Mental Illness Stigma, Help Seeking, and Public Health Programs

Globally, more than 70% of people with mental illness receive no treatment from health care staff. Evidence suggests that factors increasing the likelihood of treatment avoidance or delay before presenting for care include (1) lack of knowledge to identify features of mental illnesses, (2) ignorance about how to access treatment, (3) prejudice against people who have mental illness, and (4) expectation of discrimination against people diagnosed with mental illness. In this article, we reviewed the evidence on whether large-scale anti-stigma campaigns could lead to increased levels of help seeking. (*Am J Public Health*. Published online ahead of print March 14, 2013: e1–e4. doi:10.2105/AJPH.2012.301056)

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INCREASING EVIDENCE SUG- gests that significantly greater barriers exist to receipt of mental health care in comparison with physical health care. Worldwide, more than 70% of young people and adults with mental illness do not receive any mental health treatment from health care staff.[1] The difference between true prevalence and treated prevalence can be called the treatment gap.[2] This article describes the roles that stigma and discrimination contribute to the treatment gap[3,4] and assesses the evidence that public health approaches to stigma and discrimination can facilitate access to mental health care. We present new data from the evaluation of Time to Change, England's largest ever program to reduce mental illness stigma and discrimination.[5]

DISCRIMINATION, STIGMA, AND MENTAL HEALTH CARE ACCESS

The relationship between stigma and discrimination and access to care is multifaceted; stigma and discrimination can impede access at institutional (legislation, funding, and availability of services),[6–8] community (public attitudes and behaviors),[9] and individual levels.[10a] Descriptive studies and epidemiological surveys suggest potent factors that increase the likelihood of treatment avoidance, delays to care, and discontinuation of service use include (1) lack of knowledge about the features and treatability of mental illnesses, (2) ignorance about how to access assessment and treatment, (3) prejudice against people who have mental illness, and (4) expectations of discrimination against people who have a diagnosis of mental illness.

Addressing public stigma might reduce experienced and anticipated stigma among services users and facilitate help seeking and engagement with mental health care. For example, individual service users living in countries with higher rates of help seeking and treatment utilization, in addition to better perceived access to information about how to deal with mental health problems and less stigmatizing attitudes, tended to have lower rates of self-stigma and perceived discrimination.[10b] Globally, however, stigmatizing attitudes persist among the public and have been shown to be prevalent[11–13] and associated with a reluctance to seek help.[14–16] Specifically, beliefs about effectiveness of treatment and services at the start of treatment have been shown to influence subsequent treatment behavior.[17–19] This is significant because currently individuals often only access services once they have already experienced significant impairment, clinical symptoms, and stigma, and these effects may be difficult to reverse.

Stigma and discrimination and their influence on access to care may vary based on experience of mental distress or other sociodemographic factors. For instance, psychotic disorders are highly stigmatizing, and people with psychosis are more likely to be perceived as violent and unpredictable relative to people with other mental health problems. This can lead to high levels of experienced and anticipated discrimination in health care settings.[20,21] Moreover, substance abuse is consistently associated with high rates of public stigma and institutional discrimination that may discourage individuals with substance abuse problems from getting health care; these individuals fear poor treatment by health care providers or trouble with the authorities.[22] Multiple stigma among specific subpopulations may also exacerbate barriers to care. Different ethnic groups may have different histories and experiences with the health care system, and therefore, certain barriers may be more prevalent among individuals of different ethnic groups.[23–25] For example, negative experiences of coercion in mental health care may be more prevalent among ethnic minorities.[26] As a result, it has been suggested that future research should investigate subgroups and potential interactions between subgroups and on help-seeking attitudes and behavior.

IMPACT OF PUBLIC HEALTH PROGRAMS ON HELP SEEKING

Because of the complex multifaceted nature of stigma and discrimination and the subsequent barriers associated with accessing care, the solutions for reducing stigma and discrimination and facilitating access to care will need to be equally diverse.[27] In the United Kingdom, there are related but separate national programs to reduce stigma and discrimination in Scotland, England, and Wales. Each of these anti-stigma programs consists of multiple components aimed at specific target groups (e.g., the media, young

people) and at the general public, and operates at multiple levels (i.e., national social marketing campaigns and regional activities, such as those based on support from stakeholders), and at the level of small community groups funded to carry out local anti-discrimination work. Similar programs are also running in New Zealand (Like Minds Like Mine), Canada (Opening Minds), and Denmark (One of Us). No data are available regarding any increase in access to mental health care over the course of these programs, although it should be noted that an increase was observed over the course of a smaller scale mental health awareness program carried out in Nigeria.[28] The lack of a control group makes it difficult to interpret the extent of any change as being the result of such programs,[29] especially if there are contemporaneous policy and service developments. In Australia, however, there was variation among states and territories in the utilization of the depression program Beyondblue, allowing comparison of knowledge and attitudes toward treatment of depression to be compared across these areas.[29] Although these data suggested a positive impact of Beyondblue on attitudes toward help seeking and treatment, no data from Australia are available on whether help seeking itself increased.

In England, the Time to Change program began in 2007, and the social marketing campaign started in January 2009.[5] The second phase of Time to Change began in October 2011, and will run until March 2015. The evaluation of Time to Change is carried out by the United Kingdom's Institute of Psychiatry at King's College London. Again, the lack of a control group did not allow us to determine whether help seeking increased as a result of Time to Change. However, questions about intended help seeking were included before the start of Time to Change in the Department of Health Attitudes to Mental Illness Survey, a nationally representative survey which has been ongoing since 1994.[30] This survey thus provides a tool to evaluate the Time to Change campaign.

Using data from the survey, we found that mental health knowledge predicted intentions to seek help for a mental illness and to disclose such an illness to family and friends, which underlines the importance of mental health literacy.[31] This applied to two types of knowledge measured by the Mental Health Knowledge Schedule.[32] The first was knowledge that might influence subsequent mental health-related attitudes and behaviors. This type of knowledge was found to predict help seeking and disclosure more strongly than either attitude factor present in this survey. The second was whether major psychiatric disorders (depression, schizophrenia, and bipolar disorder) were considered mental illnesses, which was associated with help-seeking intentions from a primary care physician.[33]

Attitudes toward mental illness showed a more mixed pattern with respect to help seeking and disclosure intentions. A factor analysis of the shortened version of the Community Attitudes Toward the Mentally Ill scale,[34] used in the Department of Health Attitudes to Mental Illness Survey, suggested that intentions to seek help for a mental health problem were associated with attitudes of tolerance and support for community care, but not with stigmatizing attitudes of prejudice and exclusion. These findings suggested that the presence of strong positive attitudes might be more relevant to help seeking and disclosure than the absence of negative attitudes.

TABLE 1—Prevalence of Intended Help Seeking by Sample Characteristics: England, Department of Health Attitudes to Mental Illness Survey, 2012

Characteristic	Intended Help Seeking, Unweighted No. (Weighted %)	No Intended Help Seeking, Unweighted No. (Weighted %)
Campaign awareness		
Yes	423 (84.4)	74 (15.6)
No	1008 (81.9)	212 (18.1)
Gender		
Female	790 (85.3)	134 (14.7)
Male	641 (79.9)	152 (20.1)
Age, y		
16–24	206 (80.3)	52 (19.7)
25–34	225 (75.7)	65 (72.3)
35–44	236 (81.3)	54 (18.7)
45–54	206 (85.2)	32 (14.8)
55–64	235 (86.5)	33 (13.5)
65–74	181 (89.0)	22 (11.0)
≥ 75	142 (83.9)	28 (16.1)
Ethnicity		
Asian	128 (78.8)	32 (21.2)
Black	55 (81.4)	12 (18.6)
Other	25 (80.0)	6 (20.0)
White	1215 (83.2)	234 (16.8)
Socioeconomic status[a]		
AB = highest income	249 (85.3)	43 (15.7)
C1 = higher middle income	368 (79.6)	88 (20.4)
C2 = lower middle income	315 (85.2)	53 (14.8)
DE = lowest income	499 (82.9)	102 (17.1)
Familiarity with mental health problems		
Self	98 (89.0)	13 (11.0)
Other	781 (83.1)	145 (16.9)
None	530 (81.8)	115 (18.2)

Note. The sample size was n = 1717. Regarding the table title, the exact question wording was: "If you felt that you had a mental health problem, how likely would you be to go to your general physician for help?"

[a]Categories used are those maintained by the UK Market Research Society and based on the National Readership Survey's Social Grades. The classes are based on the chief income earner's occupation:
A = upper middle class: higher managerial, administrative or professional
B = middle class: intermediate managerial, administrative or professional
C1 = lower middle class: supervisory or clerical and junior managerial, administrative or professional
C2 = skilled working class: skilled manual workers
D = working class: semi- and unskilled manual workers
E = those at the lowest levels of subsistence: Casual or lowest grade workers, pensioners and others who depend on the welfare state for their income.

The preceding findings suggested that if social marketing campaigns were effective at improving knowledge and positive attitudes, they would result in

increased intentions toward help seeking. However, it was also possible that awareness of the campaign affected help-seeking intentions through some other mechanism. For the 2012 Attitudes To Mental Illness Survey, we included questions to assess awareness of the Time to Change social marketing campaign so that we could directly examine the relationship between campaign awareness and intended help seeking and disclosure to friends or family. Table 1 describes the prevalence of intended help seeking by sample characteristics. Prevalence of intended help seeking ranged from 79% to 89% regardless of sociodemographic characteristics, campaign awareness, or familiarity with mental health problems through knowing someone.

Table 2 shows the results of multivariable logistic regression that examined the relationship between campaign awareness and help seeking and disclosure, controlling for sociodemographic characteristics and familiarity with mental health problems. We found no relationship between campaign awareness and intended help seeking. For disclosure to family and friends, the unadjusted results suggested a marginally negative relationship; however, there was no relationship after adjustment. It was possible that those who were uncomfortable with discussing a mental health problem with friends and family were more likely to remember the campaign, which in 2012 emphasized the need to be more open in discussing mental health problems (It's Time to Talk). For both items, we found positive relationships with being female; for the help-seeking item, we also found a negative relationship for the age category 25 to 34 years, which included some of Time to Change's campaign target group of those aged 25 to 45 years with middle incomes.

TABLE 2—Multivariable Logistic Regression of Predictors of Intended Help Seeking From Primary Care and Disclosure to Family or Friends: United Kingdom, Department of Health Attitudes to Mental Illness Survey, 2012

Predictors	Help Seeking From Primary Care		Disclosure to Family or Friends	
	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Campaign awareness				
Yes	1.15 (0.84, 1.56)	1.11 (0.81, 1.52)	0.78 (0.60, 1.01)	0.88 (0.67, 1.16)
No (Ref)	1.00	1.00	1.00	1.00
Gender				
Female	1.56* (1.19, 2.05)	1.53* (1.16, 2.03)	0.91 (0.72, 1.15)	0.99 (0.78, 1.25)
Male (Ref)	1.00	1.00	1.00	1.00
Age, y				
16–24	0.72 (0.42, 1.23)	0.76 (0.43, 1.32)	1.32 (0.83, 2.08)	1.17 (0.73, 1.87)
25–34	0.54* (0.32, 0.91)	0.56* (0.33, 0.95)	1.17 (0.74, 1.84)	1.10 (0.68, 1.76)
35–44	0.75 (0.44, 1.29)	0.75 (0.44, 1.30)	0.86 (0.54, 1.38)	0.86 (0.53, 1.40)
45–54	1.04 (0.57, 1.89)	1.03 (0.56, 1.88)	0.66 (0.40, 1.10)	0.70 (0.42, 1.18)
55–64	1.12 (0.63, 2.02)	1.15 (0.64, 2.05)	0.92 (0.57, 1.47)	0.98 (0.60, 1.58)
65–74	1.35 (0.72, 2.53)	1.34 (0.71, 2.53)	1.03 (0.63, 1.69)	1.06 (0.65, 1.75)
≥ 75 (Ref)	1.00	1.00	1.00	1.00
Ethnicity				
Asian	0.74 (0.47, 1.15)	1.01 (0.61, 1.66)	2.53* (1.78, 3.61)	2.29* (1.55, 3.37)
Black	1.03 (0.50, 2.10)	1.16 (0.56, 2.43)	1.10 (0.61, 1.98)	1.06 (0.57, 1.94)
Other	0.79 (0.30, 2.08)	0.89 (0.32, 2.46)	0.30 (0.07, 1.26)	0.31 (0.07, 1.32)
White (Ref)	1.00	1.00	1.00	1.00
Socioeconomic status				
AB = highest income	1.10 (0.72, 1.66)	1.12 (0.74, 1.71)	0.81 (0.57, 1.13)	0.83 (0.58, 1.19)
C1 = higher middle income	0.78 (0.56, 1.09)	0.85 (0.60, 1.18)	0.87 (0.65, 1.17)	0.84 (0.62, 1.13)
C2 = lower middle income	1.13 (0.77, 1.65)	1.24 (0.84, 1.82)	0.86 (0.63, 1.17)	0.85 (0.62, 1.17)
DE = lowest income (Ref)	1.00	1.00	1.00	1.00
Familiarity with mental health problems				
Self	1.80 (0.95. 3.41)	1.68 (0.86, 3.30)	0.26* (0.13, 0.48)	0.33* (0.17, 0.64)
Other	1.10 (0.83, 1.45)	0.97 (0.70, 1.35)	0.77 (0.60, 0.97)	0.99 (0.76 1.29)
None (Ref)	1.00	1.00	1.00	1.00

Note. CI = confidence interval; OR = odds ratio. Regarding the table title, the exact question wording was: "If you felt that you had a mental health problem, how likely would you be to go to your general physician for help?"
*$P \leq .05$.

Thus far, we considered initial help seeking; however, examination of the relationship between anti-stigma programs and help seeking should investigate initial and subsequent actions. Negative experiences with mental health professionals perceived to be discriminatory and discrimination experienced at the hands of others because of having a mental illness might deter individuals from seeking treatment. Therefore, it is hoped that programs such as Time to Change will lead to reductions in unfair treatment by both health professionals and others. Interim data from the Viewpoint survey[35] suggested that between 2008 and 2009, after the Time to Change social marketing campaign began in January 2009, the overall level of discrimination fell. This was accounted for by reduced discrimination from a number of sources, including friends, family, dates, neighbors, employers, and education professionals. However, there was no reduction in reports of discrimination from either mental health professionals or physical health care professionals. This suggested that even if Time to Change were to increase initial treatment seeking, that is, if public knowledge, attitudes, and behaviors improved, a lack of reduction in the risk of negative experiences

with health professionals would continue to deter people from seeking further help. ■

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Contributors

C. Henderson originated the article and wrote first drafts of the article for submission and resubmission. S. Evans-Lacko conducted the statistical analyses and provided comments and edits to drafts of the article. G. Thornicroft accepted the initial invitation to submit and provided comments and edits to drafts of the article.

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