access to helping services remains one of the most important ways of reducing the severity of impact of stigma. Improving the quality of services to ensure the availability of appropriate cognitive-behavioural or equivalent treatments is a related goal.

MHYFVic Stigma Initiative

MHYFVic advocates a three-pronged approach to dealing with stigma – educating the public, reforming the media, and strengthening the resilience of victims.

The educational approach should involve the whole public, especially young people. Discussions have been initiated with the Commonwealth Department of Health and Ageing to extend the periodic public information TV broadcasts in the Community Awareness Program. Discussions have also been initiated with the Victorian Department of Education and Training advocating that all children at school participate in the 'Mind Matters' program, rather than leaving it to the discretion of individual schools.

Further, discussions have been initiated with organizations of professionals involved in delivery of mental health services aimed at enhancing their sensitivity to the impact of stigma on their clients and encouraging a more active involvement in countering stigma. This new educational approach is based on the fourteen questions in Appendix One which have the potential to significantly modify the practice of the professionals.

MHYFVic advocates continuing support and extension of media reform through the SANE StigmaWatch program.

Strengthening the resilience of victims through interventions such as cognitive-behavioural therapy is a natural corollary of improved sensitivity of mental health professionals to the nature of stigma, and improvements in their practice by incorporation of specific treatment plans.

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