REDUCTION OF MENTAL HEALTH RELATED STIGMA AND DISCRIMINATION:

GLOBAL OVERVIEW

DECEMBER 2024

THE WORLD BANK
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Ministry of Health and Welfare

National Center for Mental Health

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Acronyms

BNBR	Basic Needs Basic Rights
BTL	Beyond the Label
CAMI	Community Attitudes on Mental Illness Scale
CBM	Christian Blindness Mission
CCBC	Collaborative Community-Based Care
CINAHL	Cumulative Index to Nursing and Allied Health
DISC	Discrimination and Stigma Scale
ERIC	Education Resources Information Center
FCDO	Foreign, Commonwealth and Development Office
FGD	Focus Group Discussion
GKT	Gatekeeper Training
IOPPN	Institute of Psychiatry, Psychology and Neuroscience
KCL	King's College London
LMIC	Low- and Middle-Income Country
MAKS	Mental Health Knowledge Scale
MATES	Mates in Construction Programme
MH	Mental Health
MHFA	Mental Health First Aid
NCSS	National Council of Social Service
NGO	Nongovernmental Organization
NIMH CZ	National Institute of Mental Health, Czechia
OMS-HC	Opening Minds Stigma Scale for Health Care Providers
PMHC	People with Mental Health Conditions
RIBS	Reported and Intended Behaviour Scale
R2MR	Road to Mental Readiness
SROI	Social Return On Investment
SSCI	Social Science Citation Index
TLC3	Targeted, Local, Credible, Continuous Contact
TTC	Time to Change
TTCG	Time to Change Global
TIM	The Inquiring Mind
TWM	The Working Mind
WHO	World Health Organization

Acknowledgements

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The authors would like to thank all the contributors to the country case studies, including Shreya Rao and Shaquille Graham (Nōku te Ao, New Zealand), Micheal Pietrus (Working Minds programme/Opening Minds, Canada), Robert O'Leary and Genesis Lindstrom (batyr, Australia), Sosei Yamaguchi, Daisuke Nishi, Naoaki Kuroda, Ai Aoki (Mental Health Supporter Training Programme, Japan), Carol Liang, Odile Thiang and Candice Powell (More Than A Label, Hong Kong), Elaine Loo, Pooja Nair and Li San Tan (Beyond the Label, Singapore).

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The report was edited and formatted by Priya Thomas and Susi Victor.

This work was funded by the Ministry of Economics and Finance and reviewed by the Ministry of Health and Welfare, Republic of Korea. This work would not have been possible with the support of the World Bank Group Korea Office.

1. EXECUTIVE SUMMARY

Stigma and discrimination contravene basic human rights and have detrimental effects on people with mental health conditions by exacerbating marginalization and social exclusion—including by reducing access to mental and physical health care and diminishing educational and employment opportunities. The stigma and discrimination surrounding mental health have negative consequences for social exclusion in relation to education, the workplace, and the community, as well as for marital prospects, loss of property, inheritance, or rights to vote, and poor quality health care for mental and physical health conditions. Stigma powerfully and adversely affects individuals, families, communities, and society, and exists across all countries and cultures. A recent global survey of people with mental health conditions across 45 countries found that 80 percent agreed that "stigma and discrimination can be worse that the impact of the mental health condition itself."

The overall objective of this policy note, prepared jointly by the World Bank Group and Korean National Center for Mental Health, is to summarize global evidence for effective interventions to reduce mental health-related stigma and discrimination. The first section of this report defines stigma and discrimination, describes the adverse impact on the lives of people with mental health conditions, and summarizes results of a narrative literature review of the evidence base for interventions addressing mental illness-related stigma and discrimination. This report involved a synthesis of over 260 systematic reviews on stigma reduction and presents a detailed summary of the global evidence on how to reduce stigma and discrimination (building on earlier findings of the Lancet Commission on Ending Stigma and Discrimination in Mental Health). This review examined evidence regarding intervention impacts and summarizes key findings. Notably, this global review indicates that interventions based on the principle of social contact (whether in person, virtual, or indirect), that have been appropriately adapted to different contexts and cultures, are the most effective ways to reduce stigmatization worldwide.

Global experience, over the past 25 years, demonstrates that it is feasible to scale up anti-stigma programs to the national level to effectively reduce stigma and discrimination in large-scale populations. Consequently, the second section of this report focuses on examining implementation experiences of delivering anti-stigma and discrimination programs and includes case studies that have developed effective and evidence-based initiatives. These case studies were selected purposively to enable representation of different types of anti-stigma and anti-discrimination interventions, across a range of geographical/cultural contexts and diverse target groups.

These purposively selected case studies summarize how programs were designed, implemented, evaluated, and scaled up. The case studies demonstrate how evidence-based principles for anti-stigma interventions can be adapted and put into effective practice in a range of countries and contexts and cultures across the world. Although stigma and discrimination still seem to be one of the most neglected aspects of mental health, as these case studies show, in some countries there had been a significant shift with the transformation of mental health policy leading to the welcome transition of services from institution-based care to community-based care and support. However, the need to educate communities and transform attitudes, to create more supportive and inclusive communities and ultimately support recovery beyond the provision of treatment of symptoms, is often overlooked.

The COVID-19 era has increased awareness of the need for programs that challenge mental health stigma and support earlier help-seeking and self-care. As highlighted in this analysis, most of the case study programs have adapted global evidence-based methods—with many positive impacts reported and much learning to share. Some key components include social contact, lived experience champions/ambassadors to share their mental health experiences at social contact events and online, social marketing campaigns, targeted programs with health care professionals, employers, schools,

universities and youth audiences, and the media. Specific lessons derived from the case studies include the following:

- Social contact should be implemented with contextual and cultural adaptation to each setting. Social contact can be effective either delivered directly (in person) or indirectly (using remote, digital, and online methods). Additionally, the evidence for social contact implies that the direct involvement of people with lived experience of mental health conditions, in co-leading the program design, delivery, and evaluation, is necessary.
- Long-term programs are necessary for sustainable stigma reduction.
- Impact can be assessed by evaluating the program, by establishing a baseline assessment before the program starts, followed by periodic assessments of progress to stigma reduction.
- Reducing stigma can lead to increased help-seeking by people with mental health conditions.
- Better access to care for people with mental health conditions is expected to lead to shorter duration of symptoms and disability, greater educational attainment, lower suicide rates, less presenteeism and absenteeism in the workplace, and greater productivity for people whose mental health conditions have been treated early and well.

This briefing paper proposes the following specific recommendations:

1. Plans must be created to fund, implement, and evaluate long-term programs to reduce mental health stigma and discrimination.
2. The central component of these plans is to use the evidence-based active ingredient of social contact for stigma reduction.
3. People with a full range of mental health conditions, including more severe conditions, need to actively contribute to these plans by co-leading the design, delivery, and evaluation of the programs.
4. Specific key target audiences and outcomes need to be identified at the outset of each program.
5. The programs must operate with widespread cross-sectoral support and participation, for example with the industry, sports, music, television, film, health care, and educational sectors.

A detailed evaluation of impacts and outcomes must be conducted for each program and compared with an initial baseline assessment of key metrics.

2. THE IMPORTANCE OF STIGMA AND DISCRIMINATION IN MENTAL HEALTH

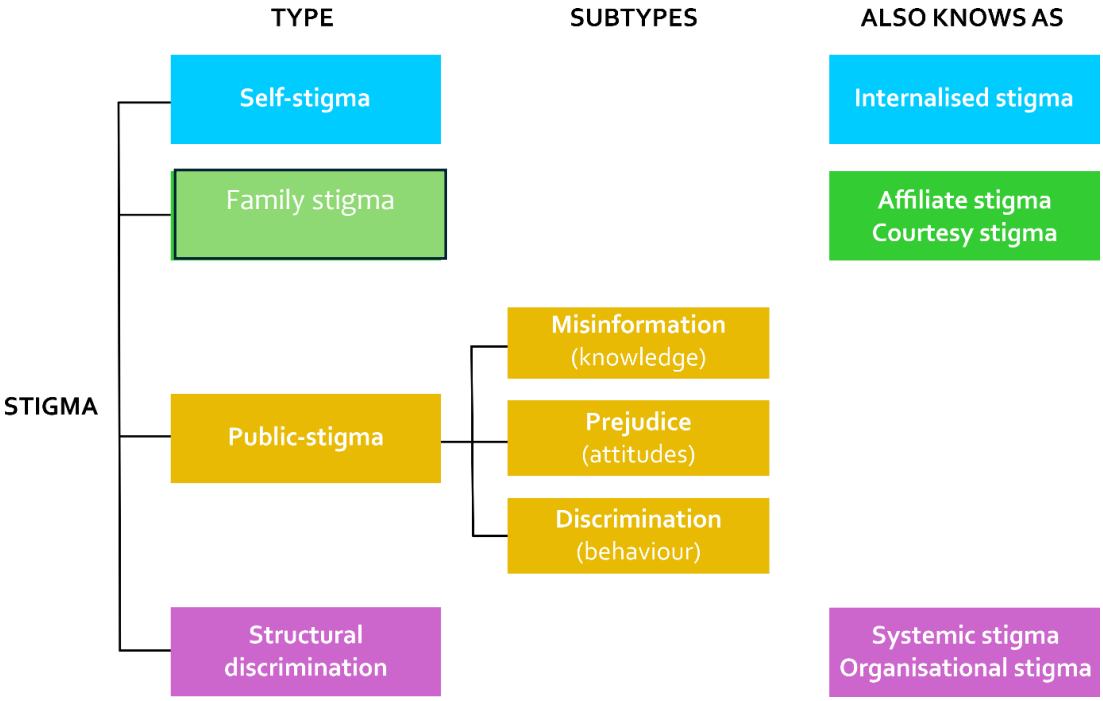
The stigma and discrimination with regard to mental health have negative consequences for social exclusion in relation to marital prospects, education, the workplace, and the community; loss of property, inheritance, or rights to vote; and poor-quality health care for mental and for physical health conditions. Stigma powerfully and adversely affects individuals, families, communities, and society, and exists across all countries and cultures. These pernicious barriers to full citizenship and social participation share one fundamental characteristic—they contravene basic human rights which are intended to apply equally to everyone. Indeed, a recent global survey of 391 people with mental health conditions from 45 countries worldwide found that 80 percent agreed that "stigma and discrimination can be worse that the impact of the mental health condition itself" (Thornicroft et al. 2022).

This World Bank policy note is structured as follows. First, the terms 'stigma' and 'discrimination' are defined. The next section describes how stigma and discrimination adversely affect the lives of people with mental health conditions—a more detailed account was published in The Lancet Commission on Ending Stigma and Discrimination in Mental Health (Thornicroft et al. 2022). A detailed summary of the global evidence on how to reduce stigma and discrimination is presented here, which summarizes and updates the evidence synthesis of the Lancet Commission. It would be useful to read this report in close conjunction with the Lancet Commission report. We have considered practical case study examples that demonstrate how these evidence-based principles for anti-stigma interventions can be adapted and put into practice in a range of countries, contexts, and cultures across the world. This briefing note closes with a series of recommendations which are intended for discussion and elaboration in terms of their relevance and applicability in different contexts.

3. DEFINING STIGMA AND DISCRIMINATION

Stigma and discrimination can be defined in terms of four components, as shown in Figure 1. The term stigma stems from ancient Greek and originally referred to a tattoo, which was used to visibly mark slaves or criminals as members of society with a diminished value (Thornicroft et al. 2022). In the social sciences, the term stigma was elaborated in the second half of the twentieth century by Goffman (1963), who defined stigma as a 'deeply discrediting' attribute which reduces a person "from a whole and usual person to a tainted discounted one." A separation is therefore created between 'us' and 'them', based on the belief that the labelled people are fundamentally different from, and of lower value than, other people. Discrimination is the unfair treatment of a person or a group of people because of a particular characteristic, such as people who have lived experience of mental health conditions. The stigmatization of people with mental health conditions needs to be considered within the broader frameworks of justice, social equity, and human rights.

Figure 1. Types of stigma



3.1. Public stigma

Public stigma has three components: knowledge, attitudes, and behaviors. The knowledge component usually refers to a lack of knowledge in populations about mental health conditions (ignorance) and to misinformation that is often found in popular discourse and is part of local beliefs. Such misconceptions include, for example, beliefs about the dangerousness or incompetence of people with mental health conditions, or the belief that such conditions cannot be treated, or are due to a curse (Corrigan et al. 2003). Attitudes refer almost entirely to the negative emotional reactions of people in the general population toward people with mental health conditions, such as fear or disgust. Behavior refers to the rejection and social exclusion of people with mental health conditions, namely discrimination (Pescosolido et al. 2013; Thornicroft, Rose, and Kassam 2007).

3.2. Self-stigma

Self-stigma, or internalized stigma, occurs when people with mental health conditions are aware of the negative stereotypes of others, agree with them, and turn them inwards against themselves. The internalization of negative beliefs can lead to diminished self-esteem and self-efficacy, and a 'why

try' effect. This occurs when people with mental health conditions give up important life goals, such as seeking a job or engaging in friendships, because they feel they will not be able to succeed (Corrigan and Watson 2006).

3.3. Family stigma

Family stigma is also known as 'stigma by association', 'courtesy stigma', or 'affiliate stigma'. This refers to stigma and discrimination as experienced by family members, as well as mental health staff, that is, people who are in close contact with people with mental health conditions. Such stigma seems to depend on the type of condition. If a mental health condition is considered hereditary, or due to karma, this can incur loss of face and greater stigma (Mak and Cheung 2012). Similarly, conditions that are believed to adversely affect marital prospects can also damage the reputation of family members of people with mental health conditions (Shi et al. 2019). It is also common for staff working in physical health care settings to have negative attitudes toward staff who work in mental health settings, which are seen as less prestigious, for example, within the field of medicine.

3.4. Structural stigma

Structural stigma (also called systemic or institutional stigma) refers to policies and practices that work to the disadvantage of people with mental health conditions. Structural stigma has been defined as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized" (Hatzenbuehler and Link 2014). Stigma is often seen as a barrier to policy change. It can play out in a lack of public demand for governmental action and investment and in misinformation, misunderstanding and lack of awareness of positive policy options among policy makers. Further examples of structural stigma include the fact that people with mental health conditions commonly experience restrictions in employment, voting, property ownership, marriage, and divorce (Thornicroft 2006). Another aspect of structural stigma relates to low levels of financial and human resources, since fewer resources are allocated to research and treatment for mental health than for physical conditions (Chisholm et al. 2019). An important consequence of structural stigma is that worldwide, most people with mental health conditions do not receive treatment. For depression and anxiety, for example, this treatment gap is estimated to be about 95 percent in low-income countries, 90 percent in middle-income countries, and 70–80 percent in high-income countries (Thornicroft et al. 2017). In addition, people with mental health conditions have less access to health care in general, and receive poorer quality of services, which leads to a 10-year mortality gap for all people with mental health conditions, and a 20-year mortality gap for people with severe mental health conditions (Walker, McGee, and Druss 2015).

4. EVIDENCE ON HOW TO REDUCE MENTAL HEALTH STIGMA AND DISCRIMINATION

4.1. Methods

We conducted a review of systematic reviews of interventions intended to reduce stigma. We searched seven databases (PsycInfo, Medline, EMBASE, Cumulative Index to Nursing and Allied Health (CINAHL), Education Resources Information Center [ERIC], Global Health, Social Science Citation Index [SSCI]) for English language literature reviews. Searches were run on December 12 and 15, 2021, for the Lancet Commission on Ending Stigma and Discrimination in Mental Health (Thornicroft et al. 2022) and updated on April 14 and 16, 2024 (all databases except SSCI). The search included four concepts: stigma and discrimination, interventions, review, and mental health conditions. Individual search strategies including specific subject headings were developed for each database. This review therefore includes and updates the Lancet Commission umbrella review.

Any review (systematic, meta-analysis, scoping, rapid, umbrella, or narrative) was eligible for inclusion. Reviews were included if they appraised qualitative or quantitative findings of interventions which aimed to reduce stigma in relation to a mental health condition. All countries and age groups were included. Interventions were included if a stigma or stigma-related outcome (for example, attitudes, beliefs, knowledge, mental health literacy, social inclusion) was either the primary or secondary outcome. The umbrella review was registered with Prospero, registration number CRD42022299682. The searches yielded 21,180 entries. After removing 9,526 duplicates, 11,654 titles or abstracts were screened. Irrelevant studies (n = 11,151) were excluded, and 503 full texts were assessed for eligibility. A total of 267 reviews were included, not all of which are cited due to some being of lower quality as well as overlap in the included studies, and hence the conclusions drawn. Here we summarize the findings for structural, interpersonal, and self-stigma.

4.2. Structural stigma

4.2.1 Policies

A few reviews targeted policies. Identified studies investigated the impact of various professional and public initiatives to reduce stigma and discrimination against people with depression in Slovenia (Valic, Knifton, and Svab 2013) and case studies on dismantling mental health and substance use related structural stigma in Canadian health care settings (Sukhera and Knaak 2022). The included studies found positive outcomes from reducing structural stigma through policies; however, the quality of many studies was low. Policies aiming to establish respect toward people with mental health conditions and stipulating their rights on their own fall short in effectively reducing discrimination.

More effective policies, legislation, and plans were often linked with community-based treatment, programs for public education, and media activities including participation of ‘champions’ with lived experience of mental health conditions and changing power relationships to allow shared understanding of the problem and alignment of values. The Canadian exemplars showed promise in improving access, health quality, and outcomes related to reduced coercion, and policy and practice change. This required managing resistance proactively, embracing disruptive innovation, and fostering trust through dialogue. Several national programs against stigma and discrimination in Asia were found to reduce experienced and anticipated stigma among people with mental health conditions and to facilitate help-seeking and engagement with mental health care, yet no data were available on whether they had actually increased access to mental health care. The potential impact of policy interventions targeting structural stigma is high, however, more research is needed on their cultural sensitivity, effectiveness, and cost-effectiveness.

In some East Asian countries, using a different term for schizophrenia was used as a strategy to reduce public stigma. There is some evidence that after the name change more people with schizophrenia were informed about their diagnosis (Yamaguchi et al. 2017). However, there is no evidence for positive effects on public attitudes or media reporting (Corrigan 2018). It is likely to be helpful if diagnostic terms which cause offense are revised with the involvement of people who have been given these diagnoses. Effective efforts to address structural stigma at the policy level have also included national mental health plans and policies and anti-discrimination laws to protect the rights and interests of people with mental health conditions in care, at work, and in wider society. Coalitions of stakeholders, often led by nongovernmental organizations (NGOs), mental health associations, and mental health professionals, with the participation of empowered people with lived experience, have played key roles in advocating for these changes. Descriptive studies have, for example, reviewed mental health parity with health policies in Commonwealth countries (Bhugra et al. 2018), and legislative mechanisms for social participation rights of people with depression in the Asia Pacific region (Ricci, Lee, and Chiu 2004). However, evaluations of the effect of such policies on people's lives, knowledge, attitudes, and behaviors have not been carried out. Potential future policy interventions include policies to make it mandatory for insurance companies to cover mental health conditions and not to exclude people from purchasing medical insurance (Zhang et al. 2019).

4.2.2 Access to care

We included seven reviews that stated how the intervention addressed stigma as a barrier to access or focused on knowledge, attitudes, or behaviors toward help-seeking to increase access. Four focused on high-income countries (Arundell et al. 2020; Joshi et al. 2021; Rosvik et al. 2020; Werlen et al. 2019) and three had no limitations (Greene, Bina, and Gum 2016; Choi and Easterlin 2018; Xu et al. 2018). Three focused on any mental health condition (Arundell et al. 2020; Greene, Bina, and Gum 2016; Xu et al. 2018), two on children and adolescents (Choi and Easterlin 2018; Werlen et al. 2019), one on people with dementia or suspected dementia (Rosvik et al. 2020 22), and one on pregnant women using opioids (Joshi et al. 2021). Greene, Bina, and Gum (2016) found that psychoeducation was the most used strategy to increase continuity of care for adults with mental health conditions in outpatient services. The interventions empowered service users by involving them in decision-making about appointments and follow-up schedules, while seeking information about their mental health condition and identifying treatment goals. The positive effect size increased with the number of specific treatment targets.

Xu et al. (2018) identified 97 studies on interventions to increase help-seeking behaviors across populations with and without mental health conditions, of which three were in middle-income countries and none in a low-income country. Some used psychoeducation or cognitive-behavioral strategies to enhance motivation to seek help. The results showed positive short-term effects on attitudes, intentions, and behaviors to seek help, and positive long-term effects on help-seeking behavior. They also found long-term positive effects of collaborative care training for primary care or community-care staff on mental health service use among individuals in primary care settings. Joshi et al. (2021) found that training health care providers to share non-stigmatizing messages with pregnant women who used opioids increased acceptability of services and access. Rosvik et al. (2020) concluded that increasing awareness of community services improved their uptake among people with dementia and their caregivers, but that there was a knowledge gap on which interventions had the most impact.

Arundell et al. (2020) used a review to identify strategies addressing stigma-related barriers to care: increasing inclusivity in programs for individuals with disabilities (for example, hearing aids, Braille, sign language); providing audiovisual displays and diagrams for people with low literacy or communication problems; using culturally relevant tools for individuals from minoritized groups; co-creating interventions with communities; training staff in communicating more effectively with marginalized communities such as migrants; or using positive language in educational materials. Choi and Easterlin (2018) reviewed interventions designed to improve access to behavioral health services

among young people in the US, concluding that while there is evidence that discussions between older adolescents and nurses or counsellors can be effective, for younger children it was essential to educate parents. A review focusing on children and adolescents (Werlen et al. 2019) identified 13 studies on universal school-based interventions and 21 studies on at-risk individuals. Most (80 percent) studies on treatment engagement for individuals at risk (for example, a family-based session to increase motivation in an emergency room) improved access. They concluded that two-stage interventions to identify people in need and then engage them in health care are necessary for a population-level effect on improving children's access to mental health care.

4.2.3 Access to work and employment

We found four reviews on interventions to increase access to work by reducing structural level stigma. One included a meta-analysis which suggested that training managers to understand and support the mental health needs of employees is effective in improving mental health related knowledge, non-stigmatizing attitudes, and self-reported supportive behavior (Gayed et al. 2018). The other reviews provided narrative syntheses of the results. An earlier review by Szeto and Dobson (2010) found no evaluation data; likewise, a review of the cost-effectiveness of initiatives to reduce stigma in the workplace found no eligible studies (Nogues and Finucan 2018). The authors pointed out that future researchers could make a clearer business case for stigma interventions by showing how stigma prevents employees from participating in employer-sponsored programs and by testing the cost efficiency of interventions involving manager training and anti-stigma components. A review by Mallick and Islam (2022) focused on partnerships between adult community mental health teams and disability employment services for people with severe mental illness in Australia. Their findings suggest that individual placement and support is an effective employment model, yet it is vital to address barriers hindering its expansion and implementation and the obstacles for individuals to participate in it.

Interventions which aim to reduce interpersonal stigma in the workplace and improve mental health knowledge, confidence in offering help, and attitudes toward seeking help, notably Mental Health First Aid (MHFA) have been evaluated (Hanisch et al. 2016; Ramirez-Vielma et al. 2023; Roche et al. 2024; Toth et al. 2023). One review focused on small and medium enterprises (Toth et al. 2023) and another on male-dominated industries (for example, construction, mining) (Roche et al. 2024). These interventions reflected multimodal programs with education components, occasional contact strategies, and digital delivery. They were generally effective for mental health literacy and help-seeking intentions and attitudes. There was less evidence for help-offering and help-seeking behaviors and mental health stigma (Ramirez-Vielma et al. 2023). Further, as Szeto and Dobson (2010) observed, this type of intervention should be evaluated using employers' data: provision of workplace accommodations; staff sickness rates; and levels of employment of people who disclose a mental health condition in response to equal opportunities monitoring questionnaires. Also, interventions could be improved through use of logic models and the theory underpinning their content (Roche et al. 2024).

Reviews of studies on interventions to support people to gain work cover intellectual disability (Nevala et al. 2019), autism (Khalifa et al. 2020), severe mental illnesses (Kinoshita et al. 2013), and other mental health conditions (Probyn et al. 2021). Most measure change at the individual level, although vocational workers can also work with employers with potential for structural change. There is a knowledge gap for interventions addressing structural stigma in low- and middle-income countries (LMICs), where formal employment is less frequent. In particular, there is a lack of evidence on how to address the systematic exclusion of people with mental health conditions from community development programs, livelihood opportunities, or microfinance schemes. Such programs are fully in line with the key theme of the United Nations Sustainable Development Goals to 'Leave no-one behind' (UN 2015).

4.3. Public stigma

4.3.1. Children, adolescents, youth, and students

A total of 55 reviews covered children, adolescents, teachers, parents, and university students (excluding health care students). Most targeted mental health conditions in general or suicide, while five covered autism, four covered developmental or intellectual disabilities, and one each covered addiction and schizophrenia specifically. Stigma and discrimination were addressed as primary outcomes in 23 of these, aiming to reduce negative attitudes, social distance, or peer victimization, or enhance social inclusion of peers affected by mental health conditions. Stigma was addressed through (a) education via lectures, texts, or internet-based programs; (b) interactive elements such as group discussions; or (c) contact with people with lived experience, either directly or indirectly via videos or the internet.

Gaiha et al. (2021) focused on arts interventions (for example, theatre, creative writing) to reduce mental health related stigma among 10–24-year-old youth. Overall, the results indicated positive effects for the use of art to address stigma related to mental health conditions among youth, although the study quality ranged from weak to moderate. A meta-analysis showed that arts interventions are generally effective when using multiple art forms, although the effects were small. Rodríguez-Rivas et al. (2022) examined technology-based interventions (for example, video games, audiovisual simulation of hallucinations, virtual reality, and electronic contact with mental health services users) to reduce stigma among high-school and university students. Their meta-analysis demonstrated that these interventions had a consistent medium effect on reducing the level of public stigma.

Ten systematic reviews with stigma as a primary outcome focused on young people with developmental disabilities, such as intellectual disabilities or autism spectrum disorders. One review concluded that the highest quality studies more often showed the interventions assessed to be effective (Morris, O'Reilly, and Nayyar 2023). Sentenac et al. (2012) identified a study that showed reduced peer victimization after an average of 25 weeks of involvement in a program using social contact to bring peers with and without disabilities together for shared activities in school and community settings. Kim et al. (2024) reviewed interventions to reduce stigma toward autistic people, which frequently involved digital delivery, based largely on educational elements with some studies also including first-person accounts or direct interactions with people with autism. Both randomized controlled trials (RCTs) and non-randomized studies suggested reductions in stigma; however, caution is needed in interpretation due to limitations in study design. Similarly, Settanni, Kern, and Blasko (2023) reviewed studies with educational and contact elements and found that, overall, the interventions had a positive impact on attitudes toward people with autism.

Several reviews indicate that direct social contact with children with disabilities can lead to improved attitudes among peers if such meetings are structured (Louw, Kirkpatrick, and Leader 2020; McManus, Saucier, and Reid 2021; Sentenac et al. 2012) **and if children, of equal status, with and without disabilities are involved** (Sentenac et al. 2012). Combining multiple strategies (for example, Birnschein, Paisley, and Tomeny 2021; Cremin et al. 2021; McManus, Saucier, and Reid 2021; Morris, O'Reilly, and Nayyar 2023; Sentenac et al. 2012) and providing different types of information (that is, descriptive, explanatory, directive) is more effective than a single strategy (Birnschein, Paisley, and Tomeny 2021; Cremin et al. 2021). Allowing children to actively engage in the intervention and giving them strategies to interact with peers with mental health conditions seems the most promising approach (Birnschein, Paisley, and Tomeny 2021; McManus, Saucier, and Reid 2021). Most of these studies were carried out in schools, but a more recent review (Louw, Kirkpatrick, and Leader 2020) found a variety of interventions to enhance social inclusion within the community, such as photovoice, dog-walking, peer support, or participation in sports. Another review noted that recent interventions frequently utilized online platforms (Kim et al. 2024). Improving the social skills of children affected with mental health conditions led to better social inclusion, possibly because these children behaved

in a more socially accepted manner (Cremin et al. 2021; Louw, Kirkpatrick, and Leader 2020). For future studies, it would be important to differentiate changes in children's social skills and in stigma among their peers.

Although there are some promising results regarding behavioral outcomes, most studies focused on knowledge and attitudes. One qualitative study included in Morris, O'Reilly, and Nayyar (2023) found that a theme of difference ('us' versus 'them') emerged post intervention, which requires further investigation. Two reviews conclude that findings for intended behavior are more varied, and how far children's actual behavior can be predicted from self-reported behavioral intentions is not clear (Cremin et al. 2021; Morris, O'Reilly, and Nayyar 2023). Stigma was included as a secondary outcome in 25 reviews which primarily focused on interventions which aimed to increase help-seeking among children, adolescents, and youth. They also aimed to support parents, teachers, or peers with gatekeeper training (GKT) on how to recognize signs of mental health conditions, how to intervene, and where to refer children, adolescents, or youth to ensure that they received adequate support and care. Positive attitudes toward mental health conditions and confidence in providing support were identified as important outcomes.

Turning to interventions for schoolteachers, Anderson et al. (2019) reviewed eight studies about providing information about the signs and symptoms associated with common adolescent mental health problems. They found positive results at follow-up. Costardi et al. (2023) reviewed digital mental health interventions (for example, brief online simulations, web-based information or programs, online courses). These interventions showed promising results in enhancing mental health knowledge, preparedness, confidence, and attitudes, indicating their potential for improving mental health literacy.

In relation to suicide, a systematic review summarized interventions among students and staff at high schools and universities (Breet et al. 2021). The findings indicated that universal interventions were effective in changing attitudes at post intervention with a small effect size, but none of the assessed interventions showed sustained changes at follow-up. For interventions that focused on stigma, results showed that psychoeducation and interpersonal contact had sustained positive impact at one-month follow-up. One intervention resulted in significant and sustained improvements in participants' attitudes toward suicide. In addition, an 'electronic bridge' mental health service, including personalized feedback and online counselling, significantly decreased personal stigma scores with a large effect and reduced public stigma among high-risk college students with a medium effect. For teachers, Torok et al. (2019) found that none of the included studies reported specific effects for measures of attitudes toward suicide, while one study found that parental attitudes improved, but that this effect was not maintained later.

Regarding mental health prevention and mental health literacy programs, the results are more mixed. In a meta-analysis, Salazar de Pablo et al. (2020) found a small effect for changes in attitudes toward people with mental health conditions across 16 studies with youth of different ages. Liang et al. (2023) conducted a meta-analysis of MHFA among college students (ages 19–27 years), showing no significant effect on stigma-related attitudes across four studies. Ng et al. (2021) conducted a review of studies of MHFA among teenagers and youth. Among teens, three of four studies that measured stigmatizing attitudes found a statistically significant improvement. For youth MHFA, six studies measured stigmatizing attitudes, four of which reported significant effects.

Reis et al. (2022) examined mental health literacy training programs other than MHFA. They included five studies that met the minimum quality standards in their narrative review. Three measured attitudes, beliefs, norms, and stigma of university students regarding mental health. Results from all three reported some positive impacts of mental health literacy training on these constructs, but the evidence was weak. Amado-Rodríguez et al. (2022) and Nazari et al. (2023) reported that mental health literacy interventions were effective in improving mental health knowledge, but not in reducing stigma

or improving help-seeking behavior. Ma, Burn, and Anderson (2023) concluded that although there is moderate evidence suggesting that school-based mental health interventions can be effective in improving mental health literacy and reducing mental health stigma, there is less evidence for long-term effectiveness. Mills et al. (2023) conducted a meta-analysis of mental health literacy interventions in young people and concluded that there was a medium to large effect size of intervention effectiveness. However, inconsistencies in methodological rigor and reporting need to be addressed, and a more nuanced understanding of effectiveness is needed (for example, teacher versus professional-led interventions or the impact of frequency, duration, and follow-up times).

Tam et al. (2024) reviewed mental health awareness campaigns conducted via media and videos on a range of platforms (for example, social media, websites/apps, television, billboards, newspaper ads). Most studies reported positive changes in the attitudes, beliefs, and intentions of young people (for example, reduced stigma) and positive changes in behaviors (for example, increased help-seeking behaviors), with only two showing no significant effects. Future work should extend campaigns to diverse populations and specific mental health concerns, consider cross-cultural validity and cultural competency, ensure audience involvement in development, and tailor interventions to specific platforms. With regard to intervention components, a comprehensive systematic mapping review of interventions with adolescents ages 12–18 found that a combination of education and social contact led to better outcomes than education alone (Patafio et al. 2021). At the same time, effects were higher for education-only interventions if they were delivered in internet and community settings. However, there was a limited number of such interventions, so the results should be interpreted with caution. A review of digital video interventions tested among youth ages 15–25 years found that videos produced better outcomes than lectures or no intervention (Ito-Jaeger et al. 2022). In two of the three studies comparing the digital video interventions to direct contact, no difference was found in attitudes toward people with mental health conditions.

Among reviews on young people, LMICs are underrepresented. Hartog et al. (2020) focused on interventions to reduce stigma related to a diversity of health conditions, such as HIV, mental health, leprosy, in LMICs. This review aimed to identify studies targeting children and adolescents, but most included studies target adults given the available literature. The stigma reduction strategies applied most often were community education, followed by individual empowerment of people with lived experience, and social contact within the community, and outcomes were mostly positive.

4.3.2 Family members

Nine reviews focused on reducing stigma among family members. A GKT intervention for family and friends of people at risk of suicide (Morton et al. 2021) found positive effects on knowledge, self-efficacy, and gatekeeper-related skills, but the results for stigma and attitudes were inconsistent. Two studies focused on children and youth in families affected by parental mental health conditions. Davies et al. (2022) found that information about hereditary risks of mental health conditions was considered important so that young people do not feel that the conditions experienced by their parents are inevitable for them. Riebschleger et al. (2017) showed that psychoeducation led to decreased stigma and improved family communication about parental mental health conditions. One review reported on mental health literacy interventions among parents, with a focus on mental health conditions that increase in prevalence during adolescence (Kusaka et al. 2022). The review reported significant improvements in mental health knowledge and confidence and/or knowledge in helping children with mental health problems, but no studies found a significant reduction in stigma and/or intention/behavior of helping.

Four studies focused on reducing negative attitudes and discriminatory behaviors from family members toward people with a mental health condition. One review identified two original studies that used psychoeducation to reduce stigma within the family in China and Korea (Armijo et al. 2013). Two other reviews concluded that psychoeducation potentially enables caregivers to cope better with

their family members' mental health condition and reduce stigma (Monnapula-Mazabane and Petersen 2023; Soo et al. 2018). Six reviews showed that disclosure and sharing within families reduced mental health stigma (Adu et al. 2021). Social networking with other families was another strategy which led to stigma reduction. A study in rural China by Ran et al. (2022) reported that an enhanced social contact model was a promising method for reducing stigma among family members. One review focused on increasing empathy among informal caregivers of people with dementia through virtual reality-based simulation interventions (Huang et al. 2024). The qualitative results showed that informal caregivers gained better insight into problems encountered by persons with dementia, but the quantitative evidence was inconsistent.

4.3.3 Health care professionals and students

Sixty-eight reviews have been published since 1994 on stigma among health care staff and students. These focused on pre-qualifying stigma reduction programs for trainees, such as nursing and medical students, and in-service programs for qualified staff. More recent reviews have covered community pharmacy staff and students (Crespo-Gonzalez et al. 2023) and physiotherapy professionals and students (Hooblaul, Nadasan, and Oladapo 2023), reflecting the recognition that stigma reduction is important to the provision of good quality care by all professionals. Most (n= 37) addressed mental health conditions generally, eleven focused exclusively on people with dementia (for example, Gkioka et al. 2020; Mulyani, Probosuseno, and Nurjannah 2021), eight on substance use disorders (for example, Bielenberg et al. 2021), five on personality disorders, three on borderline personality disorders (for example , Dicken, Hallett, and Lamont 2016), five on suicidality and self-harm (for example, Saunders et al. 2012), two on intellectual disabilities, one on neurodevelopmental disorders, and one each on psychosis and eating disorders.

The stigma-related outcomes included changes in knowledge, attitudes, and clinical skills, as well as clinical confidence and self-efficacy (for example, Ferguson et al. 2018; Maynard 2020). Over time, more studies are using measures of stigma tailored to this target group (Stubbs 2014; van Brakel et al. 2019). Six meta-analyses reported small to medium effect sizes in improved attitudes, a range in effects on knowledge from negligible to large, and medium to large effect sizes in clinical skills (Kolodziej and Johnson 1996; Lien et al. 2021; Petkari et al. 2018; Piot et al. 2020, 2022; Wong et al. 2024). The evidence base for substance use disorder stigma reduction is weaker; one review found that while 12 of 15 studies showed the intervention was associated with statistically small reductions, most studies had a moderate to high risk of bias (Wong et al. 2024). Similarly, a recent review on intellectual disability found only ten studies, out of which only two of these focused on attitudinal change (Hay et al. 2024).

A consistent finding is that interventions for health care professionals are more effective when tailored to the professionals' clinical setting and training requirements, for example, by covering specific diagnoses or providing tailor-made contact interventions (Cheung, Chan, and Cheng 2023). Another is that the evidence for improving attitudes is greater for students in clinical settings with patients with less severe conditions who demonstrated recovery (Heim et al. 2019). Two reviews recommend that interventions should be repeated regularly to sustain changes over time (Bte Abd Malik, Kannusamy, and Klanin-Yobas 2012; Wong et al. 2024). Many reviews recommend including people with lived experience in the design and evaluation of stigma interventions in addition to providing contact through live or filmed recovery testimonials, but not all have consistently done so (Brunero, Jeon, and Foster 2012; Classen et al. 2021). Studies reporting multiple kinds of contact (live or filmed) were more often associated with better outcomes on stigma-related knowledge and attitudes than were educational interventions alone (Lien et al. 2021) or interventions with only one form of contact (Knaak, Modgill, and Patten 2014). Two reviews focused on e-interventions for professionals with both reporting improved knowledge and attitudes, more humane treatment of service users, and reduced use of coercive methods (Muirhead et al. 2021; Zubala et al. 2019). Fully online interventions are effective at stigma reduction when they are multi-component including

educational tutorials, case-based instruction, and practice-based learning (Muirhead et al. 2021). Internet-based anti-stigma campaigns have also been reported to reduce stigmatizing attitudes among health care staff (Carrara et al. 2021).

The use of digital interventions and simulations, for example, 'serious games' or standardized role plays with actors or virtual patients, has increased in part due to COVID-19 pandemic restrictions. In all the studies reviewed, there was a noted benefit of simulations and serious games on stigma reduction (Adewuyi, Morales, and Lindsey 2022; Carrara et al. 2021; Goh, Ow Yong, and Tam 2021; Piot et al. 2020; Rikke Amalie Agergaard, Peter, and Kamilla 2024). A meta-analysis showed a small to medium effect size on learners' attitudes, and a large effect size on clinical skills at immediate follow-up for simulation interventions, as well as sustained benefits three months later (Piot et al. 2020). A different review reported that staff empathy improved with the narratives of students' personal experiences, exposure to other individuals with lived experience, and reflective sessions, but did not improve from simulations, suggesting that for students' direct contact and practice-based components are necessary for more positive effects on stigma reduction (Smyth, Wilson and Searby 2021). Similarly, the authors of a review on virtual reality interventions for health care and other students recommended that while these have potential, they should not be used in isolation and instead be combined with direct contact and education (Szekely et al. 2023).

Among students, all interventions targeting dementia showed positive effects in levels of comfort when working with such patients (Alushi, Hammond, and Wood 2015). Evidence suggests that face-to-face experiential learning is more effective than simulated and virtual experiential learning; however, these two approaches have not been directly compared (Adewuyi, Morales, and Lindsey 2022). Interventions were more likely to have positive results if the practice-based experience was preceded by preparatory education. Direct contact without preparation led to feelings of intimidation and inhibition on interacting with people with dementia.

For these health care staff and student interventions, the included studies were of variable quality (Brunero, Jeon, and Foster 2012), **and few studies have long-term follow-up or reports of clinical behavioral change** (Bielenberg et al. 2021; Lien et al. 2021, see also, Brunero, Jeon, and Foster 2012; Gkioka et al. 2020). Few such studies were conducted in LMICs (Caulfield et al. 2019; Keynejad, Spagnolo, and Thornicroft 2021; Liu et al. 2016), with China being the most frequently represented middle-income country (Bielenberg et al. 2021; Lien et al 2021; for example, Hiem et al. 2018, 2019; Piot et al. 2020). It is clear from many studies that greater emphasis is needed for long-term collaborations between LMICs and high-income countries (HICs) for pooling resources and data (Keynejad, Spagnolo, and Thornicroft 2021), assessment of the sustainability of impacts or effectiveness (Carrara et al. 2021), and more cultural adaptations of the anti-stigma programs (Keynejad, Spagnolo, and Thornicroft 2021; Raj 2022). A further key challenge is that not all studies have used well-adapted and validated outcome measures for stigma and discrimination, particularly in LMIC settings (Brohan et al. 2010; Caulfield et al. 2019; Heim et al. 2018; Liu et al. 2016; Magnan et al. 2024; Thornicroft et al. 2019). Researchers recommend more mixed methods with qualitative components (Brunero, Jeon, and Foster 2012). Cost-effectiveness was also a common research gap (Brunero, Jeon, and Foster 2012; Gkioka et al. 2020; Keynejad, Spagnolo, and Thornicroft 2021), as were meta-analyses (Brunero, Jeon, and Foster 2012; Gkioka et al. 2020).

4.3.4 General population

Twelve reviews focused on interventions to reduce stigma in the general population, while another three included general population samples in reviews of specific interventions or delivery methods. Corrigan et al. (2012) examined education, social contact, and protest as strategies. Both social contact and education improved attitudes and behavioral intentions, but social contact resulted in significantly greater positive change among adults. In contrast, education yielded a larger effect than contact among children and adolescents. In this review, effect sizes were significantly greater after in-person

contact than after video contact. Two recent reviews have focused on digital interventions. One review on technology-based interventions (online or online plus other modalities) to increase help-seeking found that among those that measured stigma, the majority showed positive outcomes (Johnson, Sanghvi, and Mehrotra 2022). The other covered augmented and virtual reality, ranging from virtual interactions with characters and environments to experiencing perceptual or sensory disturbances related to mental illnesses (Tay, Xie, and Sim 2023). The majority of the studies observed enhancements in knowledge, attitudes, empathy (all studies), and reduced stigma. However, none of the included studies in either review used face-to-face interventions as a control; the results are therefore most applicable to groups and settings in which face-to-face contact is not feasible.

Borschmann et al. (2014) evaluated anti-stigma campaigns in 21 European countries. Studies with an evaluation component either found little evidence of significant general stigma reduction effects or variations across different sub-populations. Dumesnil and Verger (2009) examined public awareness campaigns about depression and suicide, which included short media campaigns, GKT programs, and longer programs involving repeated exposures. Their review of 43 studies, showed that public awareness and information programs about suicide or depression improved knowledge and, with only two exceptions, attitudes. Improvements were modest and most often only measured at short term. Two reviews from Australia focused on suicide prevention, one among people living outside of metropolitan areas (rural and regional populations) (Dabkowski et al. 2022) and one reviewing a program for workers in the construction industry which has also been used in other male-dominated industries such as coal mining and the energy sector (Gullestrup et al. 2023). The first of these reviews (Dabkowski et al. 2022) found little evidence for a reduction in suicide stigma although there were other positive outcomes such as reduced use of alcohol and drugs and greater suicide literacy. The authors caution that not all programs reached their intended audience due to an overrepresentation of women. In contrast, the Mates in Construction Programme (MATES) targets men through male-dominated workplaces (Gullestrup et al. 2023). While the authors found some evidence for positive impacts on mental health stigma, they emphasized the need for higher causal inference studies and more emphasis on longer-term outcomes. In other reviews, the authors found that the concurrent use of several strategies, such as distribution of educational material, a media campaign, and training of gatekeepers and health care professionals appeared to be more effective than education alone.

Clement et al. (2013) examined the effect of mass-media interventions in the general population and its constituent groups, such as students or employers. Across sixteen studies, five assessed discrimination—of these, one found evidence on reduced discrimination, which was not replicated in two larger similar studies. In a meta-analysis, small to medium size reductions in prejudicial attitudes were found for up to six to nine months follow-up. The clearest pattern of evidence emerged for first-person narratives of people with lived experience and interventions with two or more components, which had greater effects than those with one only.

The impact on MHFA trainee behavior and the outcomes of this behavior were the focus of a review that found nine studies examining these outcomes (Forthal et al. 2022). Only three found an increase in use of MHFA skills and none identified an impact on recipients or potential recipients of trainees' helping behavior. Some studies were underpowered and suffered from attrition; the authors made design recommendations and emphasized the need for rigorous evaluations of MHFA, particularly in LMICs where MHFA research is lacking.

Makhmud, Thornicroft, and Gronholm (2022) reviewed studies of indirect social contact interventions in LMICs—of the nine studies from Africa, Asia, and Russia, eight reported positive outcomes covering knowledge, attitudes, and intended behavior. The authors identified a smaller range of media and intervention types as compared to those used in HICs, the need for more information on the interventions, a lack of information on long-term outcomes, and the need for evidence from a wider range of countries especially low-income countries. The evidence on anti-stigma interventions in the general population in China was summarized by Xu et al. (2017a). Their results showed a small and

significant effect on the reduction of negative stereotypes, and that interventions which included social contact were more effective than those which did not. They found no strong evidence that using biological attributions for the cause of mental health conditions improved mental health literacy or reduced prejudice and recommended integrating cultural factors into anti-stigma interventions and measures. Similarly, Mascayano et al. (2020) found that only 20 percent of anti-stigma interventions in LMICs had addressed cultural adaptation, concluding that more careful cultural adaptation is required.

In their review of stigma-reduction programs among African Americans, Rivera et al. (2021) concluded that such programs need to be culturally informed and tailored to African Americans. They highlighted the importance of collaboration between mental health providers and faith-based institutions due to mistrust of the medical sector. Scior (2011) reviewed the effect of contact with people with intellectual disabilities, for example in schools or via the Paralympics. As in other reviews, there were limitations such as small unrepresentative samples and cross-sectional designs. However, it appeared that positive contact could reduce desire for social distance, while negative contact experiences could do the opposite.

'Dementia-friendly communities' (Hung et al. 2021) have inclusive environmental designs, that is, adaptations to support use of services such as churches and shops. The reviewers found that active involvement of people with dementia provided a sense of value and autonomy. A qualitative study on an intergenerational choir, for example, found that young adults' involvement reduced their stigma. Hung et al. (2021) also highlighted the need to consider diversity of people with dementia in such communities. The importance of intergenerational contact was echoed in a review by Gerritzen et al. (2020). The use of mainstream recreational facilities (Fenton et al. 2017) to foster social connections, for example, physical or creative activities increased self-esteem and self-confidence and gave people with dementia a sense of accomplishment.

4.3.5 Other target groups

Breslin et al. (2022) assessed knowledge-based mental health programs in sport settings (for athletes, coaches, officials, and parents). They reported mixed stigma reduction outcomes, but improvements in mental health knowledge, confidence to help/refer for help, and intentions to seek help. Oostermeijer et al. (2023) reviewed training targeting correctional staff (probation, parole, and custodial officers). Most interventions were educational, with one including contact-based elements, and a meta-analysis of six studies found a small positive effect on stigmatizing attitudes. Future work should include more contact-based approaches and higher-quality trials. Huggins et al. (2022) assessed improving dementia knowledge through educational interventions among racial/ethnic minority groups (mainly in the US, UK, and Australia). Intervention delivery varied from workshops in faith communities to technology (for example, YouTube videos). Many studies reported improvements in knowledge and attitudes, but the overall study methodology was of low quality. Two reviews considered outcomes besides self-stigma of interventions for people living with mental health conditions. Tian et al. (2024) reported that online mental health literacy interventions improved mental health knowledge, attitudes, and self-care skills. In contrast, Jardine, Bowman, and Doherty (2022) examined digital interventions to enhance readiness for psychological therapy, found mixed results, and recommended further qualitative, naturalistic, and longitudinal research.

4.4. Specific intervention components

4.4.1 Advocacy and continuum beliefs

Advocacy, and self-advocacy, promote the rights of people with mental health conditions. Methods such as distributing printed materials have been used (Perez-Flores and Cabassa 2021). Findings were mixed for stigma outcomes, with some studies showing reduced stigma toward mental health treatments, beliefs about dangerousness, and social distance, while others have reported no reduction

in stigma toward people who take antidepressants (Perez-Flores and Cabassa 2021). Regarding advocacy programs, one review indicated that its effectiveness in reducing stigma was unknown (Pirkis et al. 2021). Public relations campaigns have been shown to result in stigma reduction for people with depression (Seroalo et al. 2014). One review (Peter et al. 2021) reported that promoting continuum beliefs, that is, that there is a continuum between mental health and mental health conditions (rather than a dichotomous approach), gave mixed results and a few studies even showed increased stigma.

4.4.2. Collaborative Community-Based Care (CCBC)

This is defined as any intervention provided by informal community care providers and only implemented in the community, and includes psychoeducation and rehabilitation strategies to improve personal, social, and vocational functioning and links to self-help groups (also known as social networking) and social and financial support (Nguyen et al. 2019). CCBC resulted in greater disclosure by families about their family member's mental health conditions to other people, which was associated with an improvement in their family's knowledge of schizophrenia and increased social inclusion for people with mental health conditions. It did not, however, reduce the experience of stigma in the people with schizophrenia. Social and financial assistance increased as a result of social inclusion (Nguyen et al. 2019). Community-based mental health care was described as less stigmatizing than hospital care. Social networking led to the normalization of people with mental health conditions (Adu et al. 2021). The use of support networks decreased negative attitudes toward suicide (Takada and Shima 2010).

4.4.3. Gatekeeper training

Gatekeeper training (GKT) discusses attitudes and provides knowledge and skills to help gatekeepers (who have direct contact with people at risk of suicide, self-harm, or mental health conditions) better inquire about and recognize the risk for mental health conditions or suicide and to intervene appropriately. Among groups such as students, teachers, social workers, pharmacists, managers, and carers for elderly people, it has been shown to improve knowledge about suicide and suicide prevention and reduce myths about suicide immediately post intervention (Holmes et al. 2021). However, these effects were not sustained 1–12 months later as was also found for GKT with children, adolescents, and teachers (see section 4.3.1).

4.4.4. Protest

Protest is a campaign-based approach designed so that a morally unacceptable perspective about a minority group is shown, followed by a reprimand against these practices. They also involve condemnation of media representations of mental illness and societal reaction in general (Griffiths et al. 2014). A review by Griffiths et al. (2014) found that protest campaigns targeting all mental health conditions significantly reduces personal stigma but not internalized stigma or perceived stigma; those targeting a specific mental disorder were more effective in reducing all types of stigma. Another review (Ashton, Gordon, and Reeves 2018) found that protest interventions reduce stigma, but the long-term impact is not clear. Two other reviews (Morgan, Wright, and Reavley 2021; Stuart 2016) concluded that the outcomes of protest campaigns in reducing stigma are unknown.

4.4.5. Psychoeducation

This provides information for family members or the public about mental health conditions, including risk factors, prevalence, symptoms, diagnosis, and care, and includes addressing misconceptions and myths. It can be provided face-to-face, through social media, theatre, or workshops. Overall, internet delivery was found to be at least as effective in reducing personal stigma as face-to-face delivery (Griffiths et al. 2014). It is debatable how far educational interventions lead to behavior change. The effect of awareness on help-seeking attitudes and behaviors is inconsistent (Bu et al. 2020; Castaldelli-Maia et al. 2019). One review indicated that psychoeducation for caregivers had

no significant effect on attitudes, empathy, or positive aspects of caregiving compared to controls (Han 2020). However, interventions that included communication strategies may facilitate self-confidence in caregivers, and improved understanding of the needs of the person with a mental health condition (Bacsu et al. 2021; Knaak, Modgill, and Patten 2014). Police officers, teachers, and other public sector workers showed positive changes in behavior on one MHFA review (Booth et al. 2017). However, a meta-analysis of 18 trials with nearly 6,000 participants found minimal positive effects in MHFA course participants' attitudes (Morgan, Ross and Reavley 2018).

4.4.6. Social contact

Social contact (sometimes called 'contact' or 'interpersonal contact') takes place when there is positive, cooperative interaction between people with lived experience of a mental health condition and a particular target group. Such contact can be direct contact (face-to-face and in-person), or indirect (for example, simulated, video, online, social media, or observed). The types of positive social contact which are likely to be most effective for stigma reduction are characterized by some key factors (Al Ramiah and Hewstone 2013; Knaak, Modgill, and Patten 2014). Contact was found to have consistently positive effects on stigmatizing attitudes, perceived stigma in help-seeking, social distancing (Ashton, Gordon, and Reeves 2018; Clay et al. 2020; Corrigan, Larson, and Michaels 2015; Corrigan, Michaels, and Morris 2015; Doley et al. 2017; Griffiths et al. 2014; Maunder and White 2019; Morgan et al. 2018; Peter et al. 2021; Schreiber and Mc Enany 2015), social interaction, fear (Zhang et al. 2019), discrimination (Schreiber and Mc Enany 2015), and coercive behavioral intentions (Corrigan, Michaels, and Morris 2015). At the population level (Thornicroft et al. 2016) and for specific groups such as students, contact-based interventions usually achieve attitudinal improvements but less often knowledge gain.

A combination of interventions (particularly of education and contact) significantly reduces stigmatizing attitudes and social distance (Hawke, Parikh, and Michalak 2013; Mascayano et al. 2020; Morgan, Wright, and Reavley 2021; Morgan et al. 2018) **and is superior to traditional educational approaches.** Interventions directly involving people with lived experience were more effective in reducing stigma compared to studies that did not (Clay et al. 2020; Corrigan, Michaels, and Morris 2015; Ren et al. 2020; Seroalo et al. 2014). No significant difference in effectiveness was found between different delivery modalities of contact, such as face-to-face, imagined, or video, in reducing stigma (Maunder and White 2019). Social contact through theatre or film has been shown to produce improved knowledge and attitudes toward people with mental health conditions and to address misconceptions (Bacsu et al. 2021; Dalky 2012; Doley et al. 2017; Hawke, Parikh, and Michalak 2013; Mascayano et al. 2020; Matsumoto et al. 2023), as well as lead to sustainable behavioral changes (Dalky 2012; Doley et al. 2017). Active interaction with people with lived experience as they described their life experiences was more effective than passive interaction. Greater reduction in stigma was seen for health care professionals compared to non-professionals (Ren et al. 2020).

4.4.7. Simulated symptoms

Simulation has been used to demonstrate the experience of auditory hallucinations, using audio segments of voice and non-voice sounds with derogatory and neutral/benevolent content, to increase empathy and understanding of such symptoms (Ando et al. 2011; Griffiths et al. 2014). While it can increase empathy for people with schizophrenia, the evidence of effectiveness on attitudes is inconsistent, and some studies indicate that it may worsen attitudes and desire for social distance (Morgan et al. 2018).

4.5. Self-stigma

Thirty-four reviews were included on interventions for self-stigma, all published during 2012–2024. Fifteen were on interventions specifically designed to address self-stigma (Alonso, Guillen, and Munoz 2019; Bannatyne et al. 2023; Büchter and Messer 2017; Jagan et al. 2023; Klein et al. 2023; Larkings

and Brown 2018; Mills et al. 2020; Mittal et al. 2012; Rüsch and Kösters 2021; Sibley, Colston, and Go 2024; Sun et al. 2022; Tsang et al. 2016; Wood et al. 2016; Xu et al. 2017b; Yanos et al. 2015). Eighteen studies were of interventions targeting other primary outcomes and included self-stigma or other related measures. Of the specific self-stigma studies, some reviews included people with any mental health condition (Rüsch and Kösters 2021) or people exposed to traumatic life events (Mittal et al. 2012). Four (Sun et al. 2022; Tsang et al. 2016; Wood et al. 2016; Yanos et al. 2015) included only studies on people with severe mental health conditions, one on people who use drugs (Sibley, Colston, and Go 2024), and one on medical students or doctors (Bannatyne et al. 2023). In general, the reviews included studies which reported either an improvement in self-stigma, or in a similar outcome such as stigma stress or self-efficacy in the absence of a positive result for self-stigma. One review (Larkings and Brown 2018), however, found evidence from six studies (both experimental and observational) of a relationship between the endorsement of biogenetic causes of mental health conditions and worse stigma outcomes, namely greater pessimism about prognosis and recovery.

Two reviews with meta-analysis found that the improvements for self-stigma became nonsignificant over time (Büchter and Messer 2017; Wood et al. 2016); the exceptions are Narrative Enhancement and Cognitive Therapy (NECT) (Jagan et al. 2023) and the Honest, Open, Proud (HOP) intervention (Klein et al. 2023; Rüsch and Kösters 2021). A meta-regression of HOP RCTs suggests that people less burdened by shame about their illness benefit more and the positive outcomes at three to four weeks on self-stigma, depression, and quality of life were positively influenced by reduced stigma stress at initial follow-up (Klein et al. 2023).

For people with schizophrenia spectrum disorders, there are now sufficient trials to allow meta-analysis of the results for each of group's psychoeducation and NECT (Jagan et al. 2023). The summary effect for psychoeducation was nonsignificant and this analysis was affected by high levels of heterogeneity; in contrast, the summary positive effect for NECT was significant and heterogeneity was much less. These authors also point out that among the most effective interventions were those that combined therapies such as psychoeducation, cognitive behavioral therapy, social skills training, mindfulness, problem-solving skills, communication skills, and support groups.

One review that focused on people who use drugs found 15 studies: eight used a psychotherapeutic approach, five used psychoeducation, and two used multiple components (Sibley, Colston, and Go 2024). The results did not allow any specific approach to be recommended; instead, the authors recommend improvements in measurement, adaptation, and trialing of NECT, and delivery outside of clinical settings including online, as most people using drugs are not engaged in treatment.

Büchter and Messer (2017) recommended differentiation of interventions for groups with different needs, for example, people experiencing intersectional stigma related to gender, ethnicity, or employment status. This and another review (Wood et al. 2016) question the responsiveness to change and validity of outcome measures used. Only two reviews focused on LMICs. Xu et al. (2017b) examined people with lived experience of any mental health condition in mainland China; Hong Kong SAR, China; Taiwan, China; and Macau SAR, China. Demissie et al. (2018) focused on people with lived experience of bipolar disorder in LMICs. Both reviews found positive effects of psychoeducation on self-stigma, self-prejudice, and coping with stigma.

Most self-stigma interventions are delivered to groups, a barrier for people unwilling to disclose a mental health condition (Jagan et al. 2023). The potential for many recovery-oriented interventions to reduce self-stigma was highlighted by Winsper et al. (2020). They found that self-stigma was rarely measured; the 18 reviews including at least some studies that measured self-stigma covered interventions that are widely accessible, such as psychoeducation (Demissie et al. 2018; Luo et al. 2022); do not require group attendance, such as peer support (Evans et al. 2023; Orock and Nicette 2021) or digital interventions (Abtahi et al. 2023); target help-seeking (Aguirre Velasco et al. 2020; Mills et al. 2020); or investigate other outcomes, for example, symptom reduction (Musiat and Tarrier 2014),

musicianship (Solli, Rolvsjord, and Borg 2013), advocacy (Weetch, O'Dwyer, and Clare 2021), or employment (Winsper et al. 2020). Aguirre Velasco et al. (2020) reviewed largely school-based interventions for adolescents, finding some improvements in help-seeking intentions, or stigma related to help-seeking, though the study quality was rather low. A clear learning is the need to assess interventions outside health care, for example, social marketing campaigns (Abtahi et al. 2023).

4.6. Cost-effectiveness

Although campaigns to reduce mental health-related stigma and discrimination need to be assessed for their cost-effectiveness to assess value for money and return on investment, no reviews were found that specifically evaluated this. There are, however, several original studies which are relevant. In California, one initiative aimed to increase help-seeking by reducing stigma (Ashwood et al. 2017) and found that for each US$1 spent, there could be US$1,251 benefits through increased employment because of improved health. Benefits to the state government were estimated at US$36 for each US$1 spent on the campaign. One modelling study to assess the cost-effectiveness of the TTC anti-stigma campaign in England estimated that the campaign cost per person with improved intended behavior was £4 (Evans-Lacko et al. 2013). In Germany, the HOP program for adolescents with mental health conditions has been subjected to a health economic analysis, which found that it is likely to be cost-effective (Mulfinger et al. 2018). The evidence which is available tends to suggest that such interventions may be cost-effective at the program and population levels.

5. OVERVIEW OF CASE STUDIES OF NATIONAL-LEVEL ANTI-STIGMA PROGRAMS

For over 25 years, a series of large-scale programs have been delivered to reduce stigma and discrimination in different countries and regions across the world. Here a series of these programs is presented, with an emphasis on programs in East and Southeast Asia, selected to show the diversity of settings and interventions, to bring the principles and evidence of stigma reduction vividly to life through actual practical experience (Table 1). Stigma and discrimination still appear to be one of the most neglected aspects of mental health. As these case studies show, in some countries there had been a significant shift with the transformation of mental health policy leading to the welcome transformation of services from institution-based care to community-based care and support. However, the need to educate the community and transform attitudes, to create more supportive and inclusive communities and ultimately support recovery beyond the provision of treatment of symptoms, is often overlooked.

The COVID-19 era has increased awareness of the need for programs that challenge stigma and support earlier help-seeking and self-care and government funding has been secured in many parts of the world. Motivations for establishing and funding these programs differed—from taking a human rights perspective to a focus on mental health promotion and prevention. Most of the case study programs have adapted global evidence-based methods and contextualized them with many positive impacts reported, and much learning to share. Most of the stigma programs have clear outcomes, targets, and target audiences.

Some core components included social contact, lived experience champions/ambassadors to share their mental health experiences at social contact events and online, social marketing campaigns, targeted programs with health care professionals, employers, schools, universities and youth audiences, and the media.

For a small number of programs, lived experience leadership was central and instrumental to all aspects from governance to design and delivery but this not true for all programs—many have some involvement of people with lived experience of mental health conditions, for example, in project steering groups at different operational levels. It has been established that changing behaviors need long-term sustained efforts. There were many examples of programs sustained for more than a generation (New Zealand, Scotland) and for a generation (England, Canada, and the Czech Republic). The work in England ended when the government funding was not renewed after 15 years, showing that programs are vulnerable to changes in governmental priorities. However, in England the majority of the local work has continued to be funded and employers, schools, the media, and sports groups have continued to focus on mental health and addressing stigma including on national television channels.

Table 1. Overview of case studies of national level anti-stigma programs

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
Time to Change (TTC) program, England **National, Regional, Local**	**A partnership of the mental health NGOs** Mind and Rethink Mental Illness. King's College London **(KCL) was the evaluation partner**. **Longest running evidence-based national program** to address mental health stigma and discrimination in England and is **one of the most researched in the world.** Voted in the **Top 20 public health achievements of the 21st century** by UK public health experts. TTC built a **social movement** of all sectors and with **lived experience** in program governance, management, design, delivery and impact evaluation.	2007–2021	**Budget: Annual average £4–5 million.** **Funders**: The **National Lottery and Comic Relief** (2007–2011). **UK Government (Department of Health & Social Care)** and Comic Relief (2011–2021). Supplementary funding from the **Department of Education** (for the Children & Young People Campaign), the **Premier League, McVitie's** (for Time To Talk Day) and **Ford cars** (male-focused campaign).	**National Level** Improvement in • Public mental health knowledge • Public attitudes • Public reported and intended behavior • Experienced discrimination • Media mental health coverage • Levels of confidence to • tackle stigma among • trained lived experience • champions.	**Target Audiences:** • **Adults aged 24–44 (subconscious stigmatizers)** • **Men** ages 24–44 (little understanding of mental health and lower socio-demographic groups) • **Children and young people (11–16)** and their **parents** • **African and Caribbean** adults ages 24–44 • **South Asian** adults (pilot) • **Employers** (3,000) • **Schools** (2,000) • **Media** companies • **Mental health professionals** (pilot) • **Primary care** professionals (pilot). **Main Methods**: • Social contact (60+ local projects) • Lived experience champions • Training and support • Social marketing • Digital owned channels (for example, 275,000 followers on X).	**12.7%** Improvement in **public attitudes** (2008–2021) **12%** Improvement in **reported and intended behavior** (2009–2020) **15%** Decrease in average levels of **discrimination** (2008–2014) **Significant improvement** in local and national **print media coverage** (2008–2016). Increased anti-stigmatizing articles (31% to 50%) decreased stigmatizing articles (46% to 35%) **61%** of trained champions in 2018 felt **increased confidence** to challenge stigma and discrimination.

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
Nōku te Ao o program (previously called Like Minds, Like Mine), New Zealand **National, Local**	**Health New Zealand | Te Whatu Ora** program managed by the Health Promotion Directorate. Delivery via organizations including Māori Public Health Organisation, Mental Health Foundation, a tertiary institute, and community-based organizations. Evaluation undertaken by a research subsidiary of a tertiary institute. **The world's longest-running** stigma and discrimination program contributed to **significant improvements in public attitudes and reductions in discrimination.** The Like Minds, Like Mine program had a **high-profile impactful advertising campaign featuring famous and everyday people**. The **focus of the new Nōku te Ao program** is to work with and for the **people most affected by discrimination including Māori and Pacific communities**. It is a multilevel program based on indigenous **kaupapa Māori principles** with **local activities.**	1997–present	**Budget:** *Information not available* **Funder: Health New Zealand | Te Whatu Ora**	Overall outcome aims for the program 1. Equitable treatment by the government and society through law, policy, and norms. 2. Fair structures in organizations, including values, policies, and procedures. 3. Positive portrayals in public communications, including media, arts, and academia. 4. Inclusive behaviors in personal interactions with whānau (family), friends, and other contacts. 5. Influential role-modelling by people with experience of mental distress in all parts of society. • Seeing improvements in all spaces but still building momentum.	**Target Audiences:** Benefit group is particularly Māori and Pacific peoples. Also, projects tackling equity issues for disabled and rainbow communities. Target audience are those where people experience discrimination (health care settings, whānau/family and friends) as well as settings that influence culture change (for example, media). **Main Methods**: • Social Action **Grants for individuals and community groups** to tackle discrimination • A **community engagement** arm to **mobilize lived experience** at the grassroots to challenge systemic discrimination through advocacy, policy engagement, storytelling, and media engagement • **Education/training** for those working with mental health service users • **Media grants, monitoring, training** and engagement • **Research** projects and symposiums • **Program evaluation.**	• **Increased engagement** among those from Māori and Pacific communities participating in program • Social media engagement • Grants are funding community-led projects engaging thousands across multiple online and offline engagements • **Improved public attitudes** to people with **severe mental distress** • **Reduced discrimination** experienced among people with mental distress (in 2014 over half of the 1,135 people who recently used mental health services reported less discrimination than during 2009–2014).

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
batyr program, Australia **National, Local**	**batyr** is the lead agency (an **Australian preventative mental health NGO**) **driven by young people, for young people** founded in 2011. It recently developed an organizational theory of change and evaluation framework in collaboration with The Centre for Social Impact. Works with a wide range of partners (400+ schools and 25 universities) delivering evidence-based programs to reduce stigma and empower young people to reach out for support. Activity is driven by young people sharing lived experience (the 'Being Herd' program trains young people to share their mental health experiences), contact-based interventions, mental health literacy training, and peer engagement.	2011–present	**Budget**: Organizational expenditure in 2020 (not all stigma-focused) AUD 7.5 million. **Funders**: Corporate sponsors, donations, government funds, and fees for services.	Linked to program activity (pre, immediately post, and at three-month follow-up) • **Help-seeking** behavioral intentions • **Attitudes** related to the stigma of mental health • Improved **awareness of mental health literacy** • Increased **skills and confidence to talk** about mental health.	**Target Audience:** • **Young people (14–30 and communities that support them.** **Main Methods:** • **'Being Herd' program. 1,200 young people (18–30)** trained to share lived experience in schools and universities. • **'OurHerd' app. digital storytelling platform/app** for young people to share lived experience. Moderated, sentiment analysis, AI, and machine learning to capture data. • **Mental health educational workshops** in **schools, universities**, **workplaces** • **Schools** (500 secondary schools) • **Campaigns.** Multimedia channel campaign • **Lived experience involvement.** Young people including those with lived experience at the center of the organization and all activity	• **70% of young people** who experienced a batyr education program reported being **more likely to reach out for support** if they need it (**compared to 22% of general Australians)** • **Reduced stigma, increased attitudes and intentions to seek professional mental health care among 500 students in 2017** (maintained at three-month follow-up) • **Increased help-seeking** for personal, emotional, and mental health from **30% to 65%** in 2023 with a **link between the batyr@school program and lower levels of stigma**. **Sharing lived experiences was the most useful aspect of the program**.

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
Time to Change Global program, Africa and India **Local (pilots) and Global Toolkit**	A partnership of **UK mental health NGOs Mind and Rethink and international NGO Christian Blindness Mission (CBM)** working with **five NGO partners in Africa and Southern India** and **111 people with lived experience** trained as champions. Champions shared their experiences at social contact events and as part of social marketing campaigns to improve public knowledge, attitudes, and intended behavior using the adapted core methodology of TTC. A Global Anti-Stigma Toolkit shared tools and experiences of partners and lived experience champions. An evaluation of the social marketing campaigns in Nairobi, Kenya and Accra, Ghana by KCL was published in 2021.	2018–2020 (program closed when funding ended but the Kenyan project ran until 2023)	**Budget:** £1.7 million (2 years) **Funders:** UK Government (Foreign, Commonwealth and Development Office, FCDO) and Comic Relief	• **Public Attitudes** among target audiences (CAMI) • **Mental health knowledge** among target audiences in Ghana and Kenya assessed by MAKS with two additional questions added relating to beliefs that mental illness is a curse and is genetically linked • **Public behavioral intentions** amongst target audiences (RIBS).	**Target Audiences:** • **General public**—specific target audiences of **young people or adults** • **Local people with lived experience** (to become 'champions' and train to share lived experiences) **Main Methods:** • **Research. Qualitative audience insight research** with local populations in each community and with **local champions.** • **Training. Capacity-building training** and support **for project leads.** • **Social contact training and events.** Training and support for champions to safely and effectively share their experiences **at social contact events** and in campaigns. • **Social marketing campaigns.** • Co-production of a **global anti-stigma toolkit https://tinyurl.com/4tv9ttaf** • **Global anti-stigma summit.**	Evaluation of the **social marketing campaigns in Ghana and Kenya**: • MAKS - statistically significant improvement in Nairobi • RIBS - statistically significant improvement in Ghana. The estimate for the magnitude of this change is the same as TTC England for the general population between 2009 and 2019, a promising result for a short-term public mental health campaign.

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
Understanding Stigma and Strengthening Cognitive Behavioral Interpersonal Skills program, World Health Organization (WHO) Caribbean region **National, Regional**	The program is a partnership between **PAHO** and **the Mental Health Commission of Canada**. An online training program in the Caribbean to improve primary health care professionals' confidence in the quality of mental health care they provide and reduce their levels of stigma. Research had shown the core barriers to changing practices in mental health care were the need to strengthen providers' capacity through knowledge and skills and address factors that impede motivation to change. Health care providers' stigmatization was also an important barrier to treatment in the Caribbean.	2021–present	Budget: Information not available Funded by PAHO and the Mental Health Commission of Canada 'Opening Minds' Anti-Stigma Initiative	Among health care professionals receiving the training, • Health care professionals' **confidence in the quality of the mental health care they provided** • **Changes in stigma** among health care staff (Opening Minds' Stigma Scale for Health Care Providers).	**Target audience:** Primary health care professionals in the Caribbean **Main methods:** The training program has two core elements: • **Online stigma-reduction component** to help professionals recognize their own stigmatizing attitudes and behaviors, their impacts, how they present in primary care, **using videos of personal stories**. • The second element is the **Cognitive Behavioral Interpersonal Skills** that are delivered virtually and designed **to increase providers' confidence to help clients recover** and reduce stigmatization.	• **Significant improvements** in all measures of **confidence and comfort in the overall quality** of mental health care they provided to clients. • **Stigmatization was reduced. The Stigma Scale showed statistically significant improvement** in scores with a medium effect size on two of the Opening Minds Stigma Scale for Health Care Providers (OMS-HC) subscales.

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
NA ROVINU (On the Level) program, Czech Republic **National, Regional**	The program is led by the National Institute of Mental Health, Czechia (NIMH CZ). In 2013, the Minister of Health approved a strategy of mental health care reform. The first phase (2013–2021) included goals of reducing self-stigma and reducing discrimination based on stigmatizing attitudes from health care staff, social workers, and others. The NA ROVINU program started in 2017 with a focus on addressing mental health stigma and discrimination and is now more focused on prevention and mental health literacy.	2017–present	**Budget:** 2017–2022 CZK 94.96 million CZK (£3.3 million) **Funder:** Ministry of Social Affairs (sourced from European Structural Investment Funds)	National-level improvements: • **Public attitudes** • **Intended behavior** • **Self-stigma** (people with lived experience)	**Target Audiences:** • **People with lived experience** • **Families** of people with lived experience • **Social workers** • **Public administration workers** • **Communities** • **Health care professionals** (General Practitioners, emergency services staff, staff in general hospitals). **Main Methods:** • **Training and support for people with lived experience**—to share their experiences as part of delivery • **Six toolkits** designed for each target audience • **Campaigns and communication** • **Lived experience involvement** was a central aspect of the program from design to delivery and evaluation.	At national population level: • **Improvement in public attitudes** with attribution to the campaign (2013–2019) • **Public intended behavior. No change** (2013–2019).

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
Working Minds program, Canada **National**	The **Mental Health Commission of Canada** oversees the program. The Opening Minds anti-stigma training program was set up in 2009, with the **Working Mind** aspect of this program now a **separate entity** that **re-invests profits** from the income of its workplace delivery back **into anti-stigma work and the Commission.**	Opening Minds (2009–present) The Working Mind (2013–present)	**Budget:** *Information not available* **Funder: Self-sustaining and funded** through its workplace training programs.	• **Reductions in stigma** • **Increases in resilience** • Overall **mental health literacy improved** • Overall **mental wellness improved.**	**Target Audiences:** • **Employers/the workforce** including special adaptations for specific groups such as first responders, health care providers, construction workers, and so on. **Main Methods:** • **Training** to reduce stigma and promote mental health in the workplace, creating a more resilient and supportive culture among employees and leaders. It is structured into **four interactive modules** with videos, case studies, and practical exercises. These cover **Mental Health and Stigma, The Mental Health Continuum, Coping Strategies, and a fourth module for Managers 'Supporting Your Team'.** The courses are offered **in person or virtually.**	The Working Mind was associated with • **Moderate reductions in stigma** • **Moderate increases in self-reported resilience and coping ability.** Both maintained at the three-month follow-up.

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
More Than a Label program, Hong Kong **National**	The program is an initiative of **Mind Hong Kong (Mind HK).** The pilot anti-stigma program started in 2019 with initial funding from a Hong Kong Foundation, followed by the program launch in 2021. The Hong Kong Government funds its own campaign which is not linked to this program.	2019–present (funding secured until 2025)	**Budget:** Annual average HKD 1.5 million (approximately £150,000) **Funders:** MINDSET (Jardine Matheson Group Charity)	• **Public attitudes**. Survey of 1,010 adults to assess attitudes conducted by Social Policy Research Ltd. • **Public mental health knowledge** • **Public reported and intended behavior** • **Stigma among health care providers.** Using OMS-HC tool in pre and post surveys, following ambassador-sharing session.	**Target Audiences:** • Hong Kong residents (adults, mostly working age) • Health care providers **Main Methods:** • **Ambassadors.** 122 local people with lived experience provided with bilingual training and ongoing support to safely and effectively share their mental health experiences in public (social contact events, online, in campaigns). • **Community events (using social contact).** 100+ events in public settings, workplaces, schools • **Social marketing campaign.** Large-scale annual campaign • **Owned social media channels.** 4,000 followers on Instagram and 31,191 views of campaign videos • **Stakeholder engagement.** Extending reach to a wide range of communities	Among a sample of public who viewed campaign videos, • **Significant positive improvement in attitudes and intended behavior but not mental health knowledge** as a total score • **Positive improvement in stigma scores** in a survey of **general and mental health nurses** after ambassadors had shared their stories • **Improved healing and self-discovery among ambassadors.** Three themes emerged: "the impact goes both ways" with sharing lived experience, the importance of the supportive community of peer ambassadors, and the support from Mind HK.
Mental Health Supporter Training program, Japan **National via Regions**	The Mental Health Supporter Training Program **was led by the National Institute of Mental Health** between 2020 and 2023**. From 2024, a private contractor is delivering a national program of training in large-scale and middle-scale cities,** with a target	**Pilot 2020–2023** **National upscale 2024–2033** (across 1,700 municipalities with a target of 1	**Budget:** Information not available **Funder: Ministry of Health**	**Primary Outcome:** • Japanese version of the **Reported and Intended Behavior Scale** (RIBS-J) **Secondary Outcomes:**	**Target Audience:** • Adult residents in Japan (no exclusion criteria) **Main Methods:** • **Face-to-face or online training** for two hours to help participants **better**	Study among Japanese people trained between October 2022 and February 2023 across 18 municipalities. Pre (T1) and immediately post training assessments (T2) and approximately six months later (T3): • Despite the mean **intended behavior** score increasing

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
	of training 1 million people as 'Cocoro Supporters' by 2033. The program is a **Japanese adaption of the MHFA program** and was first rolled out to 7,000 adults (average age 44). It is a two-hour online training course to help participants better understand mental illness and learn about support techniques for people with mental health difficulties close to them.	million people trained by 2033).		• Japanese Version of the **Mental Health Literacy Scale** (MHLS) • **Psychological distress** using the Kessler Psychological Distress Scale 6 (K6) (based on the premise that listening to people around them may reduce interpersonal conflict and improve their own mental health) • **Mental health knowledge.**	**understand mental illness** and **learn about support techniques** for people with mental health difficulties close to them. There are two additional modules that can be chosen: **Self-care t**hrough coping with stress and **Learning about mental illness.**	significantly between T1 and T2, it returned to the baseline level at T3 ***showing no longer-term effect***. The mean **reported behavior** score increased and remained the same at T3 but the effect size was small. • The scores for **Mental Health Literacy** increased from T1 to T2 at significant levels for both knowledge and attitudes and remained the same at T3. • **Mental health knowledge score** increased at significant levels from T1 to T2 and remained the same at T3. • The **Psychological distress** score showed a small but significant change at T3. **(*) 2024 update:** Findings in a new paper (the purpose of which was to modify the program evaluated in the previous study and verify its effectiveness for participants in the FY2023 program), "suggested that the combination of educational and contact-based interventions might reduce public stigma toward people with mental health problems immediately post intervention, an effect that persists 3 months later."
Beyond the Label program, Singapore	The national **Beyond the Label (BTL) movement** was initiated and funded by the **National Council of Social Service (NCSS**) and **is now a collective impact initiative co-led**	Phase 1: 2018–2021 Phase 2: 2022–2028	**Budget:** SGD 2 million SGD or £1.2 million per year.	• **Public Attitudes** • **Public Mental Health Knowledge** • **Public Behavior**	**Target Audiences:** • Families and caregivers • Children and young people	From the public survey, those who were BTL-aware were • **12.8% higher on the attitude** scale

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
National	**by TOUCH Community Services**. The 'BTL Collective' is a national movement with many public, voluntary and private sector agencies and stakeholders involved. **The movement's primary focus is addressing stigma and promoting social inclusion for people with mental health conditions.**		**Funders:** Government, corporate sponsors, trusts, donations.	Assessed via a survey of 2,000 adults that also asks about the BTL campaign and showing influence of the campaign. Scales used include Community Attitudes toward the Mentally Ill (CAMI-12) Scale, Reported and Intended Behavior Scale (RIBS), and Mental Health Knowledge Schedule (MAKS).	• Communities • Employers **Main Methods:** • **The BTL Collective**—34 agencies from the public, private, and people sectors adding leverage and reach • **Social marketing campaign**. ***Let's Get Talking***—The aim of the latest campaign is to encourage persons with mental health conditions to share their stories of strength and resilience, and to seek help early. • **Community engagement**—Events roadshows, talks/ workshops and a grant for the BTL workgroups to implement their initiatives. • **Ambassadors** with lived experience who share their stories with the public to inspire others facing similar struggles to speak up and seek help. *In the public survey, for the most negative architype (22%) the lack of contact was an issue.* • **Beyond the Label chatbot 'Belle'**—For people or their families/friends struggling with stress or anxiety, which is now also available via WhatsApp and online. Belle	• **22.6% higher on the mental health knowledge** scale • **7.3% higher on the behavior** scale.

Program: Name, Location Scale	Program Overview	Implementation Dates	Budget/Funding	Outcomes	Target Audiences and Methods	Impact Data
					will be consolidated with Mindline.sg, a digital first-stop touchpoint for mental health resources and support from January 1, 2025. Current users of Belle will be directed to Mindline.sg, where they can access a self-assessment tool that allows users to be directed to relevant mental health resources and services. • **Workplace**—Employer Pledge and Resources panel dialogue/ workshops, targeted campaign. • **Higher education**—Roadshows in institutes of higher learning. • **Schools**—Psychoeducation talks. • **BTL Plug and Play Kit.** A toolkit offering a wide range of activities for young people with resources and tips for launching their own anti-stigma initiatives.	

6. CONCLUSIONS AND RECOMMENDATIONS

This policy note demonstrates that there is now strong evidence about how to reduce stigma and discrimination in the field of mental health. A failure to act on this evidence would mean the continuation of heavy adverse impacts on individuals, families, communities, and societies. Therefore, the time to act to eradicate mental health-related stigma and discrimination is now. This briefing note also makes it clear that programs to reduce stigma and discrimination need to be carefully adapted, taking into account **cultural factors and cultural differences.**

The WHO Comprehensive Mental Health Action Plan 2013–2030 makes clear that, "The vision of the action plan is a world in which mental health is valued, promoted and protected, mental health conditions are prevented and persons affected by these conditions are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination" (WHO 2019).

The **following recommendations** are proposed.

1. The creation of plans to fund, implement, and evaluate long-term programs to reduce mental health stigma and discrimination.
2. The central component of these plans is to use the evidence-based active ingredient of social contact for stigma reduction.
3. People with a full range of mental health conditions, including more severe conditions, need to actively contribute to these plans by co-leading the design, delivery and evaluation of the programs.
4. Specific target audiences and outcomes need to be identified at the outset of each program.
5. The programs operate with widespread cross-sectoral support and participation, for example with the industry, sports, music, television, film, health care, and educational sectors.
6. A detailed evaluation of impacts and outcomes is conducted for each program, compared with an initial baseline assessment of key metrics.

APPENDIX 1. REFERENCES

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APPENDIX 2. DETAILED CASE STUDIES OF NATIONAL ANTI-STIGMA PROGRAMS

1. 'Time to Change' program, England

Time to Change (TTC) in England was the longest running evidence-based national program to address mental health stigma and discrimination (2007–2021) and one of the most researched in the world. It is listed as one of the top 20 public health achievements of the 21st century by public health experts voting in the United Kingdom Royal Society for Public Health poll in 2019. TTC built a social movement to improve levels of public mental health knowledge, attitudes, and intended behavior and reduce levels of mental health discrimination. It measured improved confidence and skills to tackle stigma among lived experience champions. Central to the whole program is the direct inclusion of people with lived experience in program governance, management, design, delivery, and impact evaluation.

Program overview

Time span	2007–2021
Scale	National outcomes with national, regional, and local delivery
Funding	The funding received was £4–5 million each year. The national Lottery and Comic Relief funded phase 1. Funding for phase 2 was secured from the UK government (Health and Education ministries). Supplementary funding was received from the football Premier League, Sport Relief, and corporate sponsors with tea and biscuit manufacturers sponsoring Time to Talk Day and funding their male-focused campaign in partnership with TTC.
Partners	TTC was a partnership of the English mental health NGOs Mind and Rethink Mental Illness, with a lived-experience-led NGO which was also a partner in the first phase of the program. KCL was the evaluation partner. There were many local organizations involved in delivering social contact events with the establishment of local TTC coordinating hubs. Market research agencies were commissioned to undertake audience-insight research, evaluation of each campaign burst, and undertake strategic reviews of audiences and impact. Advertising agencies were selected for creative design and media planning of social marketing campaigns across media platforms.
Model and evidence base	TTC was, in part, inspired by the 'Like Minds, Like Mine' program in New Zealand (now called Nōku te Ao) and 'See Me' in Scotland. Lived experience leadership and the recognition of social contact as the core activity developed within the first two years of the program.

Implementation	
Target audiences	For the national social marketing campaign, • Audience-insight research informed the selection of the primary campaign target audience **of adults ages 24–44 (subconscious stigmatizers)** (2007–2011) • Target audience of children and young people ages 11–16 and their parents (2011–2021) • African and Caribbean adults ages 24–44 • South Asian adults • After a strategic review, the new primary target audience in the final third phase (2016-2021) was men ages 24–44 from lower socio-demographic groups, with relatively little understanding of mental health.
Project activities/ methods	• National social marketing campaign • **Children and young people program**—social marketing aimed at children and parents, trained young champions, whole-school approach with over 2,000 secondary schools and head teachers' network • **Champions**—trained and supported over 7,000 adults across England and developed champions groups providing 'support' as campaign peers • **Social contact**—events across all regions in England with £3 million funding for local social contact projects with teams of trained champions and regional coordinator to support • **Employers**—supported 3,000+ employers develop action plans and pledges • **Digital**—owned channels, supported the online movement • **Media engagement**—supported the media with 80 scripts of TV/radio dramas/soap operas each year • Two pilot training programs: health staff, police, and for primary care professionals • Central management—program management, evaluation manager, digital, communications, celebrity liaison • **Lived experience involvement**. Lived Experience Advisory Panel to provide lived experience at all levels: governance, program management, project delivery, campaign advisory group, and evaluation.
Delivery team	• Total of 60 staff, including management, communications, evaluation and projects.
Outcomes	
Evaluation tools	National-scale evaluations and media coverage analysis was carried out by the Institute of Psychiatry, Psychology and Neuroscience (IOPPN), KCL, and other research bodies were commissioned for project evaluations related to employers, schools, mental health professionals, and primary care providers. Further research was undertaken through in-house analysis of people with lived experience on the extent and impact of stigma ('Stigma Shout'). The evaluation tools used were public knowledge - Mental Health Knowledge Scale (MAKS) (Evans-Lacko et al. 2009); public attitudes - Community Attitudes on Mental Illness scale (CAMI) (Taylor and Dear 1981); public levels of reported and intended stigma-related behavior (RIBS) (Evans-Lacko et al. 2011); experienced discrimination (Discrimination and Stigma Scale, DISC) (Brohan et al. 2013); and improvement in confidence to tackle stigma among trained champions. The program also evaluated media coverage of mental health issues.

Evidence of effectiveness	• **12.7 percent** improvement in public attitudes since the start of TTC (2008–2021) • **12 percent improvement** in reported and intended behavior (RIBS 2009–2020) • **15 percent** decrease in the average level of discrimination (2008–2014) • **61 percent** trained champions, feeling more confident to challenge stigma and discrimination (2018) • Significant improvement in local and national print media coverage of mental health for 2008–2016. • Significant increase of anti-stigmatizing articles (31–50 percent). • Significant decrease in stigmatizing articles (46–35 percent). • Over 50 outcome papers published by KCL (see for example, Henderson and Thornicroft 2009a, 2009b, 2013; Henderson et al. 2014, 2016). • The final impact report is available on request. • A film to mark the achievement of the 15-year program is available at https://youtu.be/p1fcPcnLQ3I.
Cost-effectiveness/ Economic evaluation	In all campaign cost–success rate combinations the **return on investment** is well above 1. Even with the worst scenario with a campaign cost of £2 million and a 1 percent success rate, the return is eight times the investment.

Lessons learned and recommendations

- This is the work of a generation—long-term, sustained approaches are required.
- If national-scale change is the ambition, then national audience-insight-informed campaigns could be required to complement more in-depth social contact approaches.
- Lived experience leadership should be central from the research and design phase to delivery, evaluation, and review as well as at management and governance levels.
- Activity needs to be tailored to each audience, context, and setting,
- Ongoing evaluation should be the central aspect of any program, against a clear baseline.
- Work must be sustained by building capacity and confidence and tools for employers and schools.

Sustainability strategy

- Support a lived experience movement by training and empowering champions to lead change.
- Use impact data to support funding bids.
- TTC hubs must embed anti-stigma focus within local policies (for example, local government and universities).
- Embed changes to employer's mental health policy and practice.
- Embed mental health stigma within school management plans.
- Provide templates for organizations to localize/contextualize.
- Secure cross-sector and cross-party political support.

Additional information

Additional information: Available at https://changingmindsglobally.com/

Name and contract details for program managers: Program ended in 2021. Contact Sue Baker OBE, Changings Minds Globally https://changingmindsglobally.com (Time to Change and Time to Change Global Founding Director) or current stigma lead at Mind, George Hoare g.hoare@mind.org.uk.

2. Nōku te Ao o program (previously called Like Minds, Like Mine), New Zealand

This is the world's longest-running mental health stigma and discrimination program (1997–present) which contributed to significant improvements in public attitudes and reductions in discrimination at the national level. The focus of the new Nōku te Ao program is to work with and for the people most affected by discrimination including Māori and Pacific communities. It is a multilevel program based on kaupapa Māori principles, with media monitoring, research, training, and grants.

Program overview	
Time span	1997–present
Scale	National and local
Partners and funders	The program is managed by the Health New Zealand | Te Whatu Ora Health Promotion Directorate. Program delivery is through a range of organizations including Māori public health organizations, the Mental Health Foundation, Te Whare Wānanga o Awanuiārangi (tertiary institute), a communications agency, and community-based organizations. Evaluation is undertaken by a research entity associated with Te Whare Wānanga o Awanuiārangi.
Implementation	
Target audiences	• Target audience are those where people experience discrimination (health care settings, whānau/family and friends) as well as settings that influence culture change (for example, media). • Benefit group is particularly Māori and Pacific peoples. Also, projects tackling equity issues for disabled and rainbow communities.
Project activities/ methods	• Social action grants - to resource projects led by individuals and community groups to tackle discrimination. • A community engagement arm to advocate the end of discrimination - to mobilize lived experience at the grassroots to challenge systemic discrimination through advocacy, policy engagement, storytelling, and media engagement. • Education and training for those working with mental health service users to understand how stigma and discrimination play a role in their services and indigenous methods for working differently. • Media grants, monitoring, training, and engagement. • Research projects and symposiums. • Program evaluation.
Delivery team	• The team comprises 3.4 FTE dedicated to the coordination of the program. The program has five NGO partners with varying degrees of staffing.
Outcomes	
Evaluation tools	The program is evaluated on a yearly basis, with some additional case studies on aspects of the program, such as grants. The current evaluation focused on the process for setting up the program, including utilizing indigenous approaches to contracting partners. Outcome evaluation will be reported in 2025.
Evidence of effectiveness	• **Discrimination:** A study published in 2014 of 1,135 people who had recently used mental health services found that over half reported an improvement in discrimination in the past five years and 48 percent thought that the 'Like

	Minds, Like Mine' program assisted in reducing discrimination (Thornicroft et al. 2013). • Wyllie and Lauder (2012).
Cost-effectiveness/ Economic evaluation	The program's evaluation methodology is kaupapa Māori which looks at outcomes, relationships, approaches, values, and equity-focus.

Lessons learned and recommendations

- Develop strong and simple key messaging and call to action.
- It is of vital importance that programs are led by people with lived experience. This means telling diverse stories of lived experience; experts, through experience, leading the program's governance, communications, marketing, decision-making, and media relations; mentoring, enhancing skills, and resourcing experts by experience.
- Cultural approaches should be prioritized when building a critical mass of supporters within a social movement to challenge discrimination. This means that cultural and indigenous knowledge informs language, methods of engagement, and conceptualization of the problem of discrimination; equity between clinical, cultural, and lived experience knowledge systems is required in decision-making and evaluation.
- Resourcing needs to be devolved to the community groups to lead their own solutions.
- Clinicians or non-cultural champions can take on advisory roles but cannot lead the overall movement. All human rights movements depend on those marginalized to be at the forefront.
- The program requires significant and sustained resourcing to generate results.
- Action is required across many levels from grassroots, systems change, media depictions, and research. Engagement with stakeholders across all sectors is needed to build profile and reach of messaging.

Lived experience involvement

This has been a key principle of the program across a wide range of communities but particularly Māori and Pacific communities. The success of the program is attributed to profile gained from well-known New Zealanders openly role-modelling as having lived experience. This became a talking point and broke down barriers to engaging with the messages as people identified themselves with these individuals who are leaders in their fields of music, sport, fashion, and culture.

It is important to showcase a diverse range of lived experiences with different diagnoses, ethnicities, genders, and other demographics. Nōku te Ao has been borne out of its predecessor Like Minds, Like Mine as the latter had not equitably benefitted everyone in New Zealand. This meant that people from Māori and Pacific backgrounds as well as those with profound experience of mental health challenges (for example, received involuntary treatment) were less likely to benefit from the work. Nōku te Ao has moved to become grounded in New Zealand's founding document, Te Tiriti o Waitangi, and led by people with lived experience from these communities. This works to change the lives of people most affected by discrimination, including Māori and Pacific communities.

Additional information

Links to programs websites: https://www.nokuteao.org.nz/

Links to key program reports/evaluations: https://kclpure.kcl.ac.uk/portal/en/publications/impact-of-the-like-minds-like-mine-anti-stigma-and-discrimination

Name and contract details for program managers: Shaquille Graham - Shaquille.graham@tewhatuora.govt.nz

3. batyr program, Australia

batyr is an Australian preventative mental health charity founded in 2011 and driven by young people, for young people. It was named after batyr ('hero') The Talking Elephant from Kazakhstan and gives a voice to the 'elephant in the room', the elephant being mental health. It delivers evidence-based programs in schools and universities that aim to reduce stigma around mental health and empower young people to reach out for support when needed. Activity is driven by young people sharing lived experience (the 'Being Herd' program trains young people to share their mental health experiences), contact-based interventions, mental health literacy training, and peer engagement.

Program overview	
Time span	2011–present
Scale	National with total reach of 408,188 young Australians "empowered to live a mentally health life" since 2011 (excluding digital reach).
Funding	Organizational expenditure report in 2020 (not all stigma-focused) AUD 7,547,262.
Partners	batyr is the lead agency, working with a wide range of partners (>400 schools and 25 universities). It is funded by donations and corporate sponsors, government funds, and fees for services.
Model and evidence base	batyr's model was influenced by Dr. Patrick Corrigan and the TLC3 model (Targeted, Local, Credible, Continuous Contact), considered an efficient way to facilitate understanding and mental health literacy. It holds young people, specifically those with lived experience, at the center of their interventions. Corrigan has done extensive research into contact-based anti-stigma interventions. Contact-based anti-stigma interventions involve planned interactions between people with a lived experience of mental ill-health and the public. A meta-analysis of 72 studies of contact interventions found that they had a positive effect on reducing public stigma in adolescents (Corrigan et al. 2012).
Implementation	
Target audiences	Young people ages 14–30 and the communities that support them
Project activities/ methods	**'Being Herd' program**. Trains young people ages 18–30 to share their lived experience of mental ill-health in a safe and impactful way and has trained over 1,200 participants through the program, 424 of whom went on to become batyr storytellers, sharing their stories in high schools and universities. **OurHerd app**. The digital storytelling platform/app is for young people to share their lived experience stories of MH focusing on hope, resilience, and positivity. Everything posted on the app is moderated to ensure the content is safe for other users. Sentiment analysis, AI, and machine learning allows batyr to capture qualitative and quantitative data to draw insights from the lived experiences stories of OurHerd users, which is fed back to key decision-makers. • Educational workshops on mental health in schools, universities, and workplaces (in-person and online).

	• **Schools.** Reaching over 400,000 students across 500 government and independent secondary schools). batyr currently runs programs with students in Years 9–12 and is developing Year 7 and Year 8 programs.
	  ○ **Teacher professional development**. Interactive, collaborative workshops, where the role of teachers in the lives and MH of their students is discussed and they hear from a trained lived experience storyteller.
	  ○ **Universities.** Young facilitators deliver educational content and with trained lived experience speakers. batyr also works with student volunteers to run activations and events on university campuses.
	  ○ **Work program**. To engage entire workforces in mental health to provide a space for employees to safely explore and discuss the topic of mental health in the workplace.
	Campaigns. A multimedia channel campaign called 'Going Beyond Polite Responses' aims to "encourage young people to open up and talk about how they really feel" was launched in 2024 https://www.batyr.com.au/going-beyond-polite-responses

Lived experience involvement	Young people and people with lived experience are kept at the center of the organization and all activity. Approximately 80 percent of the staff at batyr have had MH experiences, the board includes a young person, and a national advisory group of young people feed directly into the board.
Outcomes	
Evaluation tools	In 2020, batyr collaborated with The Centre for Social Impact to craft a theory of change and evaluation framework. This theory acts as a guide for measuring impact and linking each outcome to specific measurement tools. Help-seeking behavioral intentions and attitudes related to mental health stigma and empowerment were measured before, immediately after a workshop/activity with students, and then at three-month follow-up in a large study in 2016 (see impact section below).
Evidence of effectiveness	• About 70 percent of young people who saw a batyr education program reported being more likely to reach out for support if they need it, compared to 22 percent of general Australians who access help when needed. • A Macquarie University study in 2017 conducted an RCT with 500 students which found that the school program reduced stigma and increased attitudes and intentions to seek professional mental health care, which was maintained at the three-month follow-up. • Regarding help-seeking, at baseline: 60 percent said they would seek help; immediately after the program: 72 percent said they would seek help; three months follow-up: 68 percent. • Changes in stigma, empowerment, and recovery attitudes demonstrated significant differences in responses from baseline to immediately after the batyr program, with improved attitudes for recovery and empowerment items) but not for stigma-related items. At three-month follow-up, the positive improvement in the empowerment item was significantly sustained. • In 2023, the University of Sydney found that help-seeking for personal, emotional, and mental health increased from 30 percent to 65 percent over six months. There was a link between the batyr@school program and lower levels of stigma. Sharing lived experiences was the most useful aspect of the program.

Cost-effectiveness/ Economic evaluation	Recent analysis by the University of Sydney provided a Social Return On Investment (SROI) score which showed that for every US$1 spent on batyr programs there was an SROI of US$13.40 for their work in regional communities. This was linked to the batyr@school program in disaster-affected communities (2023).

Contextual factors

Isolation is a key factor for people living in regional and rural parks of Australia. In response to this, the 'Get Talkin' Tour' was implemented in 22 towns, reaching 3,259 people in regional communities (https://www.batyr.com.au/gettalkingtour/). The transition to a digital platform and the digital app 'OurHerd' (in response to the COVID-19 pandemic) also increased accessibility for regional, more-isolated populations, with online programs delivered to 11,000 people.

Sustainability strategy

- Diverse funding streams and longer-term funding partners
- Use of technology.

Additional information

Key reports/evaluations: https://www.batyr.com.au/our-impact

Program manager: Rob O'Leary, Lived Experience Program Manager (rob@batyr.com.au). Tom Riley, Head of Impact (tom@batyr.com.au). Amy Brown, Head of Programs (amy@batyr.com.au).

4. Time to Change Global program, Africa and India

Time to Change Global was a partnership project of UK mental health NGOs Mind and Rethink Mental Illness and the international disability and development organization CBM working with five country-level partners: Mental Health Society of Ghana , Grameena Abyudaya Seva Samsthe in India, Gede Foundation in Nigeria, Basic Needs Basic Rights Kenya, and Mental Health Uganda, and 111 people with lived experience who trained as champions across all five locations. Local champions shared their experiences at social contact events and as part of social marketing campaigns to improve public knowledge, attitudes, and intended behavior using the adapted core methodology of TTC. A Global Anti-Stigma Toolkit published in 2020 shared tools and experiences of partners and lived experience champions. An evaluation of the social marketing campaigns in Nairobi, Kenya and Accra, Ghana by KCL was published in 2021 (Potts and Henderson 2021).

Program overview	
Time span	2018–2020, program closed when funding ended but the Kenyan pilot ran until 2023
Scale	Global and in five locations across Africa (Ghana, Nigeria, Kenya, and Uganda) and India
Funding	£1.7 million (2 years)
Partners	Mind, Rethink, CBMU UK, and five NGO partners in Africa and Southern India with funding from the UK Government (FCDO) and Comic Relief.
Model and evidence base	Core elements of the TTC program in England were adapted, having first researched evidence of stigma projects and their impacts in low- and middle-income countries with research from Nigeria and India.
Implementation	
Target audiences	• Local people with lived experience, with training to share mental health experiences • General public—specific target audiences within local adult populations • Organizations and individuals interested in/already working on MH stigma (for the toolkit).
Project activities/ methods	• Research. Qualitative audience insight research with local populations via focus group discussions (FGDs) with adults in each community. Research with local champions. • Capacity-building training and support for project leads. • Training and support for lived experience champions in each location to safely and effectively share their MH experiences at social contact events and as part of the campaigns. • Social marketing campaigns. Co-production of a global anti-stigma toolkit 'Conversations Change Lives' based on the five pilot projects https://tinyurl.com/4tv9ttaf. • A global anti-stigma summit held in Kenya at the end of the program.

Lived experience involvement	As with the England program, this was a core principle and co-production was a central approach to the work. Half of the Time to Change Global (TTCG) governance board were lived experience representatives with experience of tackling mental health stigma (one person from Africa and one person from India) and local champions were instrumental in planning and delivering social contact events, in shaping the social marketing campaigns, and then featuring in some of the creative and digital assets. Many of the teams globally and nationally had their own lived experiences.
Contextual factors	It was essential that each specific local context, culture, social norms, policy and legal frameworks relating to MH and services informed the development of campaigns and social contact events and the adaption of training modules for the project co-coordinators and lived experience champions.
Delivery team	UK program team of six with one coordinator in each of the five countries

Outcomes

Evaluation tools	• Mental health knowledge among target audiences in Ghana and Kenya assessed by MAKS with two additional questions added relating to beliefs that mental illness is a curse and is genetically linked. • Public attitudes among target audiences (CAMI). • Public behavioral intentions among target audiences (RIBS).
Evidence of effectiveness	Evaluation of the social marketing campaigns in Ghana and Kenya. • MAKS - statistically significant improvement in Nairobi • RIBS - statistically significant improvement in Ghana. The estimate for the magnitude of this change is the same as TTC England for the general population between 2009 and 2019, a very promising result for a short-term public mental health campaign (Potts and Henderson 2021).

Lessons learned and recommendations

- Mental health stigma varies widely among individuals and communities worldwide, shaped by personal experiences, identity, and local contexts. Adapting any existing methods or tools to each specific context is vital with qualitative audience-insight research to understand the drivers of stigma in each location.
- Lived experience involvement in anti-stigma work is vital for anti-stigma programs.
- The pilot projects in Africa had a target audience of young people (ages 18–35) and with high levels of social media use. This allowed cost-effective campaigns with high levels of reach to be delivered via social/digital media and in some instances traditional media.

Sustainability strategy

Providing capacity-building training for local NGO teams and projects leads and for lived experience champions was aimed at sustaining the work beyond the funded period with champions continuing to campaign against stigma. The Basic Needs Basic Rights (BNBR) project in Kenya, with Mind and CBM, secured funding from Comic Relief to continue the ‘Speak Up’ stigma project until 2023. The toolkit has been widely used and referenced as an example of good practice for the global stigma toolkit being developed by the WHO and KCL. CBM UK is now the lead partner in the TTCG program and is actively seeking funding to re-start the pilots and extend and adapt the model. The same methods and some of the training modules have since been adapted with local partners and ministries by Sue Baker and her team in new regions and countries across Eastern Europe and the Caribbean.

Additional information

Links to programs websites: TTCGl website is no longer available, but information is available on other sites https://changingmindsglobally.com/.
Links to key program reports/evaluations: Evaluation of anti-stigma social marketing campaigns in Ghana and Kenya: Time to Change Global (Potts and Henderson 2021).

Name and contract details of program manager: Program ended in 2020. Contact Sue Baker OBE, Changings Minds Globally https://changingmindsglobally.com (Time to Change and Time to Change Global Founding Director).

5. Understanding Stigma and Strengthening Cognitive Behavioral Interpersonal Skills program, the Caribbean

An online training program in the Caribbean to improve primary health care professionals' confidence in the quality of mental health care they provide and reduce their levels of stigma. Research had shown the core barriers to changing practices in mental health care were the need to strengthen providers' capacity through knowledge and skills and address factors that impede motivation to change. Health care providers' stigmatization was also an important barrier to treatment in the Caribbean.

Program overview

Time span	2021–present
Scale	Across the WHO Caribbean region
Partners	PAHO and the Mental Health Commission of Canada

Implementation

Target audiences	Primary health care professionals in the Caribbean
Project activities/ methods	The training program has two elements: • Online stigma-reduction component to help professionals recognize their own stigmatizing attitudes and behaviors, their impacts, how they present in primary care, using videos of personal stories. • The second element is the Cognitive Behavioral Interpersonal Skills that are virtually delivered and designed to increase providers' confidence to help clients recover.

Outcomes

Evaluation tools	• Health care professional's confidence in the quality of the mental health care they provided was improved. • Stigma among health care staff was reduced (Opening Minds' Stigma Scale for Health Care Providers).
Evidence of effectiveness	• Significant improvements were observed on all measures of confidence and comfort in the overall quality of mental health care they provided to clients. • Stigma scale - statistically significant improvement in scores with a medium effect size on two of the OMS-HC subscales.

Sustainability strategy

To maximize sustainability and reproducibility standardized training and process documents were developed, and the Understanding Stigma component was translated into Spanish. Five tutors were trained and able to act as trainers in their country, with a booster session to aid learning retention.

Additional information

Key reports/evaluations: An initiative to improve mental health practice in primary care in Caribbean countries https://pubmed.ncbi.nlm.nih.gov/37363624/

Program managers: Mike Pietrus - mpietrus@openingminds.org, Claudina Cayetano - cayetanoc@paho.org.

6. NA ROVINU (On the Level) program, Czech Republic

In 2013, the Minister of Health approved a strategy for a mental health care reform with the first phase (2023–2021) including a goal to reduce self-stigma and discrimination based on stigmatizing attitudes from health care staff, social workers, and others. The NA ROVINU program (roughly translated as 'On the Level') started in 2017. The major priorities of this program are to support people with lived experience in need of help and to continue mental health care reform. The program started with more focus on addressing mental health stigma and discrimination until 2022 and is now focused on prevention and MH literacy.

Program overview	
Time span	2017–present
Scale	National with regional activity
Funding	2017–2022 CZK 94.96 million (£3.3 million)
Partners	The program is led by the National Institute of Mental Health, Czechia (NIMH CZ) and funded by the Ministry of Social Affairs (sourced from European Structural Investment Funds).
Model and evidence base	Someone from each target audience was involved in the development and design of the intervention. Pilots were conducted with focus groups to gain feedback on the program and structure. To evaluate progress, a pre-test was conducted one week before the program, and a post-test one week after the program, and then again three months after. The implementers consulted members of the Global Anti-Stigma Alliance http://antistigma.global/. Recruiting people with lived experience was essential to developing the program.
Implementation	
Target audiences	Specific target groups were chosen by people with lived experience as well as those eligible for funding (work with children and police officers was not eligible for funding). The chosen targets were people with lived experience, their families, social workers, public administration workers, communities, and health care professionals (general practitioners, emergency services staff, and staff in general hospitals).
Project activities/ methods	• Training and support for people with lived experience—to share their experiences as part of delivery • Six toolkits designed for each target audience, and campaigns and communication were central.
Lived experience involvement	A central aspect of the program is the involvement of people with lived experience in design, delivery, and evaluation with benefits for the program and people with lived experience involved in relation to self-esteem stigma. The ability to speak openly of one's experience is highly valued in this program.
Contextual factors	Adaptation mainly focused on molding the content of all provided modules to each of the six target groups based on situational analysis and communication with key experts and stakeholders and feedback from participants. During the COVID pandemic delivery was adapted to online methods.

Outcomes

Evaluation tools	Public attitudes (nationally); intended behavior; self-stigma (people with lived experience)
Evidence of effectiveness	Quantitative data was collected through an online questionnaire with a set of scales completed before attendance, a week afterwards, and then three months later. Each target audience has a different set of scales adapted for them, focused on attitudes and intended behaviors; for people with lived experience the focus is self-stigma. At the national population level, • Public Attitudes: 2013–2019 - improvement with attribution to the campaign (Winkler et al. 2021). • Intended Behavior: 2013–2019 - no change (Winkler et al. 2021).

Lessons learned and recommendations

- It was essential to learn how best to work with people with lived experience and ensure they felt safe and comfortable to share their stories to audiences, and plan for situations when people had to step back from activity.
- The focus on six predetermined groups was challenging because the program would at times prefer to focus on other populations, such as journalists.
- The importance of evidence-based evaluation and the level of funds required had to be justified to stakeholders in the beginning.
- Long-term monitoring and evaluation was also challenging, as the programs are short term and there is difficulty in following up with participants afterwards, particularly at the three-month follow-up.
- Due to the COVID-19 pandemic, there existed challenges in getting individuals accustomed to online implementation.

Sustainability strategy

Future funding expected from the same funder (European Structural Investment Funds) with plans to generate revenues from the workplace activity.

Additional information

Website: https://narovinu.net/

Program contact: petr.winkler@nudz.cz

Other key developments supporting anti-stigma programs

The National Institute of Mental Health runs a **perinatal project https://www.perinatal.cz/** with the goal of raising awareness of psychological difficulties in women in the perinatal period.

7. Working Minds program, Canada

The Mental Health Commission of Canada was established in 2007, following a review of mental health (MH) and addiction services in the previous year, with a ten-year mandate to reconstruct MH systems and change attitudes and behaviors of Canadians in relation to MH. 'Opening Minds' was launched in 2009 to respond to the problem of stigma being a large barrier to help-seeking. The Working Mind (TWM) is a central part of the program's work to reduce stigma and improve MH in the workplace. The Opening Minds program has a unique approach to developing, delivering, and evaluating activities to address MH stigma with all the target audiences (young people, health care workers, employers, and the media). Projects delivering similar interventions used similar evaluation tools for the effects to be compared across settings and decisions made about which to upscale on a national or international scale.

Program overview	
Time span	Opening Minds (2009–present) and The Working Mind (2014–present)
Scale	National and some international
Funding	Opening Minds is self-sustaining and funded through its workplace training programs.
Partners	The Mental Health Commission of Canada funds and oversees the program. The Working Mind aspect of this work is now a separate entity that re-invests profits from the income of its workplace delivery back into anti-stigma work and the Commission.
Model and evidence base	Opening Minds chose to target the workplace due to moral, ethical, financial, and productivity reasons to reduce stigma and improve mental health. Workplace programs that address these barriers can reduce losses to workplace productivity and gain a positive return on investment outcomes. In terms of the employee, many individuals spend most of their days at work and may experience their mental health-related problems during their prime working years (Szeto and Dobson 2010). Programs that reduce stigma and provide workplace mental health knowledge would likely increase help-seeking and may contribute to a more supportive workplace atmosphere. TWM was developed by clinicians and peers and based on scientific research and best practices. It was initially based on the Road to Mental Readiness (R2MR) program which was developed by the Department of National Defence to increase mental resiliency in soldiers with stressful and traumatic experiences.
Implementation	
Target audiences	• Working Minds: Employers/the workforce including adaptations for health care providers, first responders, lawyers, professional and amateur sportspersons, and so on. • Opening Minds: Young people, health care professionals, the media.

Project activities/ methods	• Opening Minds: Contact-based education • Mental Health First Aid (MHFA) • **The Inquiring Mind (TIM)** is designed to meet the needs of post-secondary and high school students and help them cope with the unique challenges and stressors found in an educational setting. • **The Working Mind (TWM)** training aims to reduce stigma and promote mental health in the workplace, creating a more resilient and supportive culture among employees and leaders. It is structured into four interactive modules with videos, case studies, and practical exercises. These cover 'Mental Health and Stigma', 'The Mental Health Continuum', 'Stress and Resilience', and a fourth module 'Supporting Your Team' only for managers. The courses are offered in-person or virtually.
Lived experience involvement	• Opening Minds includes the points of view of people with lived experience of mental ill health. The 'Hallway Group' consists of Canadians with lived experience as advisors. Videos used in training feature the recovery stories of people with lived experience.
Contextual factors	• TWM also operates in Australia and the US. They prioritize cultural uptake, which is enabled by organizational readiness, strong leadership support, ensuring good group dynamics, credibility of trainers, and implementing the program as one piece of a larger program (Dobson, Szeto, and Knaak 2019).

Outcomes

Evaluation tools	(The Working Mind): Reductions in stigma; increases in resilience; overall mental health literacy; overall mental wellness.
Evidence of effectiveness	• The Working Mind was associated with moderate reductions in stigma and increased self-reported resilience and coping abilities (Dobson, Szeto, and Knaak 2019). The program also decreased mental health stigma and increased self-reported resilience and coping skills which were maintained at the three-month follow-up (Dobson et al. 2021). • An evaluation of The Road to Mental Readiness (for first responders) indicated that the program increased participants' perceptions of resiliency and decreased stigmatizing attitudes, which were mostly maintained at the three-month follow-up. The program increased mental health support for first responders (Szeto, Dobson, and Knaak 2019).

Lessons learned and recommendations

- Specialized programs are more effective than generalized programs with information that is more tailored to the local context and such programs benefit from learning from the local community.
- Evidence-based information is crucial, using both quantitative and qualitative information.
- It is beneficial to start the anti-stigma process as early as possible, as children as young as two or three years old are already developing perception and young people are also more open and supportive to people with mental health conditions.
- Lowering stigma requires generational change, namely a long-term commitment.
- Challenges of this program include the absence of a large, publicly visible anti-stigma effort as would have been the case if a large media campaign had been used.
- Working Minds had the best engagement when working with someone at managerial level, who was more likely to understand the importance and effects of mental health conditions in the workplace.
- Focus on sustainability, as many anti-stigma programs unfortunately end because of lack of funding.

Sustainability strategy

- Income generation model funds the 'Opening Minds' program and returns a profit to fund other projects
- Sustainability of Impact: Booster sessions were an important component of sustainability as pre and post studies found that after training, people maintained the effects for three months, but at six months they saw a drop in the use and knowledge of the training.

Additional information

Website: https://openingminds.org/training/twm/

Program contacts: Mike Pietrus (mpietrus@openingminds.org).

8. More Than a Label program, Hong Kong

The pilot anti-stigma program started in 2019 with initial funding from a Hong Kong Foundation, followed by the program launch in 2021. The Hong Kong Government funds its own campaign which is not linked.

Program overview	
Time span	2019-present with funding secured until 2025
Scale	National population-wide since 2021
Funding	Current average budget HKD 1.5 million/approximately £150,000
Partners	Mind HK. Funder is MINDSET (Jardine Matheson Group Charity)
Model and evidence base/ foundations	All three elements are 'evidence-based best practice'. Initial methods, models, and evaluation framework guided by TTC and adapted and piloted to local content.
Implementation	
Target audiences	• Public - Hong Kong residents (adults mostly working age) and health care providers
Project activities/ methods	• **Ambassadors**—122 local people with lived experience of mental health problems provided with bilingual training and ongoing support to safely and effectively share their mental health experiences in public (social contact events, online, in campaigns). • **Community events (using social contact)**—over 100 events in public settings, workplaces, schools. • **Social marketing campaign**—large-scale annual campaign bursts with social and traditional media. • **Owned social media channels**—4,000 followers on Instagram and 31,191 views of campaign videos. • **Stakeholder engagement**—extending reach to a wide range of communities.
Delivery team	• 4 people (2 full time and 2 part time)
Lived experience involvement	• Strategic Input: Advise on strategy every cycle and all campaign planning and involved in all aspects of program development, will also be on all steering groups and the Program Advisory Board. • Activity-level Input: Co-train new ambassadors, develop and deliver some new ambassador training content, develop and plan their own social contact events, feature in campaigns, and share experiences at social contact events and on owned social media channels.
Contextual factors	• Any illness attracts a lot of shame. Stigma is related to 'not being perfect' including mental health and cancer both of which are seen as a weakness or reflection of your DNA. This is more prevalent in older generations, but some for young people this can be 'deeply ingrained'. • The attitude survey shows that almost half the population think mental health issues are a result of a lack of will power, and there is also a pressure to succeed—both result in a 'saving face' culture.

	• Ethnically Chinese ambassadors sometimes prefer to share their mental health stories in English as they feel that some mental health terminology in Chinese is stigmatizing.
Outcomes	
Evidence of effectiveness	• A sample of public who viewed campaign videos showed a significant positive improvement in attitudes and intended behavior but not MAKS as a total score but the stigma subscale did improve. • A survey of general and mental health nurses using the OMS-HC-15 scale showing positive improvement in mental health stigma scores after ambassadors had shared their stories. • Ambassadors. Three themes emerged; "the impact goes both ways" with improved healing and self-discovery, sharing lived experience is "emotionally challenging," and the importance of the supportive community of peers who are ambassadors and the support from Mind HK team.
Public attitudes of adults	• The 2021 survey of 1,010 adults to assess attitudes toward mental health issues in Hong Kong conducted by Social Policy Research Limited. • Mental Health Knowledge Scale (MAKS), Community Attitudes on Mental Illness scale (CAMI) and Reported and Intended Behaviour Scale (RIBS) validated tool in Chinese and English used on a smaller sample size before and after seeing campaign videos featuring ambassadors. • Health care providers: OMS-HC tool used in a pre and post survey following ambassador-sharing session.

Lessons learned and recommendations

- While the experience of being an ambassador and learning to shared mental health experiences showed positive results for the ambassadors, it was also a 'difficult' thing to do. People applying to become trained ambassadors will need be screened before they trained and offered ongoing support.
- Male engagement has been difficult from a cultural perspective but is improving and increasing reach with men through partnership and male-focused events.

Additional information

Website: https://www.mind.org.hk/press-releases/mind-hk-and-mindset-hong-kong-launch-honestlyspeaking-a-bold-new-campaign-to-combat-stigma-against-mental-health-conditions/

Mind HK: https://www.mind.org.hk/mtal/

Program contacts: Odile Thiang - odile.thiang@mind.org.hk,
Carol Liang - carol.liang@mind.org.uk

Other key developments supporting anti-stigma programs

- The Hong Kong Government's anti-stigma campaign 'Shall We Talk' ran for a few years. The campaign used traditional and social media channels with a high-profile celebrity singer.
- The City Mental Health Alliance HK is a Hong Kong division https://www.cmhahk.org/ with membership by large corporates focused on mental health and well-being at work. It is part of a larger global network of employers called the Mind Forward Alliance https://mindforwardalliance.uk/.

9. Mental Health Supporter Training program, Japan

The Mental Health Supporter Training Program is a Japanese adaption of the MHFA program led by the National Institute of Mental Health between 2020 and 2023.

Program overview	
Time span	Pilot 2020–2023; National upscale 2024–2033
Scale	National upscale across 1,700 municipalities with a target of 1 million people trained by 2033
Partners	The Ministry of Health funded the development and early rollout period when 7,000 adults were trained (average age 44). From 2024, a private contractor is delivering a national program of training in large-scale and middle-scale cities with a target of training 1 million people as 'Cocoro Supporters' by 2033. In recent years, there was a similar program of training to enable people to be more supportive of people with dementia that saw 10 million people trained.
Model and evidence base	The program was partly based on the original MHFA model.
Implementation	
Target audiences	Adult residents in Japan (there were no exclusion criteria)
Project activities/ methods	A two-hour online training to help participants better understand mental illness and learn about support techniques for people with mental health difficulties close to them. The content of the training focused on goal of the program (5 min); what is a mental health supporter (10 min); learning about mental illness, learning about recovery from mental illness (8 min); how to support the mental health of people close to you, workshops, and wrap-up (45 min). There are two additional modules that can be chosen: Self-care through coping with stress and learning about mental illness.
Outcomes	
Evaluation tools	The following outcomes and tools were used in the evaluation of the initial program. The research team recommended the inclusion of the stigma-related RIBS scale to measure intended and reported behavior. • Primary Outcome: The Japanese version of the Reported and Intended Behaviour Scale (RIBS-J) with both the intended and reported subscales. • Secondary Outcomes: Japanese Version of the Mental Health Literacy Scale (MHLS), psychological distress using the Kessler Psychological Distress Scale 6 (K6) (based on the premise that listening to people around them may reduce interpersonal conflict and improve their own mental health), and mental health knowledge using questions developed by the authors.
Evidence of effectiveness	The published study aimed to examine the effects of the Mental Health Supporter Training Program on mental health-related stigma, mental health literacy, and knowledge of mental health among Japanese people trained between October 2022 and February 2023 across 18 municipalities, and to investigate the feasibility of the program. Pre and post assessments were undertaken at baseline (T1), immediately after the training (T2), and approximately six months later (T3) with the following results: • RIBS-J. Despite the mean **intended behavior** score increasing at statistically significant levels between T1 and T2, it returned to the baseline level at T3

showing no longer-term effect. The mean reported behavior score increased and remained the same at T3 but the effect size was small.

- The scores for Mental Health Literacy (knowledge and attitude) increased from T1 to T2 at significant levels for both knowledge and attitudes and remained the same at T3.
- Mental health knowledge score increased at significant levels from T1 to T2 and the same at T3.
- The psychological distress score showed a small but significant change at T3.

The results show the impacts of the program on improving mental health literacy, knowledge of mental health, and reducing levels of psychological distress but not longer-term impacts on intended and reported behavior of trained participants.

Lessons learned and recommendations

- Two possible causes were discussed for the lack of sustained effectiveness: the contents of the program (with only a brief introduction to the experience of people with mental illness) and the lack of follow-up.
- Authors also discussed whether the T3 follow-up at six months was too soon for respondents to have had social contact with people with mental health problems over that period (for the reported subscale), and that changing negative behavior with only one intervention could be difficult and that other follow-up interventions might be necessary.

Sustainability strategy

The upscaling strategy, which could support sustainability efforts, is that local municipalities fund the delivery of the training (with the ending of national government funding); however, there are concerns that only those areas with more resources will be able to provide funding.

Additional information

Links to programs website. Coco-sapo https://cocoroaction.jp/en/

Program evaluation. "Effects of the Mental Health Supporter Training Program on mental health-related public stigma among Japanese people." *Psychiatry and Clinical Neurosciences Reports*, March 2024. https://onlinelibrary.wiley.com/doi/10.1002/pcn5.176.

(*) June 2024 update. Findings in a new paper (the purpose of which was to modify the program evaluated in the previous study and verify its effectiveness for participants in the FY2023 program), "suggested that the combination of educational and contact-based interventions might reduce public stigma toward people with mental health problems immediately post intervention, an effect that persists 3 months later." https://onlinelibrary.wiley.com/doi/full/10.1002/pcn5.219

Name and contact details for previous program manager. Naoaki Kuroda - nkuroda@ncnp.go.jp. Daisuke Nishi - d-nishi@m.u-tokyo.ac.jp (led until 2023)

Other key developments supporting anti-stigma programs:

- Renaming of schizophrenia in 2002, which aimed to reduce stigma (following media analysis) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472254/
- Ministry of Education has included an item on prevention and recovery from mental disorders in the high school curriculum since 2022.

10. 'Beyond the Label' program, Singapore

The national Beyond the Label (BTL) movement was initiated and funded by the National Council of Social Service (NCSS) and is now a collective impact initiative co-led with TOUCH Community Services. The 'BTL Collective' is a national movement with many public, voluntary, and private sector agencies and stakeholders involved. The movement seeks to build community expertise to convene people, private and public agencies to work toward a common goal of addressing stigma and promoting social inclusion for people with mental health conditions (PMHCs).

Program overview	
Time span	Launched in 2018 until 2021 with a second phase from 2022 to 2028
Scale	National scale from the outset in 2018
Funding	SGD 2 million /£1.2 million GBP per year. Funds from the government, corporate sponsors, trusts, donations
Partners	The NCSS set up BTL in response to data from two surveys showing that the most common drivers were low mental health literacy and stigma. • About 7 in 10 people with mental health conditions encounter challenges living with dignity due to negative attitudes and actions from others Quality of Life Study 2016 (NCSS). • The prevalence of public misconceptions about people with mental health conditions including fear, a lack of understanding, and the influence of the media contribute to "deep-seated stigma prevalent in society" in another NCSS study of Public Attitudes towards Persons with Mental Health Conditions in 2017. This also found that 75 percent would not seek help for a mental health problem for more than a year.
Implementation	
Target audiences	• Families and caregivers; children and young people; communities; employers
Project activities/ methods	• **THE BTL Collective**—34 agencies from the public, private, and people sectors adding leverage and reach. • **Social marketing campaign**. **Let's Get Talking**—the aim of the latest campaign is to encourage persons with mental health conditions to share their stories of strength and resilience, and to seek help early. • **Community engagement**—events, roadshows, talks/workshops, and a grant for the BTL workgroups to implement their initiatives • **Ambassadors** with lived experience who share their stories with the public to inspire others facing similar struggles to speak up and seek help. • **Beyond the Label chatbot 'Belle'**—for people struggling with stress or anxiety or their families/friends which is now also available via WhatsApp and online. Belle will be consolidated with Mindline.sg, a digital first-stop touchpoint for mental health resources and support from January 1, 2025. Current users of Belle will be directed to Mindline.sg, where they can access a self-assessment tool that allow users to be directed to relevant mental health resources and services. • **Workplace**—Employer Pledge and Resources, panel dialogue/workshops, targeted campaign. • **Higher education**—Roadshows in institutes of higher learning.

	• **Schools**. Psychoeducation talks, the **Beyond the Label Plug and Play Kit** is a toolkit offering a wide range of activities that provides young people resources and tips for launching their own anti-stigma initiatives.
Contextual factors	Despite some positive shifts in attitudes after the introduction of BTL, the issue of stigma is prevalent. The 2021 NCSS Study on Attitudes towards Persons with Mental Health Conditions has shown that four in five people felt that persons with mental health conditions were stigmatized, four in ten0 were willing to live with persons with mental health conditions, and one in four believed that lack of self-discipline was the cause of mental health conditions. If not addressed, these negative attitudes and misconceptions can be expected to perpetuate a culture of stigma that deters persons with mental health conditions from seeking help or being included. Since COVID-19, mental health is a national priority. An Inter-agency Taskforce on Mental Health and Well-being was established by the Government in 2021 to oversee national efforts to promote mental health and well-being beyond the COVID-19 pandemic. The taskforce has since launched Singapore's National Mental Health and Well-being Strategy in 2023, which covers the following focus areas: (a) expanding capacity of mental health services, (b) enhancing capabilities of service providers for early identification and intervention, (c) promoting mental health and well-being, and (d) improving workplace mental health and well-being. In a parliamentary motion in February 2024, the then Deputy Prime Minister stated that the government is making mental health and well-being a key priority in the national agenda.
Outcomes	
Evaluation tools	Public attitudes (including knowledge, attitudes, and behavior): A 2021 NCSS Study on Attitudes towards Persons with Mental Health Conditions of 2,000 Singaporean residents using the Community Attitudes toward the Mentally Ill (CAMI-12) Scale, Reported and Intended Behaviour Scale (RIBS), and Mental Health Knowledge Schedule (MAKS).
Evidence of effectiveness	Public survey to assess improvements in public attitudes and behavior toward persons with mental health conditions; increase in public awareness and understanding of mental health conditions and resources. • About 25 percent higher on the knowledge scale; 10 percent higher on the behavior scale; 15 percent higher on the attitude scale by the end of 2028, with 2022 data as baseline.
Lessons learned and recommendations	
• Youth play an important part in this movement. Creating a non-labelling space for young people was vital for mental health promotion and prevention approaches. Young people who need help were finding it hard to locate this, so in 2019 the online chatbot 'Belle' was developed and is now an online 'escape room' developed during COVID. Young people are also more openly discussing mental health particularly on social media. • Understanding that reducing stigma and promoting social inclusion requires moving beyond raising awareness alone, the next phase of BTL will take on a more targeted approach with intentional community outreach and engagement efforts in schools, workplaces, families, and communities.	

Sustainability strategy

NCSS has secured funding for the BTL movement until 2028.

Additional information

Program website: https://www.ncss.gov.sg/our-initiatives/beyond-the-label

Program manager: TOUCH Community Services (btl_admin@touch.org.sg) and NCSS Service Delivery (btl_admin@touch.org.sg)

Other anti-stigma projects/programs: City Mental Health Alliance Singapore https://mindforwardalliance.uk/CMHA-Singapore/1284-/CMHA-Singapore-Linklaters-Heineken