The *Lancet* Commission on ending stigma and discrimination in mental health

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Executive summary

It is time to end all forms of stigma and discrimination against people with mental health conditions, for whom there is double jeopardy: the impact of the primary condition and the severe consequences of stigma. Indeed, many people describe stigma as being worse than the condition itself. This *Lancet* Commission report is the result of a collaboration of more than 50 people worldwide. It brings together evidence and experience of the impact of stigma and discrimination and successful interventions for stigma reduction. We include material that brings alive the voices of people with lived experience of mental health conditions (PWLE). This is right in principle because we agree with the view of nothing about us without us. It is right in practice because the evidence summarised in this report shows that PWLE are the key change agents for stigma reduction. For these reasons, this report has been co-produced by people who have such lived experience and others who do not. Their voices whisper, speak, and shout in the poems, testimonies, and quotations.

The *Lancet* Commission on ending stigma and discrimination in mental health had six aims (panel 1). From traditional definitions of stigma, we have developed four main components to consider in this report: self-stigma (or internalised stigma), which occurs when people with mental health conditions are aware of the negative stereotypes of others, agree with them, and turn them against themselves; stigma by association, which refers to the attribution of negative stereotypes and discrimination directed against family members (eg, parents, spouses, or siblings) or to mental health staff; public and interpersonal stigma, which refer to the forms of knowledge and stereotypes, negative attitudes (prejudice), and negative behaviour (discrimination) by members of society towards people with mental health conditions; and structural (systemic or institutional) stigma, which refers to policies and practices that work to the disadvantage of

Key messages

- Stigma and discrimination contravene basic human rights and have severe, toxic effects on people with mental health conditions that exacerbate marginalisation and social exclusion, for example by reducing access to mental and physical health care and diminishing educational and employment opportunities
- Our umbrella review of 216 systematic reviews shows 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 stigmatisation worldwide
- Our evaluation of ten large-scale anti-stigma programmes around the world found that they are most effective when they involve people with lived experience of mental health conditions (PWLE) as co-producers in all aspects of development, when target groups are consulted on programme content and delivery, and when programmes are sustained over the long term
- The media play powerful roles in increasing stigma when they reinforce stereotypes associated with mental health conditions, such as unpredictability or dangerousness, and decreasing stigma when they align with guidelines on responsible reporting, for example of suicide
- In a global, multilanguage survey of PWLE, 391 people responded from 45 countries and territories. Most (≥70%) participants agreed that PWLE should be treated as equal to people with physical health conditions; stigma and discrimination negatively affect most PWLE; the media are an important factor in worsening stigma and discrimination; the media could play a crucial part in reducing stigma and discrimination; and stigma and discrimination can be worse than the impact of the mental health condition itself
- The findings of this *Lancet* Commission show that PWLE are key agents for change in stigma reduction and need to be strongly supported to lead or co-lead interventions that use social contact
- We propose eight key recommendations for action by international organisations, governments, employers, the health-care and social-care sectors, the media, PWLE, local communities, and civil society, each with a specific target and indicators that may be used to develop a framework for accountability and track progress towards ending mental-health-related stigma and discrimination

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For the French translation of the abstract see **Online** appendix 1

For the Spanish translation of the abstract see **Online** appendix 2

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***Panel 1*: Aims of this *Lancet* Commission on ending stigma and discrimination in mental health**

- Define stigma and discrimination, setting out the levels at which they occur
- Summarise the evidence of how people with lived experience of mental health conditions worldwide currently experience forms of stigma and discrimination and the impacts, ranging from engagement with the community and with services (barriers to help seeking) to care provision (service provider behaviour in relation to people with mental and physical conditions) and forms of social exclusion (eg, marriage, the workplace, and educational settings)
- Do a literature review on the effectiveness of interventions to reduce stigma and discrimination in the field of mental health
- Assess the experience of large-scale programmes to combat stigma and to draw together the lessons learned
- Understand how the traditional and the newer media can both contribute to and counteract mental-health-related stigmatisation
- Identify what policies, resources, initiatives, culturally relevant and appropriate narratives, and interventions are required to eradicate mental-health-related stigma and discrimination and to drive the systemic legal, financial, social, health, and environmental changes that are needed; from this analysis to propose actionable recommendations to put these changes into practice

the stigmatised group, whether intentionally or unintentionally.

This report summarises the many negative impacts of stigma and discrimination, ranging from damage to marital prospects, social exclusion in relation to education, the workplace, and the community, loss of property, inheritance, or rights to vote, and poorer health care than is given for physical conditions. Stigma powerfully and adversely affects individuals, families, communities, and society, is persistent, and exists across cultures. These pernicious barriers to full citizenship and social participation all share one fundamental characteristic: they contravene basic human rights that are intended to apply equally to everyone. We summarise these effects in four domains: personal, including self-stigma, quality of life and service use; structural, including legal provisions, human rights, and the implementation of psychosocial interventions; health and social care; and social and economic, including work.

The evidence for effective interventions to reduce stigma is summarised in an umbrella review of 216 review papers, most of which address aspects of public and interpersonal stigma. The clearly emerging core finding is that forms of social contact (direct or indirect) between people who do and do not have lived experience of mental health conditions is the most effective evidence-based way to reduce stigmatisation.

Detailed case studies of various programmes aimed at delivering anti-stigma interventions worldwide are presented. The key lessons that emerge include involving PWLE in all aspects of co-producing anti-stigma programmes; carefully creating and adapting the programme content based on context and culture; consulting closely with the identified target groups; and paying attention to the effects, outcomes, and sustainability of the programme.

This report also explores the roles of the media—traditional and newer digital media—in promoting or reducing stigma from a specific review of this literature, particularly the potential of media reporting guidelines to reduce suicide rates.

We also present findings from a global survey of PWLE commissioned for this report. From the almost 300 respondents in 45 countries (mostly low-income and middle-income countries [LMICs]) over 90% agreed that PWLE should be treated as well as people with physical health conditions, that stigma and discrimination negatively affect most people with mental health conditions, and that the media could play an important part in reducing stigma and discrimination.

In formulating the Commission recommendations, we were guided by five key principles. First, all relevant human rights instruments apply equally to people who do and who do not have experience of mental health conditions. Second, provisions that support the social inclusion of people with disabilities should be applied equally whether they arise from physical or mental health conditions. Third, health and care provision should be equitable regardless of whether people have a physical or mental health condition. Fourth, no country should have specific laws that unfairly discriminate against people based on a mental health conditions or suicidality. Fifth, initiatives and actions intended to reduce or eradicate mental health stigma and discrimination should be co-designed and co-produced with PWLE. In this context, we have agreed on six goals for stigma reduction: international guidance that all forms of stigma and discrimination towards people with mental health conditions are unacceptable should be issued; all governments should implement policies to support the end of such stigma and discrimination; workplace stigma and discrimination against people with mental health conditions should be eradicated; national curricula and vocational training for all health-care and social-care professionals should include mandatory components on the needs and rights of people with mental health conditions and should be co-delivered by PWLE; all media organisations should systematically remove stigmatising content from their products; and PWLE should be strongly supported to reduce stigma and discrimination. We also propose eight further recommendations for action by international organisations, governments, employers, the health-care

and social-care sectors, the media, PWLE, local communities, and civil society. Each recommendation has associated targets and specific, measurable indicators to set a framework for accountability and allow monitoring of progress over time.

To encapsulate all this work the *Lancet* Commission on ending stigma and discrimination in mental health issues this call to action: mental health is part of being human—let's act now to stop stigma and to start inclusion.

Aims and scope of the Commission

It is time to end all forms of stigma and discrimination against people with mental health conditions. For most such people there is a double jeopardy: the impact of the primary condition itself and the severe consequences of stigma. Indeed, as this report will demonstrate, many people with such conditions describe stigma as being worse than the condition itself.

Stigma and discrimination have many manifestations, ranging from damage to marital prospects; social exclusion in relation to education, the workplace, and the community; loss of property, inheritance, or rights to vote; and poorer health care than for physical conditions. Stigma powerfully and adversely affects individuals, families, communities, and society, is persistent, and exists across cultures.[1] These pernicious barriers to full citizenship and social participation all share one fundamental characteristic: they contravene basic human rights that are intended to apply equally to all of us (appendix 3 p 16).

In this report, we focus on the nature, impact, and consequences of stigma and discrimination and on their eradication. Evidence is now clear from high-income countries (HICs) and is emerging from LMICs that interventions to reduce stigma and discrimination can be delivered effectively. Therefore, the time is right for a detailed reappraisal and for a set of practical and radical recommendations to guide action and progressively eradicate mental-health-related stigma and discrimination at international, national, and local levels.

> "Giving voice—who has the true voice: us."
>
> *Person in Spain*

Aims and scope

The aims of this *Lancet* Commission are provided in panel 1. This report focuses on stigma and discrimination experienced by people who have mental health conditions. By this we mean not only formally classified mental disorders but also psychosocial disabilities, in alignment with the scope of the WHO 2022 World Mental Health Report.[2] These conditions include, but are not limited to, those which are included in the WHO *International Classification of Diseases* (ICD)-*11*, chapter 6, which includes all forms of common and severe mental health conditions, intellectual disabilities, substance-use conditions, and dementia. Additionally, we refer to dementia and suicidal ideas and behaviour in other ICD chapters. We include people of all ages and all structural forms of stigma (eg, low rates of investment in mental health).

Poem 1

The beast and the snake
by Anne Lai Ping Chan Ho

Stigmatisation
Adds hardship
To us with
Mental health issues

There is
Enacted stigma likened to a beast
Internal stigma likened to a snake
I have experienced them all
It had cost my career
It had cost friendships

I used to tell lies
In order to hide
Couldn't afford to tell
The truth of my unwell

I fight against stigma
I've become outspoken
Show the world my ailment
Share my story with everyone
I have killed the beast
I have got rid of the snake

But when I was told
By someone who is dearest
'You are dangerous
Stay away from my family'
Though,
An outburst of anger
Out of concern and fear
Those words broke me into
A million pieces

Hurt
But Stronger I've become
The need to stand up against stigma
Is absolutely clear
I face my beast
I face my snake
Not to be ashamed of
Who I am
Has been the key
To recovery

Working methods, structure, and approach

This report is the product of many heads and hands. The 22 commissioners formed six writing groups to draft its content. Half of the commissioners are from LMICs, and most are women (appendix 3 p 2). Invaluable contributions have also been received from the 21 international members of the Commission Advisory Board

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See Online for appendix 3

(appendix 3 p 3) and colleagues who contributed to the data analysis, communications, and launch groups (appendix 3 pp 8–10). A cross-cutting group led by the Commission Cochair (CS) has focused on a global exercise to listen to the voices of PWLE, the results of which inform all aspects of this report (appendix 3 pp 20–40).

The structure of this report follows the six aims described above, step by step, dealing sequentially with definitions of stigma and discrimination (section 2); personal impacts (section 3); the effectiveness of interventions to reduce stigma and discrimination (section 4); the experiences of large-scale programmes to combat stigma (section 5); the roles of the traditional and newer media in relation to stigma (section 6); and the stigma-related views and priorities of PWLE (section 7). The final and most important part of this report (section 8) provides the Commission's guiding principles and goals, with a set of eight key recommendations. Specific indicators form a framework of accountability, inspired by the United Nations Sustainable Development Goals.[3] Detailed appendices include further underpinning information and evidence to support this report and its recommendations. This Commission report is, therefore, intended to be an authoritative synthesis of what is known on stigma and discrimination in the field of mental health and a powerful advocacy tool for real, practical change to eradicate stigma and discrimination.

We have chosen to adopt a particular approach to this report. We intentionally include material that brings alive the voices of PWLE. We believe that this is right in principle because stigma adversely affects people with such conditions and, therefore, this report should be framed by the principle of "nothing about us without us".[4] This is also right in practice because the evidence presented shows that social contact with PWLE is the most effective method to reduce stigmatisation and that they should be involved as agents of change by informing anti-stigma interventions. For these reasons the entire report has been co-produced by people who do and who do not have such lived experience. Their voices whisper, speak, and shout in the poems, testimonies, and quotations selected from the many we received from around the world, along with the results of the global lived experience survey. This report and its recommendations rest on the twin foundations of scientific evidence and personal experience.

Concepts and terms, definitions, and human rights

> "Language is used to broadcast shame, making what was a private individual experience to a public, communally shunned and stereotype experience."
>
> *Person in Kenya*

Concepts and terms used to describe reactions to people with mental health conditions

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 diminished value.[5] In the social sciences, the term stigma was elaborated in the second half of the 20th century by Goffman,[6] who defined stigma as a "deeply discrediting" attribute that reduces a person "from a whole and usual person to a tainted, discounted one". Goffman identified three types of socially discrediting stigmas that are related to physical deformities, blemishes of character (eg, mental health conditions and criminality), and tribal origin (ie, race, nation, caste, or religion). He also introduced the concept of courtesy stigma (now more usually called stigma by association or sometimes affiliate stigma), which occurs when discrediting attributes spill over to family members, carers, or other associates.

Stigmatisation can be seen as a complex multilevel social process that encompasses the elements of labelling, stereotyping, separation, status loss, and discrimination in the context of a power situation.[7] Labelling refers to the process of identifying and highlighting human differences that matter socially. Some social differences are judged not to be relevant for labelling whereas others that are seen as highly relevant for creating groups or categories, although are based on substantial oversimplifications. Link and Phelan[7] use the term label, rather than attribute or mark, to highlight that social processes, rather than specific characteristics of stigmatised people, lead to stigma. Stigma occurs when a label is linked to negative stereotypes (ie, a set of undesirable characteristics). Experiments in the fields of cognitive and social psychology show that the use of such stereotypes is highly automatic, based on dominant cultural beliefs.[8]

Separation between groups, often termed us and them, is based on the belief that the labelled people are fundamentally different from non-labelled people. For example, people with a diagnosis of schizophrenia are labelled as schizophrenic rather than as a person (one of us) who is affected by a mental health condition. Stigma includes the processes of status loss and discrimination and, consequently, can lead to a power difference. However, if people with less power hold negative stereotypes about people who have more power, such stereotypes are less likely to result in disadvantages and marginalisation. Taken together, the stigmatisation of people with mental health conditions must be considered within the broader frameworks of justice, social equity, and human rights (appendix 3 p 16).

This *Lancet* Commission considers such conceptual issues but is more concerned with what needs to be done to actively promote social inclusion.[9] For this reason, the title of this report refers to both stigma and discrimination, although for the sake of brevity we shall sometimes refer to both under the heading of stigma.

Many different labels are linked to negative stereotypes and, by consequence, to status loss and discrimination. A person may have several characteristics that are stigmatised in a society (eg, gender, ethnic minority status, disability,

sexuality, homelessness, and mental health conditions), for which the term intersectionality has been proposed.[10] In this sense, stigma related to people with mental health conditions can be viewed within the wider context of other types of stigma and discrimination.

At the same time, there are special characteristics of stigma related to mental health. One important difference relates to the fact that mental health conditions cannot at present be diagnosed based on physical markers, such as blood tests or diagnostic imaging. This means that the diagnostic process might not be uniform within and between different societies and is substantially in the hands of mental health professionals. This has important implications for those who are affected by mental health conditions. Furthermore, mental health conditions are often linked to attributions of self-responsibility, namely factors within a person's control, which differentiates them at least in part from some other health conditions.[11] Moreover, in legal terms, the rights of people with mental health conditions have often been curtailed, which occurs much less often for all other types of health conditions.

The stigmatisation of people with mental health conditions is very common and is seen worldwide.[12] It evolves over time, through socialisation, education, media reporting, and institutional practices. At the same time, the processes of social exclusion and the societal norms that define negative stereotypes are closely intertwined with culture.[13] People with mental health conditions are discriminated against according to what matters most in people's lives within given societies;[14] for example, in marriage, social networks, and work.

Stigma definitions

Stigma against people with mental health conditions occurs at different levels (figure 1). For the purposes of this *Lancet* Commission report we shall use the following definitions. Self-stigma is defined as the way in which people with mental health conditions see themselves as being mentally unwell and, therefore, of lesser value.[5] Stigma by association refers to the internalisation of stigma by close associates of people living with mental health conditions (eg, family members).[15] Public stigma (also referred to as interpersonal stigma) refers to the way in which people in a given community or society views and acts toward people with mental health conditions.[16] Structural stigma (also called systemic or organisational stigma) refers to discrimination in laws, policies, and in cultural and organisational practices.[7] It is also recognised that the term stigma has been seen as stigmatising.[17]

Self-stigma

Self-stigma, or internalised stigma, occurs when people with mental health conditions are aware of the negative stereotypes of others, agree with them, and turn them against themselves (ie, "because I have a mental illness, I must be incompetent").[18] Internalisation 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 are not worthy or not able to succeed. The negative beliefs can lead to diminished self-esteem and self-efficacy, and cause individuals to question why they should try.[19] Self-stigma is only one way to react to negative stereotypes in societies. Stigmatised people may also react with righteous anger towards negative attitudes, which can lead to higher self-esteem than is seen in non-stigmatised people.[18] This effect is important for overcoming stigma and self-stigma. The term stigma resilience has been used to describe the process of empowering people with mental health conditions to overcome internalised stigma and take positive actions in relevant life domains. Such empowerment is reflected in campaigning by PWLE for greater acceptance of their conditions and the ability to exercise their human rights fully.

Stigma by association

Stigma by association, also known as courtesy or affiliate stigma,[6] refers to the attribution of negative stereotypes and discrimination to family members or mental health staff. Such stigma seems to depend on the type of mental health condition. For example, family members are often blamed for the onset of substance use conditions.[20] Furthermore, if a mental health condition is considered to be hereditary or considered as referring to the associated person for some other reason, this can incur loss of respect (or loss of face)[21] and can adversely affect the life opportunities of others, such as marital prospects.[14] If such stigma is internalised, it could exacerbate carer stress.[15,22] Stigma by association has also been applied to mental health professionals due to the negative attitudes of health-care staff dealing with physical conditions, leading to mental health care being perceived as less prestigious.[16]

Public stigma

Public stigma (also referred to as interpersonal stigma) refers to the link between stereotypes, negative attitudes, and discrimination against people with mental health

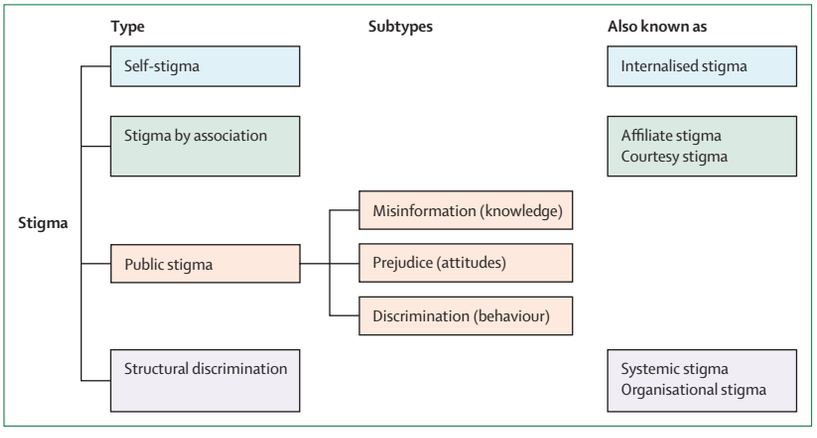

Figure 1: **Types of stigma**

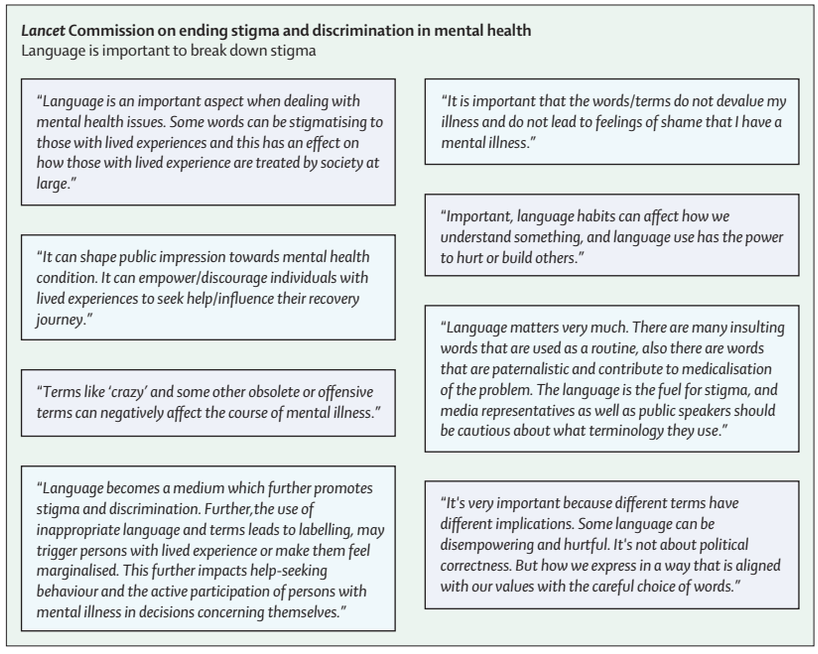

Figure 2: **Key themes from the Lived Experience Survey in relation to use of language**
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conditions in society.[7,23] While lack of knowledge can lead to negative attitudes, this is not necessarily so.[11] Indeed, the stigmatisation of patients has been described as leading to a power differential that favours medical staff.[24] In the context of public stigma, discrimination at the interpersonal level can manifest in various ways, such as avoidance, maintaining social distance, paternalistic approaches (benevolent stigma), or supporting coercive policies.[1]

A common way of understanding public stigma is to identify three separate but related components: knowledge, attitudes, and behaviours. The knowledge component usually refers to a lack of detailed knowledge in populations about mental health conditions (ignorance) but can also arise due to misinformation spread by popular discourse. Attitudes refers almost entirely to negative emotional reactions towards people with mental health conditions (ie, prejudice). Behaviour refers to the rejection and social exclusion of people with mental health conditions by discrimination,[9] which can cause harm by being anticipated as well as by being experienced.[25]

In research, discriminatory behaviours are most often measured by self-report scales that assess behavioural intentions.[26,27] One study in Germany found that over a 10-year period, public attitudes towards spending public money on services for people with depression became more positive, yet over that period, the desire for social distance from people with depression remained unchanged.[28] More subtle forms termed interactional discrimination also exist,[7] which refers to uneasiness about contact with people with mental health conditions or taking small discrediting actions, sometimes called microaggressions.[29] Negative attitudes and discriminatory behaviours are often linked to misconceptions about the prevalence, process, and causes of mental health conditions. 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.[23]

Pescosolido and colleagues[30] showed that conceptions about schizophrenia, depression, or alcohol dependence were related to beliefs about lack of control over behaviours, beliefs about an inability to recover (as the condition has supposedly affected the structure of the brain), and more prominent fears of dangerousness and unpredictability rather than genetic and biological causes—in other words, stigma.[31,32] Another misconception relates to the them or us dichotomy separating those with mental health conditions from so-called normal people.[33] This view does not correspond to the continuum model for mental health and for mental health conditions, in which mental health problems exist along a continuum from mild, time-limited distress to longer-term conditions that may become severely disabling.[34]

Misconceptions may change over time, but this does not necessarily result in a reduction in stigma or discrimination.[35] A large-scale study in 16 countries showed that mental health conditions were becoming increasingly accepted in the wider realm of health conditions, with a corresponding change from an attribution of weakness towards being responsible. However, a lack of willingness to accept people with mental health conditions in positions of authority or power remained among the public, along with a continuing fear of violence.[35]

> "Words can easily be dehumanising, discriminating and stigmatising. When you become labelled, it feels like being cornered but nowhere to go."
>
> *Person in Canada*

Structural stigma

Structural, systemic, or institutional stigma refers to policies and practices that work to the disadvantage of a stigmatised group, whether intentionally or unintentionally. Structural stigma does not necessarily represent individual prejudice or discrimination, but rather higher-order discrimination associated with human rights.[7] Hatzenbuehler and Link[36] defined structural stigma as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized". Stigmatising discourse and culture's role in stigma and discrimination are discussed more in later sections. Stigma is often seen as a barrier to policy change, sometimes through lack of public demand for governmental action and investment, and also through misinformation, misunderstanding, and lack of awareness of positive policy options among policy makers.

Globally, people with mental health conditions commonly experience restrictions in employment, voting, property

ownership, marriage, and divorce.[12] The UN Convention on the Rights of Persons with Disabilities (CRPD) emphasises a societal responsibility to create inclusive environments for all people with disabilities. Mental and physical conditions can cause long-term impairments, which, having consequences in daily life and the social and environmental contexts (eg, reduced job opportunities or limited access to public services), might in turn lead to disabilities. The CRPD acknowledges that people with disabilities are part of human diversity, which dissolves the separation of us and them. The CRPD was an important step in promoting social, political, and civil rights of people with mental health conditions, but structural discrimination remains at legal, organisational, and societal levels. The WHO QualityRights toolkit offers an important way to practically apply the requirements of the CRPD.[37]

Another aspect of structural stigma relates to the fewer financial and human resources being allocated to research and treatment for mental health than for physical conditions.[38,39] Worldwide, many people with mental health conditions do not receive even minimally adequate treatment. For depression and anxiety, for example, the treatment gap is estimated to be 95% in low-income countries (LICs), 90% in middle-income countries (MICs), and 70–80% in HICs.[11,40–42] Additionally, people with mental health conditions have less access to health care in general and the quality of services is often poorer than those treating physical disorders, which contributes to a 10-year mortality gap overall for people with mental health conditions and a 20-year gap for those with severe mental health conditions.[43,44] Such structural disadvantage is subject to transgenerational perpetuation by sustained social disadvantage within families and the inter-relationships between poverty and poor mental health.[45]

The importance of using non-stigmatising language

Language is of vital importance when it comes to stigma. Words matter because they reflect and reinforce negative attitudes and behaviour. This *Lancet* Commission recommends using person-first language, rather than identity-first language: a person with a mental health condition, or with lived experience of a mental health condition (figure 2). However, ultimately, decisions about which terms to use should be made by the people directly affected. Furthermore, some terms may be stigmatising in specific languages (figure 3). For example, in Arabic the term *soha aklia* can be stigmatising because it implicitly hints at impaired mental capacities of the person, and *soha nafsia*, which means psychological health, may be preferentially used.

Some phrases can victimise, criminalise, or misrepresent people with mental health conditions, such as the term to commit suicide. Words might be perceived as also devaluing people with mental health conditions if they carry negative connotation, such as mental illness or mental disorder. However, these terms are used in the ICD and *Diagnostic and Statistical Manual of Mental Disorders*. We acknowledge that these international classification systems have been described as stigmatising by some people who view diagnostic terms themselves as devaluing labels, particularly because the word disorder can inappropriately suggest a tendency to negative or even troubling behaviour by people with such a condition. Throughout this report, however, we assume that diagnoses are necessary for reasons of communication for health workers, PWLE, family members, and policy makers, and for planning and financing treatments and care.

The debate about non-stigmatising terminology continues, and positions differ between PWLE. In this report, we use the terms stigma related to mental health conditions and mental health condition, the reasons for which are given in the appendix 3 (p 15).

Culture and stigma

Culture has a strong influence on stigma because of the role that culture plays in determining what is considered

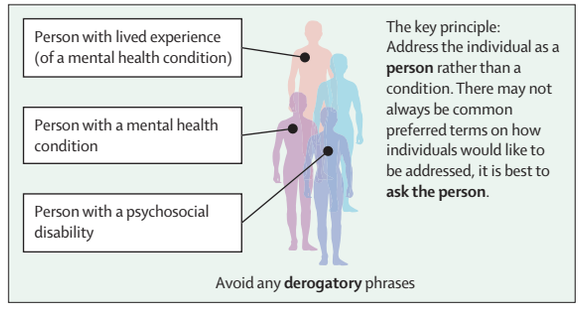

Figure 3: **The principle of person-first language**
Reproduced by permission of Charlene Sunkel.

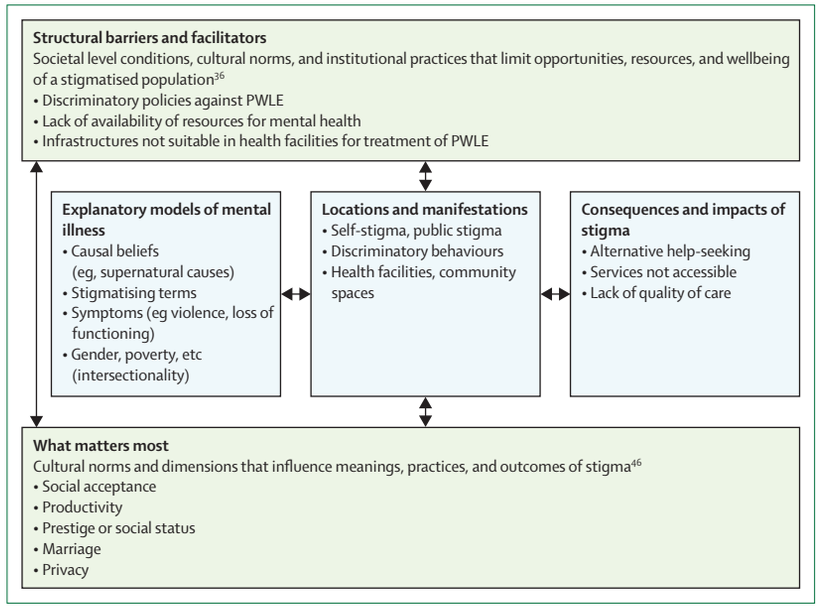

Figure 4: **Structural barriers and facilitators using the What Matters Most approach**
Reproduced from Gurung and colleagues. PWLE=people with lived experience.

Poem 2

It's All In The Head
by Nicky Chandam

You wake up
Don't know whether to be happy
You are breathing
Or be sad you are still breathing
You put in all your energy
in getting out of the bed
That you have energy for nothing else
They say you bring down energy
So you stop being around people
They say they are here to listen
But instead, they make you feel
YOU ARE NOT DOING ENOUGH
You tell them honestly you are
Unable to do the simplest of task
You take ages to order food
Select an item from Amazon
But they say you are lazy

You get recurring nightmares
Of all the traumas you had
Spoken…unspoken
You never have a sound sleep
But you have SOUNDS in your SLEEP
Your hands tremble, you stutter
You struggle to breathe
You take your meds
Your mind creates a fog
You drop your meds
Your mind explodes
Your memory plays hide and seek
They say you are irresponsible
They say you're incompetent
They say you are just weak

It is all in Your Head, Come Out of It
They say
They don't get it—It is all in My Head
Thousands struggle each day
just to have a "normal day"
But all they see are perfectly working
limbs

The able ones don't seem to care
The Government doesn't listen
The Health-care system is overworked
The loved ones are exhausted
People can't afford to care

Mental Illness is a disability
Only those who live with it KNOW.

socially acceptable behaviour and on defining the causes of mental health conditions and how they are treated. Understanding the influence of culture on mental health conditions can be grouped into three domains: cultural concepts of conditions; cultural perceptions of causes; and cultural determination of values (ie, what matters most to cultural groups; appendix 3 pp 41–46).[46] Gurung and colleagues[47] have developed a framework that incorporates the different aspects of cultural and structural stigma according to what matters most, and suggests how interventions can be designed and implemented (figure 4).

The impact of stigma and discrimination

Stigma related to mental health conditions is multifaceted with a multitude of consequences that are often underestimated. In this section we summarise the impact of stigma on four domains: personal impacts, including self-stigma, quality of life, and service use; structural impacts, including legal provisions, human rights and the implementation of psychosocial interventions; impact on health and social care; and social and economic impacts, including work. The impact of stigma may be especially severe for people with multiple stigmatised characteristics (eg, ethnic minority status or sexuality as well as having a mental health condition).[48,49] The evidence presented in this section is based on a recent systematic review (personal communication, Petr Winkler) and the results of the global survey of PWLE that was commissioned for this report.

Personal impacts

People who responded to our lived experience survey reported experiences of discrimination in all aspects of their lives, from blatant discrimination in social interactions and at work, to social isolation and loneliness, shame and secrecy, and damaged marital prospects. One participant stated, "Everyone and everything. We have a systematic issue at hand. The discrimination and stigma is embedded everywhere, in all institutions." A list of terms reported as derogatory by respondents is provided in appendix 3 (pp 23–25).

People with mental health conditions who perceived greater public stigma found their own condition more threatening than other respondents. They also reported more self-stigma, more hopelessness, poorer recovery, and reduced quality of life.[17,50] Some of these effects were mediated by self-stigma and lack of social support. Among people who anticipated or experienced high levels of discrimination, psychological distress and shame were also increased, and empowerment and quality of life were reduced (personal communication, Petr Winkler). In more collectivistic cultures, there was a stronger link between self-stigma and experienced discrimination.[51]

Self-stigma is positively associated with a why try effect, which leads people not even to attempt important activities (eg, applying for a job) because of the expectation of failure. Such a loss of confidence can have negative effects on hope, quality of life, recovery, stigma resistance, and social

functioning, and may increase suicidality (personal communication, Petr Winkler). The link between self-stigma and self-harm or suicidality was particularly strong among young people.[52] In terms of diagnoses, self-stigma was highest among people with schizophrenia and, on average, was higher in southeast Asian and Middle Eastern than in European and North American countries.[53]

Stigma stress is the perception that stigma-related harm exceeds a person's coping resources. It is associated with increased self-stigma and reduced empowerment and quality of life.[54] Stigma stress has been associated with increased suicidality.[55] Among young people at risk of psychosis, high stigma stress raises the rate of transition to schizophrenia after 1 year.[56]

Higher levels of stigma reduce help-seeking and health-service use in several ways.[49] Public stigma makes people wish to avoid being labelled. Self-stigma, shame, the 'why try' effect, demoralisation, and giving up of life goals also deter individuals from help-seeking. There is strong evidence that stigma is negatively related to help-seeking, especially among people in minority ethnic groups, young people with mental health conditions and those who live with parents with mental health conditions, members of the military, and health professionals,[57] although there is little evidence for people with substance use conditions.[58]

> "Even educated people from society consider schizophrenia a death sentence for the person, like your mind is gone forever, and you have to say goodbye to the person you used to know and care about. In worse cases there are expectations of violence, abuse, and some accidents from the person with schizophrenia, there is profound lack of trust and what the person says or does is viewed through the lens of the diagnosis."
>
> *Person in Georgia*

Structural impacts

Our review identified only qualitative and no quantitative papers on structural discrimination as a consequence of public stigma.[49] Several qualitative studies from different parts of the world described discriminatory laws or judicial practices arising from public stigma, for instance, using an unsubstantiated allegation of dangerousness against a PWLE in a court ruling. Two studies from African countries described public stigma as a barrier for PWLE to be involved in policy making. Three studies, two from Africa and one from Europe, reported participants' beliefs that public stigma led to inadequate funding and provision of health care. One English study described respondents' experience of going through the process of welfare benefit applications as stigmatising.[59]

Regarding legal provisions, striking examples of discriminatory legislation exist in many countries, including prohibitions on marriage,[60] violations against property rights,[61] and prohibition from voting in elections.[62] Laws with provisions for involuntary admission to only for people with mental health conditions are argued to be intrinsically discriminatory.[63] Psychosocial interventions, even in HICs and many with proven effectiveness, are often not implemented, for example those offering help with employment, housing, or family interventions.[1] However, some examples exist of positive structural discrimination, such as entitlement to reasonable adjustments in the workplace or housing for homeless people with mental health conditions.[1] Another example is the obligation for companies in many countries to employ a certain percentage of people with disabilities.[64]

Health-care and social-care effects

Many cross-sectional and longitudinal studies identified in our review reported the impacts of stigma and discrimination on health-related outcomes, such as symptoms of depression, anxiety, post-traumatic stress disorder, psychosis, substance use conditions, suicidality, physical symptoms, disability, and recovery.[49,65,66] Nevertheless, most evidence on these effects are from North America, Europe, and east Asia. These studies showed that such forms of stigma negatively affected clinical and personal recovery outcomes.[67] Stigma was associated with increases in the number of episodes of being unwell, the duration of condition, and psychiatric hospitalisation. Self-stigma had particularly negative effects on symptoms and recovery, mediated particularly by reduced self-esteem and increased hopelessness and social isolation.[53,68,69]

Stigma is also associated with low investment in mental health care.[70] Barriers to accessing mental health care include lower insurance benefits than for physical conditions, low rates of reimbursement by insurers to mental health service providers, and restricted insurance coverage for people with mental health conditions, especially in low-income settings.[71–73] Prejudice by health-care staff has been linked with worsened health outcomes and physical health care because of diagnostic overshadowing, in which physical symptoms are misattributed to mental health conditions.[74,75] These forms of health discrimination contribute to reduced life expectancy among people with mental health conditions.[43,76–78]

Social and economic impact

In line with the concept of what matters most, stigma and discrimination drastically limit a person's active participation in society with respect to education, employment, establishing healthy and safe social interactions, and starting a family.[1,46,49,79]

> "People see it like it is some form of weakness that comes from you. You are avoided like it is contagious. It is seen like it is not a serious problem and you can snap yourself out of it."
>
> *Person in Nigeria*

Stigma and discrimination not only affect the labelled individual but also, by association, family members and carers, for example by damaging the marital prospects of

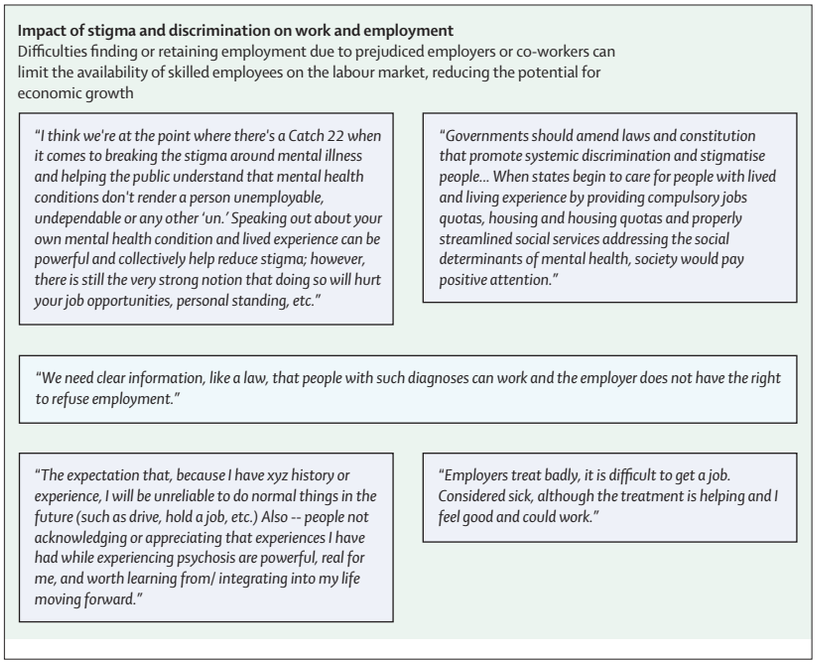

Figure 5: **Impact of stigma and discrimination on work and employment highlighted in the Commission lived experience survey**
Reproduced with permission from Charlene Sunkel. PWLE=people with lived experience of mental health conditions.

siblings, or when parents are blamed for their child's condition.[80] The anticipation of discrimination, such as the fear of being discredited by police, having to withdraw from educational activities, or being avoided by family, friends, neighbours, also accounts for substantial negative effects.[42,79] Therefore, people with mental health conditions often conceal their diagnosis, especially if they want to marry, as they might fear that their potential partner could think their children will inherit the mental health condition.[81]

> "Not being able to talk to any of my family members about what I was going through. Not knowing where to start. Moreover, opening up to a friend who in turn rubbished me saying that I am demon possessed and should go to church instead of a psychologist."
>
> *Person in Botswana*

People also often report losing friends after disclosing a mental health condition.[82] High levels of stigmatisation towards people with mental health conditions can lead to acts of neglect or abuse, such as shackling, verbal and physical humiliation or ridicule, sexual abuse, and violence,[9] which has been reported from south Asia, Africa, North America, and Europe.[83]

Evidence for stigmatisation of young people with mental health conditions has been found worldwide.[84] This is especially important given that one in every seven adolescents aged 10–19 years experiences a mental health condition,[85] and stigma has an additional adverse impact on them and their relationships with family and peers, and can lead to social exclusion from schools, sports, and other community participation.[84] The State of the World's Children survey in 13 countries showed that families can also create substantial barriers to help seeking among adolescents. Young people discussed fears of their families not caring about their problems or not taking them seriously, which can invalidate their feelings and decrease their willingness to seek support.[86] One of the most salient stigma experiences in adolescents is the fear of social rejection. Detrimental stigma outcomes in young people were mostly related to their need to preserve social identity and social capital.[87,88] Young people in that survey also reported stigma perpetrated by school staff, who expressed fear, dislike, avoidance, and underestimation of their abilities. The views of young people about mental health can differ from those of their parents, revealing important intergenerational perspectives. This is illustrated in the comments of a teenager in Jamaica, who said, "A lot of the times, my friends they want to tell their parents about something going on with their lives or that they need to go see a therapist...[but] they feel as if their parents just won't understand what they're saying...And then some have actually spoken to their parents and their parents kinda dismiss it...so now nobody confides in their parents anymore."[59]

In employment settings, many people with mental health conditions decide not to disclose their condition due to fear of discrimination (figure 5). "I can't open up about it at work since companies still have the perception that people with mental illness are unstable and unable to function normally", said a service user from Malaysia in our lived experience survey. Difficulties in finding or retaining employment due to unsympathetic employers or co-workers can limit the availability of skilled employees on the labour market and reduce the potential for economic growth. Living with a mental health condition often means not being offered equal work opportunities, being assigned less work or work with limited responsibilities and denied promotions, experiencing more bullying at work, and being refused time for health-care appointments.[49,89] Lack of employment and income due to stigma are important contributors to poverty among people with mental health conditions.[90] Additionally, housing conditions might be poor due to stigmatising attitudes of landlords who may refuse to have a tenant with a mental health condition. These cyclical inter-relationships between mental health conditions and poverty are especially pernicious in LMICs.[91]

> "The most difficult for me in the period as I was ill, was how the people at work treat me."
>
> *Person in Spain*

Evidence on interventions to reduce stigma and discrimination related to mental health conditions

Methods

We did an umbrella review of systematic reviews of interventions intended to reduce stigma. We searched

Poem 3

Mirrors
by Mar Guerrero

Mirate en mi.
Tu has convertido
En us especimen raro,
Incoherente, malo.
Otro especimen mas
De la tribu de los locos.
Seres indeferenciados,
Iguales todos
A ojos de la gente.

Deja que me mire en ti.
Me torno en un ser frio, ajendo a todo.
Practico.
Triunfador sin trofeo.
Vencedor sin oponente.
En la jungle dorada,
Donde no ya
Significados
Para los sentimientos
Ni verdad
Para las palabras.

A mi me rechazan por loca.
Me fulminam como ser humano,
Los ignorantes,
Esos que niegan
el paso de los siglos.

Pero a ti,
Que moras grato
En la cordura. A ti,
?Que te pasa?

Look at you in me.
You have turned
Into a weird, incoherent
Bad specimen.
One more specimen
From the tribe of the insane.
Undifferentiated beings.
All equal
To people's view.

Let me look at me in you.
I become a cold being, indifferent to everything.
A practical being.
Triumphant without trophy.
Victor without opponent.
In the golden jungle,
Where things are
No meanings
For feelings

Nor truth
For words.
I am rejected and obliterated
As a human being
By the ignorant.
Those who deny
The passing of the centuries.

But with you,
Placidly installed
In sanity,
What is the matter?

seven databases (PsycInfo, MEDLINE, Embase, CINAHL, ERIC, Global Health, and Social Science Citation Index) for English language literature reviews (appendix 3 pp 10–14). The search included four concepts: stigma and discrimination (eg, attitude, stereotype, and social exclusion); interventions (eg, intervention, and randomised controlled trials); review (eg, systematic review); and mental health conditions (eg, depression or schizophrenia). Individual search strategies, including specific subject headings, were developed for each database. All searches were run on Dec 12 or 15, 2021.

Any systematic review (described as systematic, meta-analysis, scoping, rapid, umbrella, or narrative) was eligible for inclusion. For a review to be included, the authors must have defined a systematic search strategy to identify studies, assessed them for inclusion, and appraised, synthesised, or summarised their findings quantitatively or qualitatively. Reviews were included if they appraised the findings of interventions that were aimed at reducing stigma in relation to any mental health condition listed in ICD-10. All countries and age groups were included. The following types of stigma were included: structural stigma; interpersonal or public stigma; and self-stigma (including internalised stigma and anticipated stigma). Interventions with one or multiple components were included. We included interventions if a stigma or stigma-related outcome (eg, attitudes, beliefs, knowledge, mental health literacy, and social inclusion) was either the primary or secondary outcome. The umbrella review was registered with Prospero, registration number CRD42022299682.

The search yielded 15 323 entries. After removing 7687 duplicates, 7636 titles or abstracts were screened. Irrelevant studies (n=7249) were excluded, and 387 full texts were assessed for eligibility. A total of 216 reviews were included. Of those, nine addressed structural stigma, 181 interpersonal stigma, and 26 self-stigma. The included reviews were published between 1994 and 2021, with 58 being published in 2021 and 30 in 2020. This weighting towards recent years reflects increasing research interest in the topic.

Structural stigma

Policies

We found very few articles that review policies targeting mental health conditions. Identified studies investigated the impact of various professional and public initiatives to reduce stigma and discrimination against people with depression in Slovenia,[92] and anti-stigma campaigns in several Asian countries.[93] Benefits and positive outcomes related to reducing structural stigma through policies were reported, but the quality of the studies was generally low. Although policies aimed to establish respect towards people with mental health conditions and to stipulate their rights, they fell short in effectively reducing discrimination. More inclusive policies, legislation, and plans that were more effective in reducing stigma were generally linked with community-based treatment, programmes of public education, and media activities, including participation of champions who had lived experience of mental health conditions. Several national-level programmes against stigma and discrimination in Asia were effective in reducing experienced and anticipated stigma and facilitated help seeking and engagement with mental health care, although no data were available on whether access to mental health care had increased.

In some east Asian countries, changing the name of schizophrenia was used as a strategy to reduce public stigma. There is some evidence that after the name change more people received a diagnosis than previously,[94] but none indicating positive effects on public attitudes or media reporting.[95] Specific diagnostic terms that cause offense in particular languages and cultures could be revised in conjunction with PWLE.

Effective efforts to address structural stigma at the policy level have included interventions through national mental health plans and policies and anti-discrimination laws for people with mental health conditions in care, at work, and in wider society. Coalitions of stakeholders, often led by non-governmental organisations, mental health associations, and mental health professionals, with the participation of empowered PWLE, have been instrumental in advocating these changes. Descriptive studies have been done that have, for example, reviewed mental health parity with health policies in Commonwealth countries[96] or legislative mechanisms for social participation rights of people with depression in the Asia-Pacific region.[97] However, the effect of such policies on people's lives, knowledge, attitudes and behaviours have not been assessed.

Potential future policy interventions include those to make it mandatory for insurance companies to cover mental health conditions.[98] The potential impact of interventions targeting structural stigma through policies is high, but more research is needed on their culturally sensitivity, effectiveness, cost-effectiveness, and effects.

Access to care

Different approaches to addressing stigma-related barriers to accessing mental health care have been developed and evaluated, such as use of online and offline self-help or training of non-professionals to deliver mental health interventions. In this review we only included reviews that explicitly mentioned how they intended to overcome stigma as a barrier to access or had identified strategies that explicitly focused on increasing knowledge or improving attitudes or behaviours towards help seeking to increase access and to make services more equitable.

Altogether seven reviews were identified. Four focused on HICs[99–102] and three had no geographical limitations.[103–105] The number of studies included in each systematic review varied from 11 to 128. Three reports focused on any mental health condition,[102,104,105] two on children and adolescents,[102,105] one on people with dementia or suspected dementia,[101] and one on pregnant women using opioids.[99,104] Formal quality assessment of constituent studies was done in four reviews.[102–105] Two studies included meta-analyses.[102,104]

Joshi and colleages[99] found that training health-care providers to share non-stigmatising messages with pregnant women who used opioids helped increase acceptability of services and access to care. Rosvik and colleagues[100] concluded that addressing lack of awareness about services improved the uptake of community-based and social welfare services among people with dementia and their caregivers, but that there was a gap in knowledge about which interventions had the greatest impact.

Arundell and colleagues[101] in their mapping review attempted to identify factors that address stigma-related barriers to access care across lifespan. They found that employing the following strategies contributed to improved access to care: increasing inclusivity in programmes for individuals with various learning disabilities (eg, through use of hearing aids, Braille texts, and sign language); audio-visual displays and diagrams for people with poor literacy or communication problems; using culturally relevant tools for individuals from different ethnicities or cultures; co-creating interventions with communities; training staff in communicating more effectively with marginalised communities, such as migrants; and using positive language while developing educational materials.

Choi and Easterlin[102] reviewed interventions designed to improve access to behavioural health services for young people mainly in the USA. They concluded that, although there is evidence that discussions between older adolescents and nurses or counsellors can be effective in increasing their access to care, for younger children it was essential also to educate the parents. A review focusing on children and adolescents,[103] identified 13 studies on universal school-based interventions and 21 studies to engage at-risk individuals. In a meta-analysis, they found significant improvements in attitudes or beliefs about seeking care could be seen in four of six studies (effect size –0·02 to 2·56). At the same time, help-seeking inten-

tions improved in two of nine studies (effect size –0·15 to 0·30) as did accessing care in one of five studies. Eight (80%) of ten studies on treatment engagement for individuals at risk (eg, a family-based session to increase motivation during an emergency room visit) showed improved access to care with interventions. The authors concluded that two-stage interventions that first identify people in need and then engage them in the health-care system are necessary to achieve a population-level effect on improving children's access to mental health care.

Greene and colleagues[104] explored factors that increased continuity of care for adults with mental health conditions in outpatient mental health services. The most frequently used strategies were improving mental health knowledge, addressing stigmatising attitudes, and reducing behavioural barriers through psychoeducational approaches. Interventions included empowerment by involving the service users in decision making about their mental health condition and about appointments and follow-up schedules, and by identifying treatment goals. The effect size for these programmes increased progressively with rising number of specific treatment targets.

Xu and colleagues[105] focused on interventions to increase help-seeking behaviours across a variety of populations with and without mental health conditions. The review identified 97 original studies, of which three were in middle-income countries and none in low-income countries. Some of these studies applied psychoeducational or cognitive-behavioural strategies to enhance motivation to seek help. The results showed positive short-term effects on attitudes, intentions, and behaviours and positive long-term effects on help-seeking behaviour. The authors also examined collaborative care training for primary care or community care staff, and they found long-term effects on mental health service use among individuals in primary care settings, including people with depression.

Access to work or employment

We found three reviews of ten studies synthesising evidence on interventions aimed at increasing access to work by reducing stigma at the structural level, but only one included an evaluation of data by meta-analysis.[106] All the interventions in that review focused on how to respond to employees' mental health needs, and some also covered job stress and workplace promotion of mental health. Training managers to understand and support the mental health needs of employees was effective in improving mental-health-related knowledge, non-stigmatising attitudes, and self-reported supportive behaviour.

A review by Szeto and Dobson[107] reported on training programmes for managers to support staff during episodes of mental ill health and in the provision of accommodations or adjustments to support people returning to work. However, at the time of their review none of the programmes included had undergone evaluation. They suggested that programme evaluators should use data available from employers, including the provision of workplace accommodations, staff sickness rates (absenteeism), and levels of employment of people who disclose a mental health condition in response to equal opportunities monitoring questionnaires. Interventions that aim to reduce interpersonal stigma in the workplace have been evaluated, such as the Mental Health First Aid (MHFA) programme.[108]

A review of the cost-effectiveness of initiatives to reduce stigma in the workplace found no eligible studies.[109] 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 programmes. They also suggested testing the cost-efficiency of interventions involving manager training and anti-stigma components.

Reviews of studies on interventions to support people into gaining work have also been published, covering intellectual disability,[110] autism,[111] severe mental health conditions,[112] and other mental health conditions.[113] However, no studies measured structural stigma in the workplace, and all outcomes were measured at the individual level. Nevertheless, there is the potential for vocational workers to collaborate with employers and elicit change at the structural level.

There is a knowledge gap for interventions addressing structural stigma experienced by people within mental health conditions in LMICs, where formal employment may be an exception. Information is needed on the systematic exclusion of people with mental health conditions from community development programmes, livelihood opportunities, and microfinance schemes. Such programmes are fully in line with the key theme of the United Nations Sustainable Development Goal to leave no one behind.[2]

Interpersonal (public) stigma

Children, adolescents, youth, and students

44 reviews covered children, adolescents, teachers, parents, and university students (excluding health professions). Different combinations of target populations were found, such as children or adolescents and parents or children, adolescents, and university students. Most studies targeted mental health conditions in general or suicide. A smaller number of studies exclusively covered autism (n=3), developmental or intellectual disabilities (n=4), or specific conditions, such as addiction (n=1) or schizophrenia (n=1).

Stigma and discrimination were addressed as primary outcomes in 19 (43%) of the included reviews. The interventions, most of which targeted children, adolescents, or youth, were aimed at reducing negative attitudes, social distance, or peer victimisation or enhancing social inclusion of peers affected by mental health conditions. Data for the primary outcome were addressed through assessments of the following approaches: education via

lectures, texts, or internet-based programmes; interactive elements, such as group discussions; or social contact with PWLE, either directly or indirectly, via videos or the internet. Our narrative summary focuses on the latest higher-quality reviews.

A comprehensive systematic review of school-based interventions on mental health stigmatisation was carried out by Schachter and colleagues.[114] They identified 43 original studies, but none was of sufficient quality to produce reliable and valid data. Only two randomised controlled trials were considered appropriate for inclusion and neither reported significant effects. Mellor[115] came to a similar conclusion and noted the lack of follow-up data in 17 studies, meaning that sustained effects of anti-stigma interventions could not be assessed.

For more on **PhotoVoice** see https://photovoice.org/

Waqas and colleagues[116] conducted a systematic review of anti-stigma interventions in educational institutions. They identified 44 studies, of which 36 (82%) had been published since 2009. Most of the included trials had been conducted in HICs, with only six studies having been done in MICs including China (n=2), Russia (n=2), Nigeria (n=1), and Brazil (n=1). None was done in a LIC. Psychoeducation was used most often (25 studies) followed by social contact-based interventions (ten studies). Stigma was directly targeted in 25 studies, of which 19 showed significant improvements. In addition, most studies which assessed attitudes showed positive changes (eight of 11), and four of seven that measured social distance also reported improvements. The overall quality of these studies was quite low, with 35 (80%) showing a high risk of bias.

Gaiha and colleagues[117] focused on arts interventions (eg, film, theatre, and creative writing) to reduce stigma related to mental health conditions among youth (aged 10–24 years). 57 studies were identified (quantitative and qualitative), eight of which were randomised controlled trials. The study quality ranged from low to moderate, with some studies reported as being methodologically strong. Overall, the results indicated positive effects and a meta-analysis showed that arts interventions are generally effective when using multiple art forms, although the effects were small.

Eight systematic reviews with stigma as the primary outcome focused on young people with developmental disabilities, such as intellectual disabilities or autism spectrum disorders, and one concluded that the original studies with the highest methodological quality were also more likely to show efficacy.[118] Sentenac and colleagues[119] showed that peer victimisation was reduced after an average of 25 weeks of involvement in a programme using social contact to bring peers with and without disabilities together for shared activities in school and community settings.

For more on the **Applied Suicide Intervention Skills Training** see https://www.papyrus-uk.org/asist/

Several reviews indicate that structured direct social contact involving children with disabilities and giving them equal status to children without disabilities can lead to improved attitudes among peers.[119–121] Four reviews concluded that the combination of multiple strategies was more effective than using any single strategy.[118–120,122,123] Allowing children to be actively engaged in the intervention and providing them with strategies to interact with peers with mental health conditions seems to be the most promising approach.[120,122] Offering different types of information (ie, descriptive, explanatory, and directive) also seems to be most effective.[122,123]

Most of the studies on interpersonal stigma among children, adolescents, and youth were done in school settings, but one review identified several community interventions aimed at enhancing social inclusion, such as PhotoVoice, dog-walking, peer support, and participation in sports competitions. Improving the social skills of children with mental health conditions can improve social inclusion, although possibly because the children behave in a more socially accepted manner.[121,123] For future studies, it would be helpful to differentiate changes in children's social skills from those in stigma among their peers.

Even though there are some promising results regarding behavioural outcomes, most original studies focused on knowledge and attitudes. One qualitative study included in the review by Morris and colleagues[118] found that a theme of difference (us and them) emerged after an intervention, which requires further investigation. Two reviews concluded that findings for intended behaviour were variable and concluded how far children's actual behaviour can be predicted from self-reported behavioural intentions was unclear.[118,123]

Stigma was included as a secondary outcome in 25 studies that primarily focused on universal, selective, or indicated interventions to prevent mental health problems (appendix 3 pp 94–96). All 25 reviews had been published since 2012, and ten were published in 2021. Such interventions aimed to increase help-seeking among children, adolescents, and youth with mental health conditions. They also aimed to support parents, teachers, or peers with gatekeeper training on how to recognise 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 towards mental health conditions and confidence in providing support were identified as important outcomes.

In relation to suicide, one systematic review summarised interventions among students and staff at high schools and universities.[124] The findings indicated that universal interventions were effective in changing attitudes, although the effect size was small (d=0·05–0·40) and changes were not sustained. For interventions that focused specifically on stigma, results showed that psychoeducation and interpersonal contact significantly reduced stigma, which was sustained at 1-month follow-up (d=0·46). One selective intervention (the Applied Suicide Intervention Skills Training intervention[125] resulted in significant and sustained

improvements in participants' attitudes towards suicide. An electronic bridging mental health service, which included personalised feedback and online counselling, significantly decreased personal stigma scores with a large effect (d=−1·07) and reduced public stigma among high-risk college students with a medium effect (d=−0·59). For teachers, Torok and colleagues[126] found that none of the included studies reported specific effects for measures of attitudes towards suicide, but one study found that parental attitudes improved between the first and the second assessment (d=0·21), although the effect was not maintained 2 months later.

Regarding prevention of poor mental health and mental health literacy programmes, results are more mixed. In a meta-analysis, Salazar de Pablo and colleagues[85] found a small effect for changes in attitudes towards people with mental health conditions across 16 studies involving youth of various ages (effect size Hedges g=0·18). Liang and colleagues[127] did a meta-analysis of MHFA among college students (aged 19–27 years) but found no significant effect on stigma-related attitudes across four studies. Ng and colleagues[128] also reviewed studies testing MHFA among adolescents and youth. Among adolescents, three of four studies that measured stigmatising attitudes found a significant reduction after training, but results were inconsistent at the item level. For youth, six studies measured stigmatising attitudes, four of which reported significant effects, again with inconsistent results at the item level.

Reis and colleagues[129] looked at mental health literacy training programmes other than MHFA. Only five studies met their minimum quality standards. Three of these five involved university students and specifically measured attitudes, beliefs, norms, and stigma regarding mental health. All three studies reported some positive impacts of mental health literacy training on these constructs, but the evidence was weak.

With regards to intervention components, a comprehensive systematic mapping review of interventions used with adolescents aged 12–18 years found that a combination of education and social contact led to better outcomes than education alone.[130] 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 and, therefore, results must be interpreted with caution. A review of digital video interventions that were tested among youth aged 15–25 years found that videos produced better outcomes than lectures or no intervention.[131] However, in two of the three studies assessed, digital video interventions and direct contact did not differ for attitudes toward people with mental health conditions.

Turning to interventions for school teachers, Anderson and colleagues[132] reviewed eight studies that assessed provision of information about the signs and symptoms associated with common adolescent mental health conditions. They found positive changes in attitudes (effect size d=0·36–1·18) after intervention and at follow-up (0·68–1·0).

LMICs are under-represented in the literature. Hartog and colleagues[133] focused on interventions to reduce stigma related to diverse health conditions, such as HIV, mental health conditions, and leprosy in LMICs. This review was originally aimed at identifying studies targeting children and adolescents but most also included adults. The stigma reduction strategy most often applied was community education, followed by individual empowerment of PWLE and social contact within the community. These strategies all had positive outcomes on stigma reduction.

Family members

Seven reviews focused on reducing stigma among family members. A gatekeeper training intervention for family and friends of people at risk of suicide led to positive effects on knowledge, self-efficacy, and gatekeeper-related skills, but the results for stigma and attitudes were inconsistent.[134] Two studies focused on children and youth in families affected by parental mental health conditions. Davies and colleagues[135] found that information about the levels of hereditary risks of mental health conditions was considered important so that young people do not feel conditions experienced by their parents will be inevitable for them. Riebschleger and colleagues[136] showed that psychoeducation led to decreased mental health stigma and improved family communication about parental mental health conditions.

Four reviews assessed negative attitudes and discriminatory behaviours from family members towards PWLE. One review identified two original studies that showed reduced stigma within families after psychoeducation in China and Korea.[137] Two other reviews concluded that psychoeducation potentially enables caregivers to cope better with family members' mental health conditions and to reduce stigma.[138,139] Six reviews showed that disclosure of mental health conditions and discussion within families reduced mental health stigma.[140] Social networking with other families was another strategy that led to stigma reduction. A randomised controlled trial in rural China showed that an enhanced social contact model is a promising method for reducing stigma among family members.[141]

Health-care professionals and students

Ways to reduce stigma among health-care workers have been extensively researched: 56 reviews were published between 1994 and 2021 and focused on prequalifying stigma reduction programmes for trainees (eg, nursing and medical students) and in-service programmes for qualified staff. 29 addressed mental health conditions generally, ten exclusively involved people with dementia, seven assessed substance use disorders, five personality disorders, three borderline personality disorder, four

For more on **Opening Minds** see https://mentalhealthcommission.ca/opening-minds/

Poem 4

My own private nightmare
by Camilla Fitzjohn

Hard to believe it.
Where am I
What have I suddenly become. I've plummeted,
Can I sink any lower?

Labelled Mentally Ill, put and contained
A mental straight jacket. I can barely stand up,
I cannot read
My eyesight is blurred.

The nurses are kind,
But I have an inner sadness
Longing for the outside.
I decide
If I leave now, this won't count,
It will be just a nightmare.
"Leave now and you will be sectioned" I stay.

Medication makes me fat.
Slow and dull witted.
Labelled self-indulgent by my Professor.

Nerve endings tingling with humiliation.

Feel alone and cold.
Stuck on a private island
Nobody wants to visit.
Backs are turned.
Hostile stares.
No one sees the real me.
What's under this cloak of insanity.

Getting used to being ignored.

Settling for being misunderstood.

Hurrah!! How I cheer
for this new brave thoughtful generation!!

Thank you!! Thank you!!
For supporting and tolerating minorities.

Liberating us.
Cancelling Prejudice.

Thank you, New World.

suicidality and self-harm, one intellectual disabilities, one neurodevelopmental disorder, one psychosis, and one eating disorders (appendix 3 pp 97–101).

The stigma-related outcomes reported included changes in knowledge, attitudes, and clinical skills as well as clinical confidence and self-efficacy. Stigma was widely measured in terms of social distance.[142,143] Five meta-analyses reported small to medium effect sizes in improved attitudes and medium to large effect sizes in knowledge and clinical skills.[144–148] One review recommended that interventions should be repeated regularly to sustain changes over time.[149]

Many of the reviews recommend including PWLE in the design and evaluation of stigma interventions, but two did not.[150,151] PWLE have been involved in the delivery of anti-stigma interventions based on some social contact, such as filmed or live recovery testimonials.[152–154] It is notable that studies reporting multiple kinds of contact (eg, live or filmed) were more often associated with better outcomes for knowledge and attitudes related to mental health than educational interventions alone.[145] A meta-analysis of uncontrolled before-and-after evaluation studies in the Opening Minds programme in Canada found that interventions including social contact in the form of personal testimony were effective and that including multiple social contact components improved outcomes for health workers compared with interventions that had only one component of social contact (appendix 3 pp 57–65).[152]

Two reviews focused on e-interventions for professionals, and both reported improved knowledge and attitudes, more humane treatment of service users, and reductions in the use of coercive methods.[155,156] Fully online multi-component interventions, such as educational tutorials, case-based instruction, and practice-based learning, showed efficacy in stigma reduction.[155] Internet-based anti-stigma campaigns have also had positive effects on stigmatising attitudes among health-care staff.[156]

One of the areas that has received increasing attention for health-care students and professionals is the use of simulations (eg, standardised role-plays with actors), which have consistently been associated with stigma reductions.[147,153,157] A meta-analysis showed a small to medium effect size for learners' attitudes and a large effect size for clinical skills at immediate follow-up after simulation interventions that was sustained 3 months later.[147] A different review that assessed undergraduate nursing students reported that empathy for people who misuse alcohol and drugs improved after exposure to narratives of students' personal experiences and PWLE and reflective sessions, but did not improve with simulations.[158] This finding suggests that for students social contact and practice-based components lead to more positive effects on stigma.

Among students, all interventions targeting dementia led to improved comfort for patients.[159] Interventions were more likely to have a positive impact if the practice-based experience was preceded by an element of preparatory educational training. Direct contact without preparation led to feelings of intimidation and inhibition when interacting with people with dementia. Another recommendation was that the evidence for improving attitudes was greater among students treating patients with less severe conditions, from which recovery could be seen.[160]

For these health-care staff and student studies, most studies were of low quality, there were few randomised controlled trials,[150] and most did not have long-term

follow-up or report clinical behavioural change.[145,161] Few such studies were conducted in LMICs, but among those that were, China was the most frequently represented.[145,147,160–165]

Greater emphasis is needed on long-term collaborations between LMICs and HICs to pool resources and data;[164] to assess the sustainability of impacts or effectiveness;[153] and on more cultural adaptations of anti-stigma programmes.[164] A further key challenge is that few studies have used well adapted and validated outcome measures for stigma and discrimination, particularly in LMIC settings.[26,162–166] Researchers recommend use of mixed methods with qualitative components.[150] Cost-effectiveness is a research gap[150,164,167] and more meta-analyses are needed. Additionally, an increase in service user outcomes has been called for.[150,167]

> "The best way is to involve us [PWLE] from the beginning, at the planning stage. Especially important is to try and contact a representative organization first. They usually are small, underfunded and will greatly benefit from collaboration and support."
>
> *Person in Georgia*

General population

Nine reviews focused on interventions to reduce stigma in the general population. Corrigan and colleagues[168] examined education, social contact, and protest as potential strategies. Contact and education both improved attitudes and behavioural intentions towards stigma, but contact resulted in significantly greater positive changes among adults. For education, the meta-analysis effect sizes were d=0·3 for attitudes, d=0·14 for affect, and d=0·25 for behavioural intentions. For social contact, the respective effect sizes were d=0·4, d=−0·06 (non-significant), and d=0·19, respectively. In contrast, among children and adolescents, education yielded a larger effect than contact. In this review, effect sizes were significantly greater after in-person contact than after video contact.

Borschmann and colleagues[169] evaluated national anti-stigma campaigns in 21 European countries but found little evidence of a significant reduction in general stigma and showed variations across different sub-populations. Dumesnil and Verger[170] examined public awareness campaigns about depression and suicide, which included short media campaigns, gatekeeper training programmes, and longer programmes involving repeated exposures on national and local scales. Their review, which included 43 studies, showed that public awareness and information programmes about suicide or depression improved knowledge and, with only two exceptions, attitudes. Improvements were modest and most often only measured in the short term. 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.

In a Cochrane review, Clement and colleagues[171] examined the effect of mass-media interventions in the general population and in population subgroups, such as students or employers. Across 16 studies, five assessed discrimination. One found evidence on reduced discrimination, but this finding was not replicated in two similar larger studies. A meta-analysis showed small to medium size reductions in prejudice, with standardised mean differences of −0·38, −0·38, and −0·49 immediately, 1–8 weeks, and 6–9 months after the intervention, respectively. The clearest pattern of evidence emerged for first-person narratives of PWLE, which were related to reduced prejudice. In addition, interventions with two or more components had greater effects than those with one only. Most studies focused on immediate outcomes, such as measures of attitudes assessed directly after the intervention, although only a few were considered to have low risk of bias.

In their review of stigma-reduction programmes among African Americans, Rivera and colleagues[172] concluded that such programmes need to be culturally informed and tailored. They highlighted the importance of collaboration between mental health providers and faith-based institutions, as there is much mistrust of the medical sector. The authors noted the feasibility of large-scale projects based on partnership between non-profit organisations, churches, community mental health centres, and other organisations.

Scior[173] focused on the effect of social contact with people with intellectual disabilities, for example in schools or in relation to the Paralympics. As in other reviews, there were methodological limitations, such as small unrepresentative samples and cross-sectional designs. Nevertheless, the authors concluded that it was important to ensure positive encounters, which seemed to reduce social distance, whereas negative encounters can have the opposite effect.

Three reviews considered strategies to foster social inclusion of PWLE in the community. Dementia-friendly communities are characterised by inclusive environmental designs with adaptations to support PWLE using community services, such as churches and shops. Hung and colleagues[174] found that the active involvement of PWLE in the design of such support provided a sense of value and autonomy. A qualitative study focusing on intergenerational activities (eg, a choir) found that young adults' involvement resulted in reduced stigma towards people with dementia. The authors also highlighted the diversity of PWLE, and the importance to consider this diversity within dementia-friendly communities. The importance of intergenerational social contact was echoed in a scoping review by Gerritzen and colleagues.[175] The use of mainstream recreational facilities showed that activities that foster social connections (eg, physical or creative activities, such as theatre, choir, or arts) increased self-esteem and self-confidence in people with PWLE and gave them a sense of accomplishment.[176]

***Panel 2*: Stigma intervention components**

Advocacy
Promoting the rights of people with mental health conditions to reduce stigma by use of individual or group sessions and distribution of printed materials (eg, fotonovelas, brochures).

Collaborative community-based care
Any intervention provided by informal community care providers and only implemented in the community, including psychoeducation and rehabilitation strategies to improve personal, social, and vocational functioning, and linkage to self-help groups and social and financial support.[179]

Constructive discourse
Transformative education about the importance of disclosure of family members' mental health problems.

Gatekeeper training
Refers to individuals who have primary contact with people at risk of suicide or self-harm or who have a mental health condition. This type of training provides knowledge and skills, discusses attitudes, and provides strategies to help gatekeepers better inquire about and recognise risks and to intervene appropriately.

Protest
A campaign-based approach that aims to highlight a morally unacceptable view of mental health conditions and that criticises people who continue to engage in such practices. It also condemns negative media representations of mental health conditions.

Psychoeducation
Provides information for family members and the public about mental health conditions, including risk factors, prevalence, symptoms, diagnosis, and care, and addresses misconceptions and myths. It can be provided face-to-face, through social media, theatre, or workshops (eg, simulations).

Social contact
Sometimes called contact or interpersonal contact, social contact takes place when there is positive, cooperative interaction between people with a 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 (eg, imagined, simulations, video, online, social media, or observed). Specific key characteristics of positive social contact that are likely to be most effective for stigma reduction have been identified.[152,180]

Social networking
Restoring social interaction through support groups and open dialogue, including the use of normalisation.

The evidence on anti-stigma interventions in the general population in China has been summarised by Xu and colleagues.[177] They showed a small and significant effect on the reduction of negative stereotypes and found that interventions which included social contact were more effective than those that did not. They could find no strong evidence that using biological attributions for the cause of mental health conditions improved mental health literacy or reduced prejudice. They also recommended integrating cultural factors into anti-stigma interventions and measures for Chinese people. Similarly, Mascayano and colleagues[178] looked at integrating culture into anti-stigma interventions in LMICs. They found that only 20% of studies had addressed cultural adaptation and concluded that a more careful cultural adaptation of anti-stigma interventions is required in future.

Interpersonal stigma: specific intervention components

Having considered interventions to reduce interpersonal stigma for these various target groups, in the next section we discuss the evidence on specific intervention components to reduce stigma (panel 2).

Awareness creation, education, and training interventions

20 reviews assessed creation of mental health awareness, mental health education, and training the general population and other specific population groups. As noted previously, most of these were based on studies from HICs and upper MICs. Only one review included studies from Africa (Tanzania and Malawi).[181]

Awareness-raising interventions were psychoeducational (panel 2) and involved providing information about mental health conditions, including information about risk factors, prevalence, symptoms, and diagnosis, as well as confronting misconceptions and myths. The reviews identified multiple intervention delivery methods: face-to-face, social media, theatre, workshops, didactic training, constructive discourse, and the use of social network and support.[157,182–185]

In most studies, awareness-raising interventions targeted mental health conditions in general, but some addressed specific mental health conditions, such as schizophrenia, psychosis, bipolar disorder, depression, anxiety, dementia, eating disorders, obsessive-compulsive disorder, post-traumatic stress disorder, and other conditions, such as Tourette's syndrome and attention-deficit hyperactivity disorder in children or young people. Most of these reviews found the activities efficacious across multiple formats,[182–188] but one review reported no difference between the intervention group and the comparison.[189]

The effectiveness of online awareness-raising activities was mixed. One review found that online methods were as effective as offline interventions in reducing stigmatising attitudes in the general population,[157] and in another internet programmes were at least as effective as face-to-face delivery in reducing personal stigma.[190] However, one review found that although internet-based interventions led to improved literacy and to reduced stigma in adults, stigma among high school students was not affected.[191]

There is considerable debate on how far educational interventions lead to behaviour change. The effect of awareness on help-seeking attitudes and behaviours is inconsistent.[184,185] One review indicated that psychoeducation for caregivers had no significant effect on attitudes, empathy, or positive aspects of caregiving when compared with controls.[189] However, interventions that included communication strategies might facilitate self-confidence in caregivers, leading to improved understanding of the needs of the person with a mental health condition.[152,182]

Training was another type of awareness-raising intervention that was reported. MHFA used with police officers, teachers, and other public sector workers has shown positive changes in behaviour.[190] However, a meta-analysis of 18 trials with nearly 6000 MHFA course participants assessed attitude changes and found only minimal positive effects (d=0·12).[192] Gatekeeper training improved knowledge about suicide and suicide prevention and reduced belief in myths about suicide immediately after the training intervention in a range of groups, such as students, teachers, social workers, pharmacists, managers, and carers, but these effects were not sustained.[193]

Social contact with and without education

29 reviews reported the effectiveness of social contact in reducing stigma or in improving knowledge and attitudes toward people with mental health conditions across different target populations. Most of the primary studies included in the reviews were done in HICs. Social contact aimed at creating awareness or reducing stigma through sharing the experiences of PWLE was evaluated in relation to mental health conditions overall and for various specific conditions. Awareness-raising or educational activities were provided to participants before the social contact interventions.

Social contact through theatre or film improved knowledge and attitudes towards people with mental health conditions, addressed misconceptions,[178,194–197] and led to some sustainable behavioural changes.[194,195] Combined interventions, particularly those including educational and social contact components, significantly reduced stigmatising attitudes and social distance.[178,196,198,199]

Interventions that directly involved PWLE were more effective in reducing stigma than those that did not.[200–203] Social contact had a consistently positive effect on reducing stigmatising attitudes, perceived stigma in help seeking, and social distance.[186,195,198,203–208] Social contact was also associated with more social interaction, reduced fear,[98] and reduced experience of discrimination.[206]

Social-contact-based education was superior to traditional educational approaches. Video-based contact combined with education was effective in reducing stigma among students in general and among health professionals,[198,199,209–211] and led to a more balanced portrayal of people with mental health problems by media professionals.[212]

Active interaction with PWLE who described their experiences was more effective than passive interaction in reducing stigma and led to greater reductions among health-care professionals than among non-professionals.[201] Effectiveness did not differ significantly in reducing stigma between delivery methods for social contact interventions, such as face-to-face, imagined, or video.[204]

At the population level, reasonably consistent benefits were seen with social contact interventions in relation to attitude change and weaker evidence suggested knowledge improvement, although most studies only assessed short-term outcomes, including in specific target groups.[210]

Simulated symptoms

Some reviews considered whether simulating symptoms of health conditions helped to reduce stigma among people who have not had such experiences. Simulation has been used, for example, to communicate what is it like to experience auditory hallucinations by the use of audio segments of voice and non-voice sounds with both derogatory and neutral or benevolent narratives.[186,213] Although simulated hallucinations increased empathy for people with schizophrenia, the evidence for their effectiveness in causing attitude change is inconsistent, with some studies indicating that they may worsen rather than improve attitudes and desire for social distance.[198]

Advocacy, campaigns, and protest

13 reviews assessed interventions related to advocacy, campaigns, and protest, including from seven to 123 original studies. Most of the studies were done in HICs (eg, Australia, Japan, the UK, the USA, and western European countries) and upper MICs (eg, Brazil, Chile, China, and Türkiye). Target populations included the general population,[214] health-care professionals,[185,205,207] students and teachers,[185] people with mental health conditions, and caregivers.[199]

> "My decision is to make mental health and mental illness a normal subject in my life and my circle. It's a fierce battle but I remain engaged because I have seen how many people have benefitted from my advocacy."
>
> *Person in Trinidad and Tobago*

Various types of advocacy methods, such as individual or group sessions, and distribution of printed materials (eg, fotonovelas and brochures) can reduce stigma related to mental health conditions.[215] Findings were mixed for specific stigma outcomes, with some studies showing reduced stigma toward mental health treatments, beliefs about dangerousness, and social distance, whereas others reported no reduction in stigma towards people who take antidepressants.[215] One review reported that promoting continuum beliefs about mental health—that is, a continuum between mental health and mental health conditions (rather than a dichotomous approach)—gave mixed results for stigma and even found increased stigma in some studies.[216] Advocacy programmes were assessed in one review, which

Poem 5

Make a Difference
by Anne Hoffman

Sometimes when I'm on the bus
I tell people about my schizophrenia story
I don't hold back or make a fuss
Some listen while others leave in disgust
Every case is unique
Not everyone is violent or scary
It all comes down to belief
If people can understand and feel relief
The media portrays fear
They inform the public about the tragic side
As individuals we need to make it clear
Tell people our story, achievements
What they like to hear
Make a difference
It's up to you
It can't hurt
To give your point of view
Tell the truth, how it feels to you
Change people's image and point of view
Some people get up and walk away
There's always hope it will change one day

concluded that efficacy was unknown.[202] Public relations campaigns have resulted reductions in stigma about people with depression.[207] Protest interventions might reduce stigma in the short term but the long-term impact is unclear.[214]

Protest interventions are designed to show that specific perspectives about a minority group are unacceptable and to reprimand against continuation, including representations in the media and societal reactions.[186] We found four studies that evaluated the effectiveness of protest interventions. A review by Griffiths and colleagues[186] found that protest campaigns targeting all mental health conditions overall significantly reduced personal stigma but not internalised or perceived stigma. Interventions targeting specific mental health conditions were more effective in reducing all types of stigma. Another review by Ashton and colleagues[214] found that protest interventions reduced stigma in the short term, but the long-term effects were unclear. Two other systematic reviews concluded that the outcomes of protest campaigns in reducing stigma are unknown.[199,209] Hence, evidence for whether or not protest programmes are effective in reducing stigma is generally lacking.

Collaborative community-based care and social networking

Collaborative community-based care is defined as any intervention provided by informal community care providers and implemented only in the community. Approaches include psychoeducation and rehabilitation strategies to improve personal, social, and vocational functioning along with links to self-help groups and social and financial support.[179] Four reviews focused on collaborative community-based care interventions via social networking.[98,140,179,217] The number of studies assessed in each review ranged from five to 123, and these studies were conducted in HICs and LMICs, and conditions of interest were severe mental health conditions,[179] suicide,[217] or mental health conditions in general.[98,140] The types of intervention described referred to mental health care in the community,[98] developing support networks,[217] and carer groups.[140] Disclosure about family members' mental health conditions increased, which was associated with improvements in knowledge of schizophrenia and social inclusion.[179] However, the experience of stigma was not reduced. Social and financial assistance increased due to improved social inclusion. Community-based mental health care was described as less stigmatising than hospital care. Social networking led to the normalisation of people with mental health conditions.[140] The use of support networks decreased negative attitudes towards suicide.[217]

Self-stigma

26 reviews were included on interventions for self-stigma and, notably, all were published between 2012 and 2021 (appendix 3 pp 107–108). Ten assessed interventions specifically designed to address self-stigma and 16 considered interventions targeting other primary outcomes but included self-stigma or other closely related measures.

Among reviews addressing self-stigma specifically, a range of conditions were involved, including any mental health condition,[218] traumatic life events,[219] or severe mental health conditions.[220–222] Reviews generally included studies that reported improvements in self-stigma or in similar outcomes, such as stigma stress or self-efficacy in the absence of a positive result for self-stigma. One review, though, found evidence from six studies (experimental and observational) of a relationship between the endorsement of biogenetic causes of mental health conditions and worse outcomes, namely increased pessimism about prognosis and recovery, indicating that biogenic causal models of mental illness may make stigma worse rather than better.[223]

In meta-analyses short-term follow-up showed sustained moderate improvements,[218] but two reviews found that the improvements became non-significant over time.[221,224] Two broader reviews covered various intervention types for people with different conditions.[221,224] A review on self-stigma in relation to people with a diagnosis of schizophrenia,[221] reported that the most methodologically robust study they included showed the largest effect for internalised stigma reduction.[225] The authors recommended that larger-scale randomised controlled trials are done in the future. Similarly, Büchter and Messer[224] recommended differentiation of interventions

addressing self-stigma from other interventions and whether needs differ by intersectionality (eg, gender, ethnicity, and employment status). These reviews questioned whether the outcome measures used in studies were sufficiently responsive to change[224] and addressed traditional characteristics such as validity and reliability.[221] The potential for a wide range of recovery-oriented interventions to reduce self-stigma was also made by Winsper and colleagues,[226] but they found that recovery is rarely measured. Most self-stigma interventions involve groups, which can create barriers for people who are not willing to disclose a mental health condition to others.

The 16 reviews of other interventions related to self-stigma refer to interventions that are already widely accessible, such as psychoeducation;[227] do not require group attendance, such as peer support;[228,229] assess initial help-seeking;[230] or investigate other salient goals, including symptom reduction,[231] musicianship,[232] advocacy,[233] or competitive employment.[226] One review by Mills and colleagues[234] focused on self-help interventions to reduce self-stigma, and found a study that showed reduced help-seeking among refugee men with post-traumatic stress disorder.[235] Aguirre Velasco and colleagues[230] summarised largely school-based interventions for adolescents, and found some improvements in help-seeking intentions, stigma related to help-seeking, or both, although study quality was low. A clear take-home message from these reviews is the need to assess interventions outside institutional settings, for example anti-stigma social marketing campaigns.

Only two reviews focused on LMICs. Xu and colleagues[236] examined PWLE in mainland China, Hong Kong, Taiwan, and Macau. And Demissie and colleagues[227] focused on people with PWLE of bipolar disorder in LMICs. Both reviews found positive effects of psychoeducation on reduced self-stigma and self-prejudice, and improved coping with stigma.

Cost-effectiveness

No reviews specifically evaluated the cost-effectiveness of anti-stigma interventions. The *Lancet* Commission did, however, identify several original research studies. In California, a campaign aimed at increasing help-seeking by reducing stigma found that for each US$1 spent there could be a $1251 benefits through increased employment because of improved health.[237] Benefits to the state government were estimated to be $36 for each $1 spent on the campaign. One modelling study used data from Scotland and found that if a campaign led to a 10% change in attitudes, costs could be reduced by £35 per person for those who had felt that people with mental health conditions are dangerous and by £186 per person among those who felt that the public needs protection from people with mental health conditions.[238] This approach was subsequently also used to assess the cost-effectiveness of the Time to Change anti-stigma campaign in England and found that the campaign cost per person with improved intended behaviour was estimated at £4.[239] In Germany the Honest, Open, Proud programme for adolescents with mental health conditions was thought to be cost-effective.[240] While clearer evidence is needed, the findings so far suggest that anti-stigma interventions could be cost-effective at the programme and population levels.

Practical experiences of delivering anti-stigma programmes

In this section, we present the practical experiences of delivering large-scale and long-term anti-stigma programmes, including national-level and smaller programmes that have developed successful and evidence-based initiatives in LMICs. We discuss the successes, challenges, and lessons learned from various points of view, including that of PWLE. We discuss the wider impacts and unintended consequences of anti-stigma activities and the contextual influences affecting their delivery. We also look at how selected programmes were developed, delivered, evaluated, and scaled up through purposively selected case studies. The methods and data sources used to generate this information are provided in the appendix 3 (pp 47–91).

Key characteristics of anti-stigma programmes

Large-scale programmes to reduce stigma can vary according to the wider policy context. For example, the On the Level in Czechia was provided in the context of larger mental-health-care reforms (figure 6).[241] Key characteristics

Figure 6: **Tightrope artists symbolically connecting the Ministry of Health with the Ministry of Labour and Social Affairs in Prague, Czechia**
This event illustrated the need for better cooperation between the two ministries. The On the Level anti-stigma initiative is a part of the National Mental Health Action Plan for 2020–30. Produced with permission from Michaela Koubová.

Panel 3: Selected case studies of delivering anti-stigma programmes

- Like Minds, Like Mine programme from New Zealand: one of the world's longest-running stigma reduction programmes
- Batyr in Australia: created and operated by young PWLE and delivered to other young people
- SMART Mental Health in India: operates in a low-resource setting, uses innovative multimedia approaches, has cross-sectional and longitudinal evaluations, and is currently in the process of being scaled up
- Reducing Stigma among Healthcare Providers (RESHAPE) project in Nepal: highlights an innovative visual narrative technique (PhotoVoice) for involving people with lived experiences to reduce stigma among primary healthcare providers
- Guangzhou Mental Health programme in China: initially provided training for community mental health staff and later expanded to care assistant workers and people with schizophrenia
- Time to Change Global programme and the Understanding Stigma and Strengthening Cognitive Behavioral Interpersonal Skills (CBIS) programme (run by Opening Minds in collaboration with the Pan American Health Organization): examples of programmes designed to adapt know-how from long-term successful programmes in HICs to newly launched initiatives in LMICs
- On the Level programme in the Czech Republic: launched in the context of a larger mental-health-care reform and might be informative for other countries reforming their mental health system
- Working Minds programme in Canada (run by Opening Minds): an example of a programme that has been able to generate resources to ensure long-term sustainability
- The Carter Centre Mental Health programme in Liberia: an example of a programme targeting journalists and implemented in a low-resource setting
- Time to Change programme in England: one of the most intensively researched national anti-stigma programmes in the world

HICs=high-income countries. LMICs=low-income and middle-income countries. PWLE=people with lived experience of mental health conditions. SMART=systematic medical appraisal, referral, and treatment.

might include specific changes in the health context, such as the impact of the COVID-19 pandemic on mental health,[242] or in response to high-profile failures in a health care system, such as the Life Esidimeni tragedy in South Africa.[243] Some programmes address the needs of specific country networks, such the Time to Change (TTC)-Global programme, which has been implemented in several LMICs,[244] Systematic Medical Appraisal, Referral and Treatment (SMART) Mental Health in India,[245] or Reducing Stigma among Healthcare Providers (RESHAPE) in Nepal.[246]

Stigma reduction can also be an intended or unintended consequence of policies delivered in the field of mental health. For instance, public stigma may be exacerbated by the structure of mental health services in a given country, and deinstitutionalisation can facilitate stigma reduction.[241] Stigma might be also tackled via various usually small-scale activities that are connected to cultural initiatives, such as exhibitions, festivals, or artistic performance. Here we focus on large programmes in HICs and smaller successful programmes in LMICs.

Selected case studies from HICs and LMICs

We selected case studies purposively that were representative of different types of anti-stigma interventions in a wide variety of geographical and cultural locations and with diverse target groups (panel 3, table 1). Invitations to participate in our survey were distributed through our networks and, therefore, the selection is also inherently attached to either the global mental health movement or Global Anti-Stigma Alliance.

Involving PWLE in all levels of anti-stigma programmes

Inclusion of PWLE in the delivery of anti-stigma programmes is crucial for effectiveness and was a key component identified in almost all the selected case studies. Most programmes went further and involved PWLE at the heart of planning, development, and refinement of the interventions and evaluation of the programme. Having PWLE in leadership roles was noted to be especially powerful. Respondents to our survey indicated that involvement in anti-stigma programmes could not only reduce self-stigma but also be an important contribution to an individual's recovery journey. In the case studies, the need to provide training and structures that supported PWLE was repeatedly emphasised, with particular emphasis on having control over disclosures (eg, in the RESHAPE programme) and enabling safe exits from public events if the audience questions led to discomfort (TTC-Global). Nonetheless, the emotional labour of social contact was thought to increase turnover of staff in one of the programmes assessed.

The lived experience survey done for this *Lancet* Commission further clarified understanding of the range of experiences of PWLE who have been involved in anti-stigma programmes (appendix 3 pp 20–22). Of 391 respondents, 181 had been involved in the provision of anti-stigma programmes. These responses were in the following languages: Arabic n=2, English n=59, Spanish n=34, French n=3, Russian n=35, and Chinese n=48. Key positive and negative aspects of these experiences are summarised in table 2. As well as distress from disclosures and testimonies, PWLE reported sometimes feeling the negative impacts of being exposed to stigmatising audiences and co-workers. The importance of training, feedback, peer support, and remuneration were all emphasised. Importance was placed on the need for PWLE to be involved at every

	Country (income level)	Scope	Aim	Components	Delivery method	Target group	Mental health condition targeted	Extent of involvement of PWLE	Duration	Type of evaluation	Extent of the programme	Funding source
Like Minds, Like Mine	New Zealand (HIC)	National	Anti-stigma media campaign focused on addressing prejudice and discrimination associated with mental distress and promoting greater social inclusion by utilising a "human rights approach to disabilities"; promotes new inclusive attitudes, behaviour, and structures and provides mental health support to individuals with mental distress	Resources for PWLE, journalists, and public figures on portrayal of mental health conditions, with links to the Mental Health Foundation, and showcasing collaboration between organisations and campaigns aimed at broadening the reach of these resources	In person and online	Everyone in New Zealand	All mental health conditions	Evaluation of progress and development of community initiatives, especially Māori communities; delivery of content for intervention (eg, videos, programme development, management, implementation, and evaluation); programme is led by PWLE	Ongoing since 1997	Mixed methods	Part of other mental health programmes	Government
Batyr programme	Australia (HIC)	National	Reduce self-stigma, discrimination, or both; improve skills, knowledge, attitude, behaviours; increase help seeking and service provision; reduce structural stigma, discrimination, or both	Education-based stigma-reduction strategies; contact-based strategies; peer support; focused on recovery	In person and online (eg, social media, content creation, and online courses)	Children, adolescents, PWLE	All child and adolescent mental health conditions	Provision of content for interventions (eg, videos; programme development, management, implementation, evaluation, and leadership)	Ongoing since 2011	Mixed methods	Stand alone	Government and private (including philanthropy)
SMART Mental Health	India (LMIC)	Regional	Improve knowledge, attitudes, and behaviours related to mental health and reduce stigma perceptions related to help seeking	Education, social contact, celebrities, drama, animation videos; focused on help-seeking and recovery	In person and multimedia	Adults and expanding to adolescents	Stress, depression, anxiety, increased suicide risk	Social contact via video; programme co-creation and implementation	Ongoing since 2016 with scale-up	Mixed methods, cross-sectional, and longitudinal assessments	Part of a larger programme providing technology-enabled mental health care	International peer-reviewed grants
Reducing Stigma among Healthcare Providers (RESHAPE)	Nepal (LMIC)	Local	Reduce mental health stigma among primary care providers and improve quality of care through active involvement of PWLE and caregivers	Social contact through PhotoVoice recovery narratives, dispel myths, and interaction with aspirational figure	In person, photographic recovery narratives, stigma didactics, and experience sharing by aspirational figures	Primary care providers	Depression, psychosis, alcohol use disorder, anxiety	Delivery (with training) of recovery narratives through PhotoVoice process; participation in health facility management committee meetings for ongoing quality improvement	Started in 2016	Pilot cluster randomised controlled trial; full cluster randomised controlled trial underway	Anti-stigma programme is embedded into mhGAP training of primary care providers	Peer-reviewed research grants

(Table 1 continues on next page)

	Country (income level)	Scope	Aim	Components	Delivery method	Target group	Mental health condition targeted	Extent of involvement of PWLE	Duration	Type of evaluation	Extent of the programme	Funding source
(continued from previous page)												
Guangzhou mental health programme	China (LMIC)	Local	Reduce self-stigma and self-discrimination; improve knowledge, attitudes, and behaviour; address structural stigma	Education based	In person	PWLE; health-care workers; community, police, and community cadres	Schizophrenia and severe mental health conditions	PWLE are recipients	Started in 2013	Quantitative	Integrated in a larger programme on mental health promotion at workplace	Government
Time to Change Global	Kenya, Nigeria, Ghana, Uganda, and India (LMIC)	Regional (started pilots in capital cities in Kenya, Ghana, Uganda, Nigeria, and India)	Reduce self-stigma and self-discrimination; improve skills; improve knowledge, attitude, and behaviour	Marketing campaigns in capital cities via traditional (eg, billboards) and social media platforms to disseminate information and dispels myths associated with mental health conditions; training of 111 champions to run events	In person and online	Target segments of the local population and PWLE	Any mental health conditions	Trained as champions to run anti-stigma social contact events and sharing of personal stories in person and through media outlets; champion's caregivers also involved for support	2018–20 (except Kenya 2018–23)	Quantitative	Stand alone	Government (UK) and philanthropy (Comic Relief)
On the Level	Czechia (HIC)	National	Reduce self-stigma, self-discrimination, or both; improve knowledge, attitudes, behaviours, and skills; increase help seeking and service provision	Education-based, social contact	In person and partly online due to COVID-19 restrictions, multi-media	PWLE and their relatives, health-care, social care, and public administration workers, communities (NIMBY syndrome)	Schizophrenia and severe and common mental health conditions	Inclusion at all levels of decision making and programme planning, design, development, delivery, and evaluation; provision of social contact content (video)	Ongoing since 2017	Mixed methods	Stand-alone programme	Government
Opening Minds: a) general; b) Working Minds; c) Understanding Stigma and Strengthening Cognitive Behavioral Interpersonal Skills Program for Latin America	a and b: Canada (HIC); c: LMICs	a and b: national; c: international	Reduce structural stigma, discrimination, or both; reduce self-stigma, self-discrimination, or both; improve knowledge, attitudes, behaviours, and skills; increase help seeking and service provision	Education-based stigma-reduction strategies; contact-based strategies; focused on recovery	a and b: in person and online; c: online	a: adults, children and adolescents, students, public administration workers, police and correctional facility staff, and teachers and workers in the education sector; b: employers and workers in different sectors; c: health-care workers	All mental health conditions	Involvement in delivering content and programme development, management, and implementation	Ongoing since 2009	Mixed methods	a: stand-alone; b and c: integrated within larger programme	a and c: national and regional government; b: revenues generated by the programme

(Table 1 continues on next page)

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	Country (income level)	Scope	Aim	Components	Delivery method	Target group	Mental health condition targeted	Extent of involvement of PWLE	Duration	Type of evaluation	Extent of the programme	Funding source
(continued from previous page)												
Carter Centre Mental Health Programme	Liberia (LMIC)	National	Reduce stigma among key stakeholders (eg, health workers, police officers, journalists, pharmacists, religious leaders, and teachers); promote involvement of PWLE in advocacy organisations and policy making	Social contact through engagement with PWLE; develop positive messaging in media; skills training in mental health care for nurses, teachers, police, etc	In person	Health-care workers (eg, nurses and physicians' assistants), pharmacists, religious leaders, police officers, teachers, and caregivers	All mental health conditions	Co-facilitation of training of stakeholders; participation in advocacy activities and policy making; support other PWLE	Ongoing since 2010	Mixed methods	One of three national mental health care pillars: stigma reduction, skills training, and policy making or advocacy	International non-governmental organisation
Time to Change, England	England (HIC)	National	Reduce self-stigma, self-discrimination, or both; improve skills and public knowledge, attitudes, and intended behaviours; reduce structural stigma, discrimination, or both	Social marketing (key element); train PLWE champions; social contact events; employer programme; children and young people programme; media engagement project, '300 Voices' young African and Caribbean male project; mental-health-care professionals pilot; primary care pilots (Education Not Discrimination)	In person and online	Adults, men, African and Caribbean adults, children and adolescents, mental-health-care professionals, police, teachers education workers, employers and workers, and health-care workers	All mental health conditions	Inclusion at all levels of decision making; programme planning, design, development, delivery, and evaluation; provision of social contact content (video)	2007–21	Mixed methods	Stand-alone programme	Government and private (including philanthropy)

HIC=high-income country. LMIC=low-income and middle-income country. mhGAP=mental health gap action programme. NIMBY=not in my back yard. PWLE=people with lived experience of mental health conditions.

Table 1: **Key elements of selected anti-stigma programmes**

	Illustrative quotations
What was most difficult with your involvement in anti-stigma programmes?	
• Encountering stigma (eg, ignorance, lack of sympathy, blame, pity) • Reliving past difficult experiences • Coping with others becoming upset • Challenging interpersonal encounters during and after programme involvement, and with health professionals • Tokenistic involvement • Practical challenges (eg, time commitments) • Feeling anxious or nervous • Lack of awareness and recognition of mental health • Engaging the intervention target group	• "The most difficult thing is the moralisation and condemnation of people with health problems. False beliefs of ordinary people about vulnerable people. It is often said that 'they are to blame for their own problems'" (Republic of Kyrgyzstan) • "The hardest bit is being asked to describe your own experience as this means reliving at least some of how you felt through that and it is painful to do so" (UK) • "I think it's to share past experiences that might bring back some unpleasant memories" (Hong Kong) • "[It is] hardest to share a story or deliver a workshop if a safe space is not created first" (Norway) • "…when organised by professionals, they don't know how to work with us" (Spain) • "One of the most important barriers that I have found, are the people who consider that mental illness does not exist, it has been difficult for me to work with this population. They become fundamentalists and it is very difficult to establish a dialogue" (Uruguay)
What made your involvement in anti-stigma programmes easier or more rewarding?	
• Training and support with shaping one's narrative • Practical support at an organisational level • Receiving payment for the involvement • Having expertise through experience validated • Feedback on the impact of the programme • Peer support • Personal sense of satisfaction	• "It takes training to turn one's own experience into a story of hope" (Hong Kong) • "Certainly, payment offers a way of validating how serious the sponsoring group is in their message" (USA) • "Critical to pay people if possible. Sharing a lived experience is a vulnerable thing, and a skill. It should be paid in the same way other work should be paid" (Norway) • "It's the confidence in my skills, and the fact that I'm treated like a teacher. Like another" (Switzerland) • "I believe feedback on what I've delivered has been the most beneficial and rewarding" (Ireland) • "I also treasure the peer support within the organisation. We need a safe organization to grow and learn" (Hong Kong)
Recommendations for how to best involve PWLE in programme delivery	
• Including PWLE at every stage of programme • PWLE in leading positions of programme activities • Participation arranged on terms of PWLE • Involving people at appropriate stage of recovery • Involving diverse range of people • Provided a platform to share their lived experience • Include facilitative factors: training, payment, and instrumental support • Prepare for challenges	• "Be convinced that people with lived experience in mental health are essential for the execution of programmes" (Spain) • "Include them [PWLE] in the design of the programme and not as recipients or participants of something already decided" (Argentina) • "Include them [PWLE] from the beginning of the process in the reflection on the programme (not just like 'testimony machines')" (Switzerland) • "Participants can stop sharing at any time, and can choose the content they want to share, which is protected and cared by the provider to avoid pressure from third parties [institutions, groups]" (Hong Kong) • "Support helping people who are reluctant to share or fear retribution to feel empowered and to deliver their message in a way that resonates with the intended audience and also makes the sharer know how important their candour is on so many levels" (USA) • "Provide training and workshops to make it easier for me to reflect such as searching for my soul" (Hong Kong)

PWLE=people with lived experience of mental health conditions.

Table 2: **Key findings from the lived experience survey about participating in anti-stigma programmes**

stage of anti-stigma programmes and not just to provide testimonies.

Lessons learned

To draw lessons from this wealth of experience in delivering anti-stigma programmes, we identified information from the following sources: the relevant literature; online case study survey; the case studies; online survey of PWLE perspectives; and qualitative analyses of material recorded and transcribed from the 2021 World Psychiatric Association international Together Against Stigma conference organised in Prague, Czechia.

For an anti-stigma initiative or programme, we recommend that the preparation phase includes the defining of aims, target groups, and desired change, and a clear focus on what matters most. Evidence-based interventions should be adapted to the local context, taking into account relevant considerations as shown in figure 7. Identifying previously successful programmes and adapting their materials can be helpful. Since each programme needs to be tailored to the specific needs of the target population, it is important to understand the cultural, historical, political, and economic nuances of the setting or settings and to engage with the full range of local stakeholders, including governmental ministries and agencies. Even when a programme is at the national level, taking a bottom-up approach and linking together multiple local initiatives rather than using top-down anti-stigma messaging can help to ensure relevance and sustainability (eg, Opening Minds Canada).

Collaboration with PWLE is necessary from the planning stage and they should have as much involvement as possible throughout. The importance of this was highlighted in the case studies, Together Against

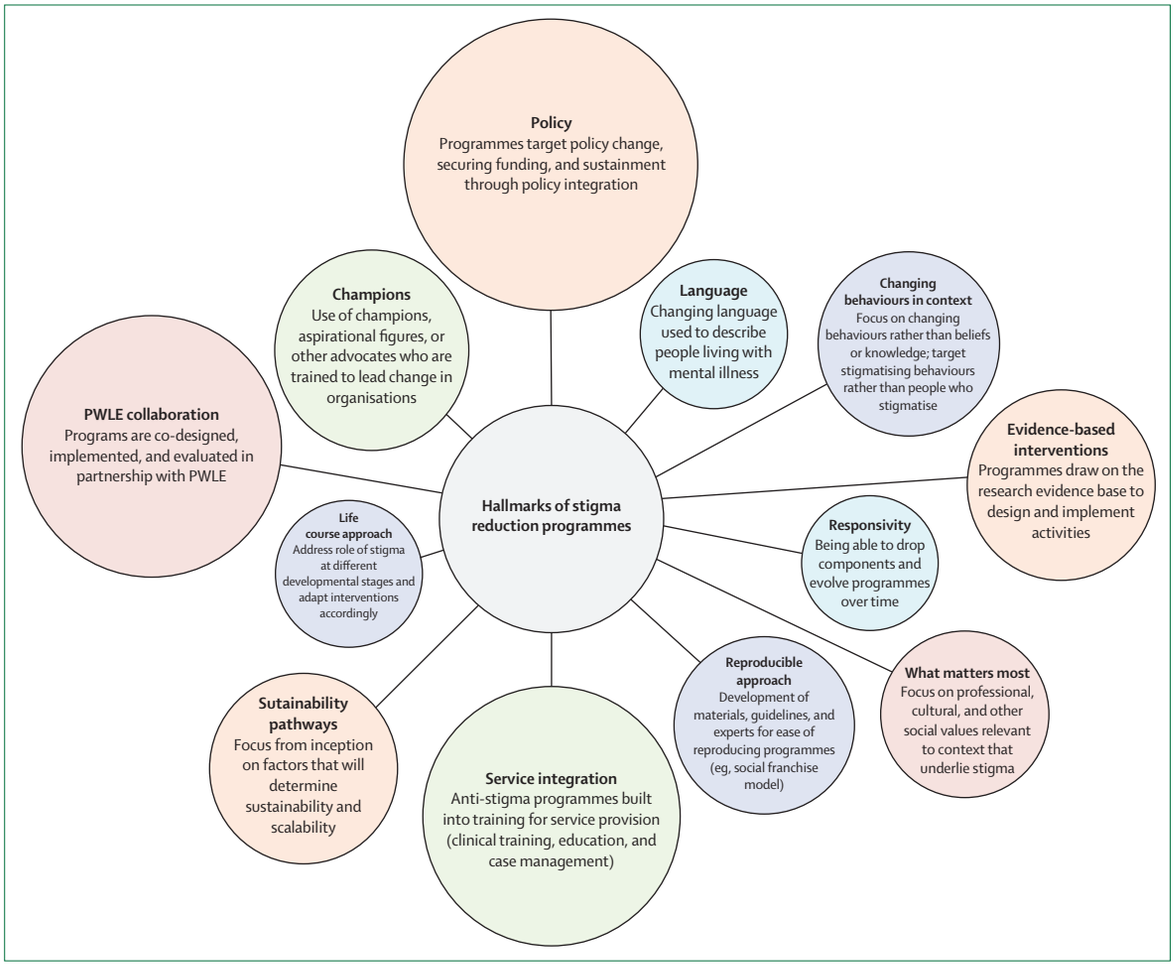

Figure 7: **Key hallmarks of stigma reduction programmes**
Balloon sizes represent the relative importance of key components and activities. PWLE=people with lived experience of mental health conditions.

Stigma conference presentations, and the online PWLE experience survey. Efforts should be taken to maximise emotional safety when sharing stories in front of target audiences. Providing training to PWLE champions well before their involvement in the anti-stigma campaign was reported as an important element to avoid high turnover rates. The RESHAPE programme in Nepal, TTC-Global, and other programmes had training packages prepared by PWLE for advocacy and social contact interventions and incorporated specific measures to facilitate peer-to-peer support. The Honest, Open, Proud programme[220] is one of the most evidence-based practices in this respect. PWLE can also help to sustain the programme, for example when champions trained in advocacy continue their work after completion of the pilot initiative via social media and blogs, as in TTC-Global in Kenya. Social contact needs to carry an inspiring message of hope with details about achievements and successes and should be delivered in a manner that directly portrays recovery.[152] Balanced against this, however, is the need to retain an authentic voice that acknowledges, for example, mental health setbacks (eg, the Batyr programme).

To ensure relevance and relatability, the case studies and PWLE experience survey emphasised the importance of including members of the target groups in the programme design and delivery to maximise precise selection of stakeholders. In RESHAPE in Nepal, for example, PWLE from the national association were less relevant for developing the programme content than those from the local area. In Guangzhou, China, the project achieved positive results by integrating anti-stigma activities into the routine mental health training programme of health and care workers, including primary-health-care staff and community police officers.[247] Cultural adaptations are vital. For example, substantial adaptations of previously generated materials were needed for the TTC-Global programme and for the Like Minds, Like Mine programme to extend its reach to Māori populations. Indeed, many of the case studies

included targeted subcampaigns for specific audiences, sometimes marked out with distinct names that were still related to the overall programme name (eg, The Working Minds; Batyr@school/Batyr@uni as part of the Opening Minds programme).

Linking anti-stigma interventions to the wider reform or scale-up of the mental health system might be beneficial. Although mental health care is scarce in low-resource settings, the services that do exist are often institutionalising and may reinforce stigma or exclusion. A commonly stated goal of anti-stigma programmes is to increase help seeking for mental health care and, therefore, it is essential that the care available is of good quality, respects human rights, and is worth seeking. The case studies in China, India, Liberia, and Nepal embedded interventions within efforts to expand access to mental health care. In New Zealand, Canada, and Czechia, anti-stigma programmes were linked to efforts to reform the mental health system.

The evidence we gathered suggests that the duration of a specific programme may be less important than the quality of the social contact. The programme content should be directly culturally and socially relevant to the target audiences. For example, considering the case studies, SMART Mental Health in India successfully used drama relevant to villagers in a rural area to share messages about mental health along with emphases on help seeking and personal recovery.[248] Creating a social movement as part of a coordinated campaign can also provide for more enduring social inclusion of PWLE, and the Like Minds, Like Mine programme in New Zealand adopted this approach. Both in-person and online multimedia approaches have been beneficial, as shown in the Time to Change programme in England and in Like Minds, Like Mine. Using digital communication methods can be very effective, and they have been suggested to be important components in delivering anti-stigma campaigns.[131] In addition to the core concepts of social and personal contact,[249] the hallmarks of successful programmes are shown in figure 7.

Anti-stigma programmes should be evaluated regularly from the beginning and be designed to track whether the key intended changes have been achieved. Some programmes have used generic scales, such as the Reported and Intended Behaviour Scale,[250] the Mental Health Knowledge Schedule,[251] or the Discrimination and Stigma Scale.[26] Others have included scales more specific to the target groups, such as the Mental Illness: Clinicians' Attitudes Scale.[252,253] Evaluation should not be viewed merely as an academic exercise or as a way to satisfy donors, but rather as an essential way to monitor how to improve programme quality and impact over time (as happened in Opening Minds, Canada; Like Minds, Like Mine, New Zealand; and *Na Rovinu* [which translates to On the Level], Czechia).[242,254]

Programme sustainability was reported as one of the greatest challenges. Some of the better-funded programmed, such as the Time to Change in England, have closed. Diverse funding, variation of programmes for multiple target groups, crowd-funding activities (such as those employed by Batyr, Australia), and revenue-generating programmes (eg, as used in Working Minds, Canada) can all complement governmental funding and help programmes to continue in the long-term. However, fundraising is time consuming. Integration of anti-stigma interventions into larger governmental priorities, such as the COVID-19 pandemic, might also support longevity.

Other challenges that we identified included lack of funds for disadvantaged population subgroups; no funds or funding mechanisms to provide payments to PWLE for their work in anti-stigma initiatives; difficulty in adapting interventions to digital platforms during the COVID-19 pandemic; limited supply of mental health assessment and care services where demand has risen because of effective anti-stigma campaigns; and no or poor-quality evaluation of programmes, especially in LMICs, including cases where funders did not wish to have feedback on outcomes. All these issues strongly point to the needs to hold governments to account for funding treatment and anti-stigma campaigns and to build a parity of esteem between mental and physical conditions.

> "Have the person with lived experience at the centre of the programme delivery."
>
> *Person in Kenya*

> "I am setting up a foundation /organisation towards it in my hometown. I have personally been very, very vocal about my struggles and how I overcame it. I believe that through heart-to-heart dialogue with people, you can communicate and help them understand."
>
> *Person in India*

Stigma and the media

The media wield great power over citizens and influence perceptions of reality and interpretation of the world. Media messaging affects all elements of stigma, including knowledge, attitudes, behaviours. Media can be beneficial (actively reducing stigma) or harmful (perpetuating stereotypes or negative attitudes or behaviours). For example, there is increasing concern that substantial social media use is associated with low self-esteem, anxiety, and depression, especially among young women.[255,256]

The evidence on the impact of media messaging on different types of stigma is evolving. Most research has focused on the traditional media, but evidence is growing on the influences of newer media platforms.

The range of the media

The media industry has been defined as "the specialised and separate institutions and organisations in which people worked: print media and the press, photography, advertising, cinema, broadcasting (radio and television),

publishing and so on".[257] In the digital age, the media landscape has expanded to include traditional and new media.[258,259]

> "Social media have two sides, it can increase stigma and it can reduce stigma. Many people talk about serious things like they know everything that's why it's dangerous. But if we are smart, we can get more knowledge or use them as campaign to reduce stigma."
>
> *Person in Indonesia*

The traditional media include print media (including newspapers, magazines, books, flyers, billboards), broadcast media (including television, radio, and films), and print advertising.[259] Until only about 20 years ago, these media were the main source of mass information and professional journalists were almost exclusively the ones who served as disseminators of news and information. For this reason several anti-stigma programmes have identified the media as a target group for interventions. During the Time to Change anti-stigma programme in England, for example, coverage of mental health issues by newspapers has substantially improved.[260–262]

Several positive aspects of the impact of social media have been described in relation to mental health. Platforms such as *Twitter*, for example, can provide a supportive environment for the development of reciprocal relationships in which people can disclose mental health conditions.[263] Despite the positive aspects, the largely unregulated nature of these media means that they also present serious challenges, such as credibility and trustworthiness of information[264] and, while not being inherently harmful, might be sources of risk for stigma. For many young people social media are among their most vital tools for community, self-expression, and for challenging stigma. A young person in Chile said "You sometimes lock yourself on the internet because there are people who you can get to know, who can have for example your same interests and there you no longer feel rejected…The people around you, they do not accept you….[the internet] can make you feel better, like you are not alone."[86]

Review of evidence on media impact on mental health stigma and discrimination

Methods

We did a literature review of publications on the media, mental health conditions, and stigma. We searched three databases (PsycInfo, PubMed, and Cochrane Library) for relevant papers published after a major recent systematic review.[265] Our search terms referred to the following three concepts: stigma (eg, attitude, stereotype, discrimination), media (eg, journalism, radio, Instagram), and a broad range of mental health conditions (eg, depression, schizophrenia), including fictional depictions of mental health conditions. Any type of study (qualitative, randomised controlled trial, systematic review, meta-analysis, scoping, or narrative review) was eligible for inclusion. Included studies were those published in English after November, 2017, with a clear stigma measure or outcome (eg attitudes, beliefs, knowledge, mental health literacy, and social inclusion). All countries and age groups were eligible. Details of the full search strategy and search terms are available from the authors upon request. All searches were run on Dec 13–15, 2021. The search yielded 1826 results. After screening the titles and abstracts and removing duplicates, 102 papers were chosen for full-text review, and of these 24 publications were included in the final analysis.

Results

Many studies confirmed that the media can have both positive and negative influences on mental-health-related stigma and discrimination. Compared with earlier systematic reviews, where most of the outcomes were related to news reports by journalists,[265] our review included wider ranges of media types, including social and other online media and stigma-related impacts.

Some of the most powerful ways that the media perpetuate stigma worldwide are by using stigmatising language and by simplistically or inaccurately linking mental health conditions with violence.[266,267] A review of Spanish news coverage reported that a quarter of the analysed news stories included stigmatising contents, often using stereotypes of danger and unpredictability.[268]

> "By using discriminatory, insulting language, by using associations with violence, by using photos that insult persons with lived experience (for example "funny" TV shows where players are required to escape from a straight jacket). By using over-medicalised messages and wrong information in general. By silence. Because silence contributes to lack of knowledge."
>
> *Person in Georgia*

Conversely, positive anti-stigma results emerged when the media content focused on representations of recovery, social contact, service user involvement in creating media content, celebrity disclosure, and using social media to generate conversations about mental health.[269–272] We did identify evidence that the media can also serve as a powerful method of communication to increase awareness of mental health and normalise psychiatric illnesses.[269]

Several studies examined the impact of news reports on members of the public. Negative reports that focused on danger or which irresponsibly reported on suicide led to more stigmatising attitudes[273,274] and a reduction in willingness to disclose one's own mental health difficulties.[199,275] In Germany in 1990, for example, public attitudes worsened following two violent attacks on politicians Oskar Lafontaine and Wolfgang Schäuble by people reported to have schizophrenia.[276] In contrast, positive and recovery-oriented accounts improved public attitudes.[273]

The quantity of mental-health-related content on social media has increased markedly in the past decade, leading

to a mixed picture. For example, terms such as psychosis are often used negatively or as an insult but medical information about the mental health conditions, including sources of help, that is often factually correct is also present and can help to increase public knowledge.[277] Posts about personal experiences of mental health conditions led to more positive attitudes on social media if they had good narrative quality and were endorsed by positive comments.[278]

While we found limited qualitative evidence for the effects of social media on self-stigma,[279] we did find evidence that using social media can help people with severe mental health conditions to overcome social isolation.[280] Exposure of service users to news about the Germanwings aircraft crash, in which the pilot was reported to have had a mental health condition, significantly increased self-stigma.[281] A multimedia self-stigma reduction campaign showed that campaign exposure was associated with positive recovery beliefs, and greater use of mental health care.[282] Given the evidence of the power of the media to affect public attitudes and policy, it is probable that media reporting can also increase or reduce structural discrimination, through their influences on voters and policy makers, but there is a lack of empirical evidence to support this view at present.

Some interventions have specifically targeted the media to reduce stigma. Guidelines encourage media professionals to produce include recovery-oriented content about people with mental health conditions for balance. Most of these guidelines have been developed by civil society or non-governmental organisations at the national level. The evidence for the effectiveness of such general guidelines is mixed.[212] Regarding media and suicide prevention, in 2017, WHO released updated guidelines for media professionals.[283] Several studies have been undertaken to examine adherence to guidelines in traditional and new media.[284,285] With the exception of a small number of countries, including Canada[286] and Australia, they are rarely adhered to.[287] Overall these data suggest that media guidelines on suicide reporting may be important for stigma reduction, but that they are often incompletely implemented.

Social-contact-based interventions for media professionals and service users have clear stigma-reduction effects.[212] In the age of the new media, non-journalist PWLE have been successfully trained to produce media content that focuses more on recovery and less on crime than professionally produced media content.[288] Media awards for positive reporting have also been found to be a promising intervention to increase adherence to media guidelines on reporting suicide.[289]

The media can also be used as channels for interventions to reduce stigma among the general public, and media messaging is most effective when using social-contact methods.[290–294] These approaches directly challenge negative perceptions (deframing),[295,296] and focus on normalising people with mental health conditions and on portraying recovery. Social contact interventions were applied in several studies using video content with service users,[291,292] virtual reality simulation, or social media profiles,[294] and helped to engage and inform the public and to reduce stigma.

Several studies found that fictional accounts of people with mental health conditions in television programmes and in films can have substantial effects on shaping stigma. Stereotypical (negative) portrayals of people with mental health conditions increased stigma,[297,298] whereas positive portrayals improved knowledge and attitudes.[299,300] Most of these studies measured attitudes but mental -health-related knowledge was not well assessed and very few measured changes in behaviour. The long-term effects of media-based anti-stigma interventions remain unknown because the maximum follow-up has been 2 years.[292]

As the social media continue to be integral forms of communication and social connection in many countries worldwide, leveraging the bottom-up, user-driven nature of online peer networks could potentially be important to support mental health recovery and empowerment and to combat stigma.[301] In a study that focused on mental health conditions in adolescents, for example, the authors reported that the relative anonymity afforded by the internet, particularly social media channels, allowed adolescents to search for information and participate in supportive communities.[263]

Suicide and the media

WHO reports that more than 700 000 people die every year due to suicide, and it is the fourth leading cause of death among young people worldwide.[302] In relation to suicide, the media play a major role in influencing stigmatising knowledge (ignorance) and attitudes (prejudice), and can perpetuate stigma through irresponsible portrayals of individuals who have self-harmed or died by suicide or reduce stigma through by disseminating helpful information or mobilising campaigns to improve public opinion and attitudes.[303,304]

The use of stigmatising language can have effects related to suicide. The term committed suicide, for example, might suggest that suicide is a criminal act, even where it has been decriminalised whereas died by suicide is non-judgemental. Reports that narrowly attribute violent suicides to mental health conditions can perpetuate stigma, which can prevent help seeking and delay a psychiatric diagnosis. Perhaps paradoxically,

Poem 6

Mental health is part of being human. Let's act now to stop stigma and to start inclusion.

suicide should not be destigmatised in such a way that it becomes normalised or sensationalised. Poorly considered media reports that portray suicide in this way can result in a contagion effect and have been associated with the Werther effect, in which suicide attempts may mimic other such attempts, such as following high-profile celebrity suicides or popular fictional portrayals of suicide. This effect is more common where suicide is portrayed as a natural or inevitable response to life's challenges in such fictional accounts. Conversely, the Papageno effect occurs when media show how people can positively overcome a suicidal crisis and turn towards recovery.[305] To prevent such copycat suicides, the South Korean Government enacted a suicide prevention law in 2012 and revised their media guidelines for suicide reporting. A study found that these regulatory measures were associated with a substantial reduction in deaths by suicide.[306]

An illustration of such suicide narrative is the fictional television series *Thirteen Reasons Why* (Netflix, Los Gatos, CA, USA), which began in 2017 and was streamed across 32 countries. The series chronicles the lives of a group of US teenagers, including the lead character who has several serious stressors in her life and whose suicide is graphically depicted. Over 100 articles have reported how this portrayal of suicide affected viewers. The series received both praise and critique, as it powerfully reduced stigma, especially among those with no personal experience relating to suicide but also led to contagion of suicidality when media guidelines on suicide reporting and portrayal were not followed.[307–310]

Adherence to suicide reporting guidelines is especially low in LMICs, where suicides are often sensationalised, stigmatised, and even criminalised in their portrayals in the media. One study of reporting in India, for example, found that "sensational reporting on suicides is rampant".[311] A notable exception in India is the national newspaper *The Hindu*, which does follow guidelines. Every report of a suicide is accompanied by helpline contact details for people who need support. *The Hindu* has been recognised by the support hotline Sneha for its excellence in the reporting and prevention of suicides. As the media become ever more complex and influential, robust research and concerted action will be needed to understand how to reduce the damaging effects and maximise reductions in stigma and discrimination. Approaches must multisectoral, guided by evidence, and underpinned by civil society and PWLE voices holding the media to account.

The views and priorities of PWLE

As we wrote in the introduction to this report, our intention is to put the voices of PWLE centre stage. As one part of this approach we have conducted, specifically for this report, a global survey of views and priorities, and report the main findings here.

Lived experience survey methods

We did a cross-sectional online survey in which PWLE were invited to submit their views using quantitative and qualitative assessment methods. No screening process was used, and participants were recruited via a self-selecting snowball sampling method.[312] Potential participants were contacted through local and international mental health organisations who work with PWLE, including the Global Mental Health Peer Network, United for Global Mental Health, Club House International, Fountain House New York, Mind UK, and

	Number (%) of responses
Lived experience of a mental health condition	
Yes	322 (82%)
No	69 (18%)
Activist with experience in research, policy making, or local community organisations or non-governmental organisations	
Yes	132 (34%)
No	259 (66%)
Participated in activities to reduce stigma and discrimination related to mental health conditions	
Yes	202 (52%)
No	188 (48%)
Age (years)	39.37 (14.08, 16–78)
World bank income category	
High-income	99 (25%)
Upper-middle-income	254 (65%)
Lower-middle or low income	38 (10%)
WHO region	
African	18 (5%)
Americas	52 (13%)
European	184 (47%)
Eastern Mediterranean	9 (2%)
Southeast Asia	11 (3%)
Western Pacific	117 (30%)
UN area code	
North Africa	1 (<1%)
Sub-Saharan Africa	18 (5%)
Southern Asia	14 (4%)
Eastern Asia	109 (28%)
Western Europe	20 (5%)
Eastern Europe	106 (27%)
Southern Europe	38 (10%)
Latin America and Caribbean	32 (8%)
Australia and New Zealand	4 (1%)
Northern America	20 (5%)
Northern Europe	12 (3%)
Western Asia	4 (1%)
Southeastern Asia	5 (1%)
Central Asia	7 (2%)

Data are number (%) or mean (SD, range). PWLE=people with lived experience of mental health conditions.

Table 3: **Participant characteristics for global survey of people with lived experience (n=391)**

For more on **Sneha** see https://snehaindia.org/new/

TTC-Global. The leaders of these organisations disseminated the survey link to members of their organisations and via social media channels. The message with the survey link also encouraged recipients to share the link with people they knew with mental health conditions.

Eligible respondents were people who identified as PWLE and were willing to share their experiences of stigma and discrimination due to a diagnosis of a mental health condition. The minimum age was 16 years with no upper limit. Ethics approval for this work was granted by the Health Faculties Research Ethics Subcommittee at King's College London, UK (RESCM-21/22-25892). The opening webpage of the survey provided information about completion and emphasised that participation was anonymous and voluntary. Participants were invited to provide online informed consent via a forced-response question at the start of the survey. Participants could only proceed to the subsequent survey questions if they had consented to take part.

Survey procedure and data collection

The survey was done with the Survey Monkey online platform (Momentive, San Mateo, CA, USA), and consisted of three sets of questions: brief participant characteristics; quantitative questions with Likert-style response options; and qualitative open-ended questions (appendix 3 pp 20–22). In terms of participant characteristics, respondents were asked to indicate their age, country of residence, whether they identified primarily as a PWLE, or as an activist who works or has worked in research or policy making, or has been involved in local community organisations, or both. Participants were also asked whether they had ever participated in activities or projects to reduce stigma and discrimination in mental health.

The eight quantitative questions gathered perspectives and experiences on stigma and discrimination and how they can be reduced. Responses were scored on a five-point Likert scale ranging from strongly disagree to strongly agree. The 19 qualitative questions were open-ended and asked respondents to reflect on their experiences regarding diagnoses, language, and terminology related to mental health, the impact of stigma and discrimination on their lives, experiences with anti-stigma interventions, and their opinion of how traditional and digital media can contribute to making stigma and discrimination worse or better.

The questions used in this survey were specifically developed for this report by the *Lancet* Commissioners, including PWLE. Before launching the survey, the questions were piloted with PWLE to ensure question content, timing, and comprehension were appropriate. To increase the inclusiveness and reach of the survey, it was made available for completion online in Arabic, Chinese, English, French, Russian, and Spanish, reflecting the six official WHO languages. Survey data collection took place in from Dec 13, 2021, to Feb 18, 2022.

Statistical analyses

We required a minimum sample size of 100 participants because the survey collected quantitative and qualitative data. We found no previous similar quantitative surveys from which to estimate statistical power and to guide sample size calculations. For the qualitative data, a sample of 100 or greater would reflect a mid-range sample for online qualitative surveys.[313] With this type of

	Strongly disagree (n [%])	Disagree (n [%])	Neither agree nor disagree (n [%])	Agree (n [%])	Strongly agree (n [%])	Mean (SD)	Agree or strongly agree (%)
PWLE should be treated as well as people with physical health conditions	5 (1%)	7 (2%)	16 (4%)	104 (27%)	259 (66%)	3·55 (0·77)	93%
Stigma and discrimination do negatively affect most people with mental health conditions	7 (2%)	11 (3%)	21 (5%)	132 (33%)	219 (56%)	3·40 (0·86)	90%
The media could play a major role in reducing stigma and discrimination	8 (2%)	9 (2%)	21 (5%)	134 (35%)	215 (56%)	3·39 (0·86)	90%
My government should invest in a long-term national programme to reduce stigma and discrimination	8 (2%)	14 (4%)	45 (12%)	141 (36%)	181 (47%)	3·22 (0·93)	83%
Stigma and discrimination can be worse than the impact of the mental health condition itself	8 (2%)	29 (8%)	41 (11%)	142 (37%)	169 (43%)	3·12 (1·01)	80%
The media is a major factor in making stigma and discrimination worse	7 (2%)	41 (11%)	66 (17%)	136 (35%)	140 (36%)	2·93 (1·05)	71%
PWLE must lead anti-stigma efforts	18 (5%)	76 (20%)	112 (29%)	128 (33%)	56 (14%)	2·33 (1·09)	47%
Overall stigma and discrimination in my country have been reducing over the last decade	29 (8%)	66 (17%)	114 (29%)	134 (34%)	46 (12%)	2·26 (1·10)	46%

PWLE=people with lived experience of mental health conditions.

Table 4: **Ranked responses for lived experience survey quantitative items (n=391)**

Panel 4: Guiding principles of the *Lancet* Commission on ending stigma and discrimination in mental health

- All relevant human rights instruments apply equally to people who do and who do not have experience of mental health conditions (appendix pp 16–18)
- Provisions that support the social inclusion of people with disabilities should apply equally to people who have disabilities related to physical health conditions and those who have disabilities related to mental health conditions
- Health and care services should be provided in relation to need, regardless of health condition, and should be provided equitably to people with physical health conditions and mental health conditions
- Specific laws that unfairly discriminate against people on the basis of a mental health condition or suicide status should be struck off in all countries
- Initiatives and actions intended to reduce or eradicate mental health stigma and discrimination should be co-designed and co-produced with PWLE to align with the principle of nothing about us without us and because the evidence base clearly shows that the most effective methods are based on social contact, especially positive social contact, with people with mental health conditions.[316] Such initiatives need to consistently use language that is respectful, in the eyes of people with lived experience

PWLE=people with lived experience of mental health conditions.

Panel 5: Goals of the *Lancet* Commission on ending stigma and discrimination in mental health

- International non-governmental organisations should issue guidance that all forms of stigma and discrimination towards people with mental health conditions are unacceptable
- Governments of all nations should implement policies to support the end of stigma and discrimination against people with mental health conditions
- Ensure that stigma and discrimination against people with mental health conditions in the workplace is eradicated
- National training curricula for all health-care and social-care professional and vocational training courses should include mandatory training sessions on the needs and rights of people with mental health conditions, co-delivered by people with such conditions
- All media organisations should systematically remove stigmatising content from their products
- People with lived experience of mental health conditions are strongly supported to reduce stigma and discrimination

PWLE=people with lived experience of mental health conditions.

data collection method, sample sizes are usually much larger than those studies that use individual interviews. Larger sample sizes ensure the survey dataset provides richness and depth of data when viewed in its entirety.

For the quantitative data analyses, frequencies and percentages were used to summarise categorical participant characteristics and quantitative responses. Means with SDs were used to summarise participant age and were calculated for the quantitative questions. Values are displayed for the total sample and by World Bank Income Group (high, upper-middle, lower-middle, or low income) and WHO region (African region; region for the Americas; European region; Eastern Mediterranean region; southeast Asian region; and Western Pacific region). Country-level data were also grouped into regions according to the UN standard country or area codes for statistical use.

Four researchers (HL, NVSJ, AM, and PCG) did the qualitative data analysis. Participants' responses to each question were synthesised through a combination of digital text network analysis using InfraNodus (version Pro 2022) and thematic content analysis.[314] First, responses to each question were translated to English using Google Scholar, and selected quotes were cross-checked by native speakers of each language. The text was uploaded to InfraNodus and algorithms were sued to generate semantic networks to identify the most influential words and keyword clusters. Participants' answers conforming to these clusters were explored by researchers for a more detailed content review and data synthesis. Essential participant quotes were included in the summaries to substantiate the results.

Survey results

391 participants responded to the survey from 45 countries and territories: Argentina, Australia, Bangladesh, Belgium, Botswana, Cameroon, Canada, China (including Hong Kong and Macau), Colombia, Denmark, Egypt, France, Georgia, Germany, Ghana, India, Indonesia, Ireland, Kazakhstan, Kenya, Kyrgyzstan, Malaysia, Mali, Mexico, Nepal, New Zealand, Nigeria, Norway, Pakistan, Peru, South Korea, Russia, Serbia, Singapore, South Africa, Spain, State of Palestine, Switzerland, Trinidad and Tobago, United Arab Emirates, United Kingdom, United States, Uruguay, Uzbekistan and Zimbabwe.

254 (65%) respondents come from upper-middle -income countries and territories. Among all participants, 132 (34%) had experience as activists in research and policy making, had been involved in local community organisations, or both (table 3). 202 (52%) had participated in activities, meetings, or projects to reduce stigma and discrimination related to mental health conditions. The invitations to participate were extended only to PWLE, yet 69 (18%) did not disclose that they that they had a mental health condition experience, although respondents could reply that they were mental health activists without such experience.

For the quantitative results, the most commonly

For more on the **UN's standard country or area codes for statistical use** see https://unstats.un.org/unsd/methods/m49/m49regin.htm

For more on **InfraNodus** see https://infranodus.com/

	Target	Indicators
International organisations		
Goal: international non-governmental organisations should issue guidance that all forms of stigma and discrimination towards people with mental health conditions are unacceptable		
Recommendation 1: UN agencies, led by WHO, work with heads of state and health ministers should implement the reform of mental health policies, plans and laws in line with international and regional human rights instruments, as set out in the WHO Comprehensive Mental Health Action Plan,[317] explicitly committing to reduce stigma and discrimination	WHO Action Plan Global Target 1.1: 80% of countries should have developed or updated their policy or plan for mental health in line with international and regional human rights instruments by 2030; WHO Action Plan Global Target 1.2: 80% of countries should have developed or updated their law for mental health in line with international and regional human rights instruments by 2030	WHO Action Plan Indicator 1.1: existence of a national policy or plan for mental health that is being implemented and is in line with international human rights instruments; WHO Action Plan Indicator 1.2: existence of a national law covering mental health that is being implemented and is in line with international human rights instruments (source: WHO Mental Health Atlas)
Recommendation 2: WHO and its international partners should develop, issue, and encourage use of an evidence-based practical toolkit for adaptation and implementation in all countries to reduce stigma and discrimination	WHO and partners should publish the toolkit by the end of 2023 to support countries to reduce stigma and discrimination, and at least 75 countries report its use by 2030	As reported to the World Health Assembly, WHO should add new indicators to the WHO Mental Health Atlas on implementation of the Stigma Toolkit; other international partners to track progress through their reporting mechanisms (source: WHO)
Governments		
Goal: governments of all nations should implement policies to support the end of stigma and discrimination against people with mental health conditions		
Recommendation 3: all UN member states should be called to take action under objective 3 of the WHO Comprehensive Mental Health Action Plan: "Amend or repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders and psychosocial disabilities, including the decriminalisation of suicide, and so to contribute to the suicide reduction indicator of UN Sustainable Development Goals"[317]	WHO Action Plan Global Target: all countries should decriminalise suicide and suicidal behaviour by 2030	Number of countries where suicide and suicidal behaviour remain a crime (source: International Association for Suicide Prevention)
Employers		
Goal: employers should ensure that stigma and discrimination against people with mental health conditions in the workplace are eradicated		
Recommendation 4: UN member states, agencies, and employer organisations should implement the guidelines issued by WHO on Mental Health and Work and apply them to all government agencies	UN member states should be called to take evidence-based action to fully implement by 2030 objective 3 of the WHO Comprehensive Mental Health Action Plan: "Address discrimination in educational institutions and the workplace and promote full access to educational opportunities, work participation and return-to-work programmes for people with mental disorders and psychosocial disabilities"	WHO should develop indicators and a monitoring system for the implementation of guidelines on Mental Health and Work issued in 2022; International Labour Organisation indicators (Article 19 or Article 22; source: WHO Comprehensive Mental Health Action Plan)
Health-care and social-care sectors		
Goal: national training curricula for all health-care and social-care professional and vocational training courses should include mandatory sessions on the needs and rights of people with mental health conditions, co-delivered by PWLE		
Recommendation 5: all prequalifying courses for health-care and social-care staff should include evidence-based sessions on stigma reduction among providers and help providers to respond to stigma and discrimination experiences among patient, clients, and other beneficiaries	By 2030, the majority of prequalifying courses for medical and nursing training courses should include such training	The World Psychiatric Association and the International Council of Nurses should be invited to monitor the provision of such training periodically and to report their findings
Media		
Goal: all media organisations should systematically remove stigmatising content from their products		
Recommendation 6: all national and international media organisations (traditional and new media) should be called upon to issue policy statements and action plans (based on the findings of this *Lancet* Commission) on how they promote mental health and contribute to reduction of stigma and discrimination in mental health	By 2030, all national and international media organisations should have issued policy statements and action plans on how they promote mental health and contribute to the reduction of stigma and discrimination in mental health	A major media group should be identified to create an inventory of relevant media organisations and from 2023 should run annual online surveys to assess which have issued such policy statements and action plans, and should publicise their findings
PWLE, local communities, and civil society		
Goal: PWLE should be strongly supported to reduce stigma and discrimination		
Recommendation 7: all current and future national government programmes for the reduction of mental health related stigma and discrimination should be led or co-led by PWLE, using the evidence-based principle of social contact	By 2030, all national government programmes for the reduction of mental health related stigma and discrimination should be led or co-led by PWLE	WHO should add an additional question to the WHO Mental Health Atlas: are all national anti-stigma programmes led or co-led by PWLE? (Source: WHO Mental Health Atlas)
Recommendation 8: funded programmes to support people with lived experience should be provided in the following three categories: mutual help or peer support networks; integration of PWLE as providers of health and social services provision (eg, peer support workers); and service users receive support with disclosure decisions	By 2030, most programmes to support PWLE should report that all three types of support are being provided	From 2023, the Global Mental Health Peer Network should conduct annual online surveys of programmes to support people with lived experience and assesses whether the programmes provide support in the three given categories

PWLE=people with lived experience of mental health conditions.

***Table 5: Lancet* Commission goals, recommendations, targets, and indicators**

***Panel 6*: Further recommendations proposed by the *Lancet* Commission**

International organisations

- A long-term international mechanism should be agreed and established to share freely evidence-based materials and experience-based learning on delivering programmes to reduce stigma and discrimination (building on the work of the Global Anti Stigma Alliance, particularly emphasising the needs of LMICs) and to develop and use outcomes directly relevant for PWLE

Governments

- A national-level body (eg, a National Mental Health and Social Inclusion Council) should be established in UN member states to oversee measures to reduce stigma and discrimination, promote social inclusion of people with mental health conditions, and to report on impact directly to the country's minister for health
- UN member states should be urged to implement in full the stigma and social-inclusion-related recommendations of the WHO Guidelines on Work and Mental Health• UN member states should be called to take action on objective 3 of the WHO the Comprehensive Mental Health Action Plan: "Develop universal and indicated (targeted) school-based promotion and prevention, including... programmes to counter stigmatization and discrimination of persons with mental disorders and psychosocial disabilities"

Education sector

- National training curricula for all teaching and education system professions should include training sessions to reduce mental health-related stigma and discrimination
- School and college curricula should include sessions for students on evidence-based interventions to improve understanding of mental health conditions and to reduce stigma and discrimination

Health-care and social-care sectors

- Evaluation of stigma and discrimination of health-care and social-care providers should assess not only knowledge and attitudes, but also focus on providers' behaviours and impacts on caregiving burden and quality of care
- Experiences of stigma and discrimination should be systematically documented in health-care and social-care settings, and responded to with mitigation measures

LMIC=low-income and middle-income countries. PWLE=people with lived experience of mental health conditions.

endorsed stigma item was PWLE should be treated as well as people with physical health conditions with 363 (93%) agreeing or strongly agreeing (table 4). Most of the participants also agreed or strongly agreed that stigma and discrimination negatively affect most people with mental health conditions and that the media could play a major role in reducing stigma and discrimination (both 90%). The items with the lowest endorsement included overall stigma and discrimination in my country have been reducing over the last decade and PWLE must lead anti-stigma efforts (table 4). The qualitative survey results are summarised in appendix 3 (pp 26–40) and many quotations are shown throughout this report.

Conclusions: Commission guiding principles, goals, recommendations, and call to action

The time to act to eradicate mental-health-related stigma and discrimination is now. Such forms of social exclusion are quite simply no longer acceptable. WHO's Comprehensive Action Plan 2013–30 clearly states, "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 care 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."[315]

> "There needs to always be an emphasis on choice and on agency - rather than things being done to someone regarding their mental health."
>
> *Person in the UK*

Guiding principles for the *Lancet* Commission recommendations

In formulating the recommendations from this *Lancet* Commission, we were guided by five key principles (panel 4).

> "The language matters, but more important are the actions."
>
> *Person in Spain*

Lancet Commission goals and recommendations

The detailed evidence synthesis in this report highlights the overwhelming and negative impacts of stigma and discrimination. A survey of *Lancet* Commissioners and Advisory Board members has identified six key goals for action (panel 5). Inspired by the UN Sustainable Development Goals,[2] we have gone on to agree eight actionable recommendations, each with specific targets and indicators (table 5). We have also identified eight further recommendations (panel 6).

Call to action

Based upon all the information presented in this *Lancet* Commission report our single, simple key message is the following: mental health is part of being human, let us act now to stop stigma and to start inclusion.

Contributors

All authors contributed to the writing, recommendations, and conclusions of this report. All authors had full access to the data in the

For more on **WHO's Mental Health Atlas** see https://www.who.int/publications/i/item/9789240036703

For more on **WHO's work** see https://www.who.int/

For more on **the International Association for Suicide Prevention** see https://www.iasp.info/

study and accept responsibility to submit for publication.
The Commission report was co-ordinated by the Commission Co-Chairs (GT and CS) and also supported by the members of the Commission Steering Committee and Secretariat (KD, EH, PCG, EL, PKM, MM, NR, CS, TTS, GT, NV, and PW). Appendix 2 show all members of the Commissioners group (p 2), Commission Advisory Board (p 3), Commission Communications and Launch Group (p 8), and other collaborators whom we are pleased to acknowledge (p 9).

Declaration of interest
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References

1 Rüsch N. The stigma of mental illness: strategies against social exclusion and discrimination. London: Elsevier, 2022.
2 WHO. World mental health report: transforming mental health for all. Geneva: World Health Organization, 2022.
3 UN. The 2030 agenda for global action and the Sustainable Development Goals. New York, NY: United Nations, 2015.
4 UN. Convention on the rights of persons with disabilities. New York, NY: United Nations, 2006.
5 Arboleda-Flórez J, Stuart H. From sin to science: fighting the stigmatization of mental illnesses. *Can J Psychiatry* 2012; **57:** 457–63.
6 Goffman E. Stigma: notes on the management of spoiled identity. Harmondsworth: Penguin Books, 1963.
7 Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol* 2001; **27:** 363–85.
8 Bargh JA, Chen M, Burrows L. Automaticity of social behavior: direct effects of trait construct and stereotype-activation on action. *J Pers Soc Psychol* 1996; **71:** 230–44.
9 Thornicroft G, Rose D, Kassam A, Sartorius N. Stigma: ignorance, prejudice or discrimination? *Br J Psychiatry* 2007; **190:** 192–93.
10 Crenshaw K. Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *Univ Chic Leg Forum* 1989; **1:** 139–67.
11 Henderson C, Noblett J, Parke H, et al. Mental health-related stigma in health care and mental health-care settings. *Lancet Psychiatry* 2014; **1:** 467–82.
12 Thornicroft G. Shunned: discrimination against people with mental illness. Oxford: Oxford University Press, 2006.
13 Koschorke M, Evans-Lacko S, Sartorius N, Thornicroft G. Stigma in Different Cultures. In: Gaebel W, Rossler W, Sartorius N, eds. The stigma of mental illness: end of the story. Heidelberg: Springer, 2017.
14 Yang LH, Thornicroft G, Alvarado R, Vega E, Link BG. Recent advances in cross-cultural measurement in psychiatric epidemiology: utilizing 'what matters most' to identify culture-specific aspects of stigma. *Int J Epidemiol* 2014; **43:** 494–510.
15 Mak WW, Cheung RY. Affiliate stigma among caregivers of people with intellectual disability or mental illness. *J Appl Res Intellect Disabil* 2008; **21:** 532–45.
16 Sheehan L, Nieweglowski K, Corrigan PW. Structures and types of stigma. The stigma of mental illness—end of the story? Cham, Switzerland: Springer International Publishing, 2017: 43–82.
17 Sheehan L, Fominaya AW, Bink AB, Kraus DJ, Schmidt A, Corrigan PW. Stigma by any other name. *Psychiatr Serv* 2016; **67:** 1373–75.
18 Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. *Clin Psychol Sci Pract* 2002; **9:** 35–53.
19 Corrigan PW, Larson JE, Rüsch N. Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. *World Psychiatry* 2009; **8:** 75–81.
20 Corrigan PW, Watson AC, Miller FE. Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *J Fam Psychol* 2006; **20:** 239–46.
21 Mak WW, Cheung RY. Psychological distress and subjective burden of caregivers of people with mental illness: the role of affiliate stigma and face concern. *Community Ment Health J* 2012; **48:** 270–74.
22 Shi Y, Shao Y, Li H, et al. Correlates of affiliate stigma among family caregivers of people with mental illness: a systematic review and meta-analysis. *J Psychiatr Ment Health Nurs* 2019; **26:** 49–61.
23 Corrigan PW. Mental health stigma as social attribution: implications for research methods and attitude change. *Clin Psychol Sci Pract* 2000; **7:** 48–67.
24 Link BG, Phelan J. Stigma power. *Soc Sci Med* 2014; **103:** 24–32.
25 Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *Lancet* 2009; **373:** 408–15.
26 Brohan E, Clement S, Rose D, Sartorius N, Slade M, Thornicroft G. Development and psychometric evaluation of the Discrimination and Stigma Scale (DISC). *Psychiatry Res* 2013; **208:** 33–40.
27 Brohan E, Slade M, Clement S, Thornicroft G. Experiences of mental illness stigma, prejudice and discrimination: a review of measures. *BMC Health Serv Res* 2010; **10:** 80.
28 Angermeyer MC, Matschinger H, Link BG, Schomerus G. Public attitudes regarding individual and structural discrimination: two sides of the same coin? *Soc Sci Med* 2014; **103:** 60–66.
29 Barber S, Gronholm PC, Ahuja S, Rüsch N, Thornicroft G. Microaggressions towards people affected by mental health problems: a scoping review. *Epidemiol Psychiatr Sci* 2019; **29:** e82.
30 Pescosolido BA, Martin JK, Long JS, Medina TR, Phelan JC, Link BG. "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *Am J Psychiatry* 2010; **167:** 1321–30.
31 Phelan JC. Genetic bases of mental illness—a cure for stigma? *Trends Neurosci* 2002; **25:** 430–31.
32 Lebowitz MS, Appelbaum PS. Biomedical explanations of psychopathology and their implications for attitudes and beliefs about mental disorders. *Annu Rev Clin Psychol* 2019; **15:** 555–77.
33 Link BG, Stuart H. On revisiting some origins of the stigma concept as it applies to mental illnesses. The stigma of mental illness—end of the story? Cham, Switzerland: Springer International Publishing, 2017: 3–28.
34 Patel V, Saxena S, Lund C, et al. The *Lancet* Commission on global mental health and sustainable development. *Lancet* 2018; **392:** 1553–98.
35 Pescosolido BA, Medina TR, Martin JK, Long JS. The "backbone" of stigma: identifying the global core of public prejudice associated with mental illness. *Am J Public Health* 2013; **103:** 853–60.
36 Hatzenbuehler ML, Link BG. Introduction to the special issue on structural stigma and health. *Soc Sci Med* 2014; **103:** 1–6.
37 WHO. WHO QualityRights Tool Kit. Geneva: World Health Organization, 2012.
38 Hazo JB, Gervaix J, Gandré C, Brunn M, Leboyer M, Chevreul K. European Union investment and countries' involvement in mental health research between 2007 and 2013. *Acta Psychiatr Scand* 2016; **134:** 138–49.
39 Chisholm D, Docrat S, Abdulmalik J, et al. Mental health financing challenges, opportunities and strategies in low- and middle-income countries: findings from the Emerald project. *BJPsych Open* 2019; **5:** e68.

40 Alonso J, Liu Z, Evans-Lacko S, et al. Treatment gap for anxiety disorders is global: results of the World Mental Health Surveys in 21 countries. *Depress Anxiety* 2018; **35:** 195–208.

41 Thornicroft G, Chatterji S, Evans-Lacko S, et al. Undertreatment of people with major depressive disorder in 21 countries. *Br J Psychiatry* 2017; **210:** 119–24.

42 Moitra M, Santomauro D, Collins PY, et al. The global gap in treatment coverage for major depressive disorder in 84 countries from 2000–2019: a systematic review and Bayesian meta-regression analysis. *PLoS Med* 2022; **19:** e1003901.

43 Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. *Br J Psychiatry* 2011; **199:** 441–42.

44 Walker ER, McGee RE, Druss BG. Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. *JAMA Psychiatry* 2015; **72:** 334–41.

45 Lund C, Cois A. Simultaneous social causation and social drift: longitudinal analysis of depression and poverty in South Africa. *J Affect Disord* 2018; **229:** 396–402.

46 Yang LH, Chen FP, Sia KJ, et al. "What matters most:" a cultural mechanism moderating structural vulnerability and moral experience of mental illness stigma. *Soc Sci Med* 2014; **103:** 84–93.

47 Gurung D, Poudyal A, Wang YL, et al. Stigma against mental health disorders in Nepal conceptualised with a 'what matters most' framework: a scoping review. *Epidemiol Psychiatr Sci* 2022; **31:** e11.

48 Oexle N, Corrigan PW. Understanding mental illness stigma toward persons with multiple stigmatized conditions: implications of intersectionality theory. *Psychiatr Serv* 2018; **69:** 587–89.

49 Gabbidon J, Farrelly S, Hatch SL, et al. Discrimination attributed to mental illness or race-ethnicity by users of community psychiatric services. *Psychiatr Serv* 2014; **65:** 1360–66.

50 Mak WW, Poon CY, Pun LY, Cheung SF. Meta-analysis of stigma and mental health. *Soc Sci Med* 2007; **65:** 245–61.

51 Yu BCL, Chio FHN, Mak WWS, Corrigan PW, Chan KKY. Internalization process of stigma of people with mental illness across cultures: a meta-analytic structural equation modeling approach. *Clin Psychol Rev* 2021; **87:** 102029.

52 Eliasson ET, McNamee L, Swanson L, Lawrie SM, Schwannauer M. Unpacking stigma: meta-analyses of correlates and moderators of personal stigma in psychosis. *Clin Psychol Rev* 2021; **89:** 102077.

53 Dubreucq J, Plasse J, Franck N. Self-stigma in serious mental illness: a systematic review of frequency, correlates, and consequences. *Schizophr Bull* 2021; **47:** 1261–87.

54 Rüsch N, Müller M, Lay B, et al. Emotional reactions to involuntary psychiatric hospitalization and stigma-related stress among people with mental illness. *Eur Arch Psychiatry Clin Neurosci* 2014; **264:** 35–43.

55 Xu Z, Müller M, Lay B, et al. Involuntary hospitalization, stigma stress and suicidality: a longitudinal study. *Soc Psychiatry Psychiatr Epidemiol* 2018; **53:** 309–12.

56 Rüsch N, Heekeren K, Theodoridou A, et al. Stigma as a stressor and transition to schizophrenia after one year among young people at risk of psychosis. *Schizophr Res* 2015; **166:** 43–48.

57 Clement S, Schauman O, Graham T, et al. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychol Med* 2015; **45:** 11–27.

58 Hammarlund R, Crapanzano KA, Luce L, Mulligan L, Ward KM. Review of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug- and alcohol-use disorders. *Subst Abuse Rehabil* 2018; **9:** 115–36.

59 Hamilton S, Pinfold V, Cotney J, et al. Qualitative analysis of mental health service users' reported experiences of discrimination. *Acta Psychiatr Scand* 2016; **134** (suppl 446): 14–22.

60 Bhugra D, Pathare S, Nardodkar R, et al. Legislative provisions related to marriage and divorce of persons with mental health problems: a global review. *Int Rev Psychiatry* 2016; **28:** 386–92.

61 Bhugra D, Pathare S, Joshi R, et al. Right to property, inheritance, and contract and persons with mental illness. *Int Rev Psychiatry* 2016; **28:** 402–08.

62 Bhugra D, Pathare S, Gosavi C, et al. Mental illness and the right to vote: a review of legislation across the world. *Int Rev Psychiatry* 2016; **28:** 395–99.

63 Szmukler G. Involuntary detention and treatment: are we edging toward a "paradigm shift"? *Schizophr Bull* 2020; **46:** 231–35.

64 Callard F, Sartorius N, Arboleda-Florez J, et al. Mental illness, discrimination and the law: fighting for social justice. London: Wiley Blackwell, 2012.

65 Pyle M, Morrison AP. "It's just a very taboo and secretive kind of thing": making sense of living with stigma and discrimination from accounts of people with psychosis. *Psychosis* 2014; **6:** 195–205.

66 Burke E, Wood L, Zabel E, Clark A, Morrison AP. Experiences of stigma in psychosis: a qualitative analysis of service users' perspectives. *Psychosis* 2016; **8:** 130–42.

67 Mak WW, Chan RC, Wong SY, et al. A cross-diagnostic investigation of the differential impact of discrimination on clinical and personal recovery. *Psychiatr Serv* 2017; **68:** 159–66.

68 Pellet J, Golay P, Nguyen A, et al. The relationship between self-stigma and depression among people with schizophrenia-spectrum disorders: a longitudinal study. *Psychiatry Res* 2019; **275:** 115–19.

69 Fox AB, Smith BN, Vogt D. How and when does mental illness stigma impact treatment seeking? Longitudinal examination of relationships between anticipated and internalized stigma, symptom severity, and mental health service use. *Psychiatry Res* 2018; **268:** 15–20.

70 DeLuca JS, Clement TW, Yanos PT. Does individual stigma predict mental health funding attitudes? Toward an understanding of resource allocation and social Climate. *Isr J Psychiatry Relat Sci* 2017; **54:** 6–16.

71 Bishop TF, Press MJ, Keyhani S, Pincus HA. Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry* 2014; **71:** 176–81.

72 Ghosh M. Mental health insurance in India: lack of parity. *Lancet Psychiatry* 2021; **8:** 860.

73 Appelbaum PS, Parks J. Holding insurers accountable for parity in coverage of mental health treatment. *Psychiatr Serv* 2020; **71:** 202–04.

74 Knaak S, Mantler E, Szeto A. Mental illness-related stigma in healthcare: barriers to access and care and evidence-based solutions. *Healthc Manage Forum* 2017; **30:** 111–16.

75 Jones S, Howard L, Thornicroft G. 'Diagnostic overshadowing': worse physical health care for people with mental illness. *Acta Psychiatr Scand* 2008; **118:** 169–71.

76 Henderson C, Noblett J, Parke H, et al. Mental health-related stigma in health care and mental health-care settings. *Lancet Psychiatry* 2014; **1:** 467–82.

77 Gissler M, Laursen TM, Ösby U, Nordentoft M, Wahlbeck K. Patterns in mortality among people with severe mental disorders across birth cohorts: a register-based study of Denmark and Finland in 1982–2006. *BMC Public Health* 2013; **13:** 834.

78 Tiihonen J, Lönnqvist J, Wahlbeck K, et al. 11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study). *Lancet* 2009; **374:** 620–27.

79 Lasalvia A, Zoppei S, Van Bortel T, et al. Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *Lancet* 2013; **381:** 55–62.

80 Moses T. Stigma and family. In: Corrigan PW, ed. The stigma of disease and disability: uderstanding causes and overcoming injustices. Washington DC: American Psychological Association, 2014: 247–68.

81 Elkington KS, Hackler D, Walsh TA, et al. Perceived mental illness stigma, intimate relationships and sexual risk behavior in youth with mental illness. *J Adolesc Res* 2013; **28:** 378–404.

82 Lasalvia A, Van Bortel T, Bonetto C, et al. Cross-national variations in reported discrimination among people treated for major depression worldwide: the ASPEN/INDIGO international study. *Br J Psychiatry* 2015; **207:** 507–14.

83 Loganathan S, Murthy RS. Living with schizophrenia in India: gender perspectives. *Transcult Psychiatry* 2011; **48:** 569–84.

84 Ferrie J, Miller H, Hunter SC. Psychosocial outcomes of mental illness stigma in children and adolescents: a mixed-methods systematic review. *Child Youth Serv Rev* 2020; **113:** 104961.

85 Salazar de Pablo G, De Micheli A, Nieman DH, et al. Universal and selective interventions to promote good mental health in young people: systematic review and meta-analysis. *Eur Neuropsychopharmacol* 2020; **41:** 28–39.

86 UNICEF. United Nations Children's Fund. The state of the world's children 2021: on my mind—promoting, protecting and caring for children's mental health. New York, NY: UNICEF, 2021.

87 Moses T. Being treated differently: stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Soc Sci Med* 2010; **70:** 985–93.

88 Gronholm PC, Thornicroft G, Laurens KR, Evans-Lacko S. Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: a systematic review. *Psychol Med* 2017; **47:** 1867–79.

89 van Beukering IE, Smits SJC, Janssens KME, et al. In what ways does health related stigma affect sustainable employment and well-being at work? A systematic review. *J Occup Rehabil* 2021.

90 Trani JF, Bakhshi P, Kuhlberg J, et al. Mental illness, poverty and stigma in India: a case-control study. *BMJ Open* 2015; **5:** e006355.

91 Lund C, De Silva M, Plagerson S, et al. Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *Lancet* 2011; **378:** 1502–14.

92 Valic M, Knifton L, Svab V. A review of the literature and media reports of patterns of mental health stigma and addressing stigma in Slovenia until 2010. *Zdr Varst* 2013; **52:** 47–58.

93 Zhang TM, Wong IY, Yu YH, et al. An integrative model of internalized stigma and recovery-related outcomes among people diagnosed with schizophrenia in rural China. *Soc Psychiatry Psychiatr Epidemiol* 2019; **54:** 911–18.

94 Yamaguchi S, Mizuno M, Ojio Y, et al. Associations between renaming schizophrenia and stigma-related outcomes: a systematic review. *Psychiatry Clin Neurosci* 2017; **71:** 347–62.

95 Corrigan PW. The stigma effect: unintended consequences of mental health campaigns. New York, NY: Columbia University Press, 2018.

96 Bhugra D, Pathare S, Joshi R, Kalra G, Torales J, Ventriglio A. A review of mental health policies from Commonwealth countries. *Int J Soc Psychiatry* 2018; **64:** 3–8.

97 Ricci C, Lee M-B, Chiu C-H. A review of the legislative mechanisms available to protect the social participation rights of people with depression in the Asia Pacific region. *Australas Psychiatry* 2004; **12** (suppl 12): S16–27.

98 Zhang Z, Sun K, Jatchavala C, et al. Overview of stigma against psychiatric illnesses and advancements of anti-stigma activities in six Asian societies. *Int J Environ Res Public Health* 2019; **17:** E280.

99 Joshi C, Skeer MR, Chui K, Neupane G, Koirala R, Stopka TJ. Women-centered drug treatment models for pregnant women with opioid use disorder: a scoping review. *Drug Alcohol Depend* 2021; **226:** 108855.

100 Røsvik J, Michelet M, Engedal K, et al. Interventions to enhance access to and utilization of formal community care services for home dwelling persons with dementia and their informal carers. A scoping review. *Aging Ment Health* 2020; **24:** 200–11.

101 Arundell L-L, Greenwood H, Baldwin H, et al. Advancing mental health equality: a mapping review of interventions, economic evaluations and barriers and facilitators. *Syst Rev* 2020; **9:** 115.

102 Choi KR, Easterlin MC. Intervention models for increasing access to behavioral health services among youth: a systematic review. *J Dev Behav Pediatr* 2018; **39:** 754–62.

103 Werlen L, Gjukaj D, Mohler-Kuo M, Puhan MA. Interventions to improve children's access to mental health care: a systematic review and meta-analysis. *Epidemiol Psychiatr Sci* 2020; **29:** 29.

104 Greene JA, Bina R, Gum AM. Interventions to increase retention in mental health services: a systematic review. *Psychiatr Serv* 2016; **67:** 485–95.

105 Xu Z, Huang F, Kösters M, et al. Effectiveness of interventions to promote help-seeking for mental health problems: systematic review and meta-analysis. *Psychol Med* 2018; **48:** 2658–67.

106 Gayed A, Milligan-Saville JS, Nicholas J, et al. Effectiveness of training workplace managers to understand and support the mental health needs of employees: a systematic review and meta-analysis. *Occup Environ Med* 2018; **75:** 462–70.

107 Szeto ACH, Dobson KS. Reducing the stigma of mental disorders at work: a review of current workplace anti-stigma intervention programs. *Appl Prev Psychol* 2010; **14:** 41–56.

108 Hanisch SE, Twomey CD, Szeto AC, Birner UW, Nowak D, Sabariego C. The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *BMC Psychiatry* 2016; **16:** 1.

109 Nogues S, Finucan J. Economic evaluations of workplace mental health interventions: a critical review. *Can J Adm Sci* 2018; **35:** 551–62.

110 Nevala N, Pehkonen I, Teittinen A, Vesala HT, Pörtfors P, Anttila H. The effectiveness of rehabilitation interventions on the employment and functioning of people with intellectual disabilities: a systematic review. *J Occup Rehabil* 2019; **29:** 773–802.

111 Khalifa G, Sharif Z, Sultan M, Di Rezze B. Workplace accommodations for adults with autism spectrum disorder: a scoping review. *Disabil Rehabil* 2020; **42:** 1316–31.

112 Kinoshita Y, Furukawa TA, Kinoshita K, et al. Supported employment for adults with severe mental illness. *Cochrane Database Syst Rev* 2013; **2013:** CD008297.

113 Probyn K, Engedahl MS, Rajendran D, et al. The effects of supported employment interventions in populations of people with conditions other than severe mental health: a systematic review. *Prim Health Care Res Dev* 2021; **22:** e79.

114 Schachter HM, Girardi A, Ly M, et al. Effects of school-based interventions on mental health stigmatization: a systematic review. *Child Adolesc Psychiatry Ment Health* 2008; **2:** 18.

115 Mellor C. School-based interventions targeting stigma of mental illness: systematic review. *Psychiatr Bull (2014)* 2014; **38:** 164–71.

116 Waqas A, Malik S, Fida A, et al. Interventions to reduce stigma related to mental illnesses in educational institutes: a systematic review. *Psychiatric Quarterly* 2020; **91:** 887–903.

117 Gaiha SM, Salisbury TT, Usmani S, Koschorke M, Raman U, Petticrew M. Effectiveness of arts interventions to reduce mental-health-related stigma among youth: a systematic review and meta-analysis. *BMC Psychiatry* 2021; **21:** 364.

118 Morris S, O'Reilly G, Nayyar J. Classroom-based peer interventions targeting autism ignorance, prejudice and/or discrimination: a systematic PRISMA review. *Int J Incl Educ* 2021; 1–45.

119 Sentenac M, Arnaud C, Gavin A, Molcho M, Gabhainn SN, Godeau E. Peer victimization among school-aged children with chronic conditions. *Epidemiol Rev* 2012; **34:** 120–28.

120 McManus JL, Saucier DA, Reid JE. A meta-analytic review of interventions to improve children's attitudes toward their peers with intellectual disabilities. *Contemp Educ Psychol* 2021; **65:** 65.

121 Louw JS, Kirkpatrick B, Leader G. Enhancing social inclusion of young adults with intellectual disabilities: a systematic review of original empirical studies. *J Appl Res Intellect Disabil* 2020; **33:** 793–807.

122 Birnschein AM, Paisley CA, Tomeny TS. Enhancing social interactions for youth with autism spectrum disorder through training programs for typically developing peers: a systematic review. *Res Autism Spectr Disord* 2021; **84:** 84.

123 Cremin K, Healy O, Spirtos M, Quinn S. Autism awareness interventions for children and adolescents: a scoping review. *J Dev Phys Disabil* 2020; **33:** 27–50

124 Breet E, Matooane M, Tomlinson M, Bantjes J. Systematic review and narrative synthesis of suicide prevention in high-schools and universities: a research agenda for evidence-based practice. *BMC Public Health* 2021; **21:** 1116.

125 Shannonhouse L, Lin YD, Shaw K, Wanna R, Porter M. Suicide intervention training for college staff: program evaluation and intervention skill measurement. *J Am Coll Health* **65:** 450–56.

126 Torok M, Calear AL, Smart A, Nicolopoulos A, Wong Q. Preventing adolescent suicide: a systematic review of the effectiveness and change mechanisms of suicide prevention gatekeeping training programs for teachers and parents. *J Adolesc* 2019; **73:** 100–12.

127 Liang M, Chen Q, Guo J, et al. Mental health first aid improves mental health literacy among college students: a meta-analysis. *J Am Coll Health* 2021; published online July 9. https://doi.org/10.1080/07448481.2021.1925286.

128 Ng SH, Tan NJH, Luo Y, Goh WS, Ho R, Ho CSH. A systematic review of youth and teen mental health first aid: improving adolescent mental health. *J Adolesc Health* 2021; **69:** 199–210.

129 Reis AC, Saheb R, Moyo T, Smith C, Sperandei S. The impact of mental health literacy training programs on the mental health literacy of university students: a systematic review. *Prev Sci* 2022; **23:** 648–62.

130 Patafio B, Miller P, Baldwin R, Taylor N, Hyder S. A systematic mapping review of interventions to improve adolescent mental health literacy, attitudes, and behaviours. *Early Interv Psychiatry* 2021; **15:** 1470–501.

131 Ito-Jaeger S, Perez Vallejos E, Curran T, et al. Digital video interventions and mental health literacy among young people: a scoping review. *J Ment Health* 2021; **May 19:** 1–11.

132 Anderson M, Werner-Seidler A, King C, Gayed A, Harvey SB, O'Dea B. Mental health training programs for secondary school teachers: a systematic review. *School Mental Health* 2019; **11:** 489–508.

133 Hartog K, Hubbard CD, Krouwer AF, Thornicroft G, Kohrt BA, Jordans MJD. Stigma reduction interventions for children and adolescents in low- and middle-income countries: systematic review of intervention strategies. *Soc Sci Med* 2020; **246:** 112749.

134 Morton M, Wang S, Tse K, et al. Gatekeeper training for friends and family of individuals at risk of suicide: a systematic review. *J Community Psychol* 2021; **49:** 1838–71.

135 Davies G, Deane FP, Williams V, Giles C. Barriers, facilitators and interventions to support help-seeking amongst young people living in families impacted by parental mental illness: a systematized review. *Early Interv Psychiatry* 2022; **16:** 469–80.

136 Riebschleger J, Grové C, Cavanaugh D, Costello S. Mental health literacy content for children of parents with a mental illness: thematic analysis of a literature review. *Brain Sci* 2017; **7:** E141.

137 Armijo J, Méndez E, Morales R, et al. Efficacy of community treatments for schizophrenia and other psychotic disorders: a literature review. *Front Psychiatry* 2013; **4:** 116.

138 Monnapula-Mazabane P, Petersen I. Mental health stigma experiences among caregivers and service users in South Africa: a qualitative investigation. *Curr Psychol* 2021; published online Aug 27. https://doi.org/10.1007/s12144-021-02236-y.

139 Soo SA, Zhang ZW, Khong SJE, et al. Randomized controlled trials of psychoeducation modalities in the management of bipolar disorder: a systematic review. *J Clin Psychiatry* 2018; **79:** 17r11750.

140 Adu J, Oudshoorn A, Anderson K, Marshall CA, Stuart H, Stanley M. Policies and interventions to reduce familial mental illness stigma: a scoping review of empirical literature. *Issues Mental Health Nurs* 2021; **42:** 1123–37.

141 Ran MS, Wang YZ, Lu PY, et al. Effectiveness of enhancing contact model on reducing stigma of mental illness among family caregivers of persons with schizophrenia in rural China: a cluster randomized controlled trial. *Lancet Reg Health West Pac* 2022; **22:** 100419.

142 Stubbs A. Reducing mental illness stigma in health care students and professionals: a review of the literature. *Australas Psychiatry* 2014; **22:** 579–84.

143 van Brakel WH, Cataldo J, Grover S, et al. Out of the silos: identifying cross-cutting features of health-related stigma to advance measurement and intervention. *BMC Med* 2019; **17:** 13.

144 Kolodziej ME, Johnson BT. Interpersonal contact and acceptance of persons with psychiatric disorders: a research synthesis. *J Consult Clin Psychol* 1996; **64:** 1387–96.

145 Lien Y-Y, Lin H-S, Lien Y-J, et al. Challenging mental illness stigma in healthcare professionals and students: a systematic review and network meta-analysis. *Psychol Health* 2021; **36:** 669–84.

146 Petkari E, Masedo Gutiérrez AI, Xavier M, Moreno Küstner B. The influence of clerkship on students' stigma towards mental illness: a meta-analysis. *Med Educ* 2018; **52:** 694–704.

147 Piot M-A, Dechartres A, Attoe C, et al. Simulation in psychiatry for medical doctors: a systematic review and meta-analysis. *Med Educ* 2020; **54:** 696–708.

148 Piot M-A, Dechartres A, Attoe C, et al. Effectiveness of simulation in psychiatry for nursing students, nurses and nurse practitioners: a systematic review and meta-analysis. *J Adv Nurs* 2021; **78:** 332–47.

149 Bte Abd Malik NN, Kannusamy P, Klanin-Yobas P. The effectiveness of mental health-related theoretical education and clinical placement in mental health settings in changing the attitudes of health care students towards mental illness: a systematic review. *JBI Library Syst Rev* 2012; **10:** 4019–76.

150 Brunero S, Jeon Y-H, Foster K. Mental health education programmes for generalist health professionals: an integrative review. *Int J Ment Health Nurs* 2012; **21:** 428–44.

151 Classen B, Tudor K, Johnson F, McKenna B. Embedding lived experience expertise across the mental health tertiary education sector: an integrative review in the context of Aotearoa New Zealand. *J Psychiatr Ment Health Nurs* 2021; **28:** 1140–52.

152 Knaak S, Modgill G, Patten SB. Key ingredients of anti-stigma programs for health care providers: a data synthesis of evaluative studies. *Can J Psychiatry* 2014; **59** (suppl 1)**:** S19–26.

153 Carrara BS, Fernandes RHH, Bobbili SJ, Ventura CAA. Health care providers and people with mental illness: an integrative review on anti-stigma interventions. *Int J Soc Psychiatry* 2021; **67:** 840–53.

154 Rennick-Egglestone S, Morgan K, Llewellyn-Beardsley J, et al. Mental health recovery narratives and their impact on recipients: systematic review and narrative synthesis. *Can J Psychiatry* 2019; **64:** 669–79.

155 Muirhead K, Macaden L, Smyth K, et al. Establishing the effectiveness of technology-enabled dementia education for health and social care practitioners: a systematic review. *Syst Rev* 2021; **10:** 252.

156 Zubala A, Lyszkiewicz K, Lee E, Underwood LL, Renfrew MJ, Gray NM. Large-scale online education programmes and their potential to effect change in behaviour and practice of health and social care professionals: a rapid systematic review. *Interact Learn Environ* 2019; **27:** 797–812.

157 Goh Y-S, Ow Yong QYJ, Tam WW. Effects of online stigma-reduction programme for people experiencing mental health conditions: a systematic review and meta-analysis. *Int J Ment Health Nurs* 2021; **30:** 1040–56.

158 Smyth D, Wilson C, Searby A. Undergraduate nursing student knowledge and attitudes of healthcare consumers with problematic alcohol and other drug use: a scoping review. *Int J Ment Health Nurs* 2021; **30** (suppl 1)**:** 1293–309.

159 Alushi L, Hammond JA, Wood JH. Evaluation of dementia education programs for pre-registration healthcare students—a review of the literature. *Nurse Educ Today* 2015; **35:** 992–98.

160 Heim E, Henderson C, Kohrt BA, Koschorke M, Milenova M, Thornicroft G. Reducing mental health-related stigma among medical and nursing students in low- and middle-income countries: a systematic review. *Epidemiol Psychiatr Sci* 2020; **29:** e28.

161 Bielenberg J, Swisher G, Lembke A, Haug NA. A systematic review of stigma interventions for providers who treat patients with substance use disorders. *J Subst Abuse Treat* 2021; **131:** 108486.

162 Liu G, Jack H, Piette A, et al. Mental health training for health workers in Africa: a systematic review. *Lancet Psychiatry* 2016; **3:** 65–76.

163 Caulfield A, Vatansever D, Lambert G, Van Bortel T. WHO guidance on mental health training: a systematic review of the progress for non-specialist health workers. *BMJ Open* 2019; **9:** e024059.

164 Keynejad R, Spagnolo J, Thornicroft G. WHO mental health gap action programme (mhGAP) intervention guide: updated systematic review on evidence and impact. *Evid Based Ment Health* 2021; **26:** 124–30.

165 Heim E, Kohrt BA, Koschorke M, Milenova M, Thornicroft G. Reducing mental health-related stigma in primary health care settings in low- and middle-income countries: a systematic review. *Epidemiol Psychiatr Sci* 2018; **29:** e3.

166 Thornicroft G, Bakolis I, Evans-Lacko S, et al. Key lessons learned from the INDIGO global network on mental health related stigma and discrimination. *World Psychiatry* 2019; **18:** 229–30.

167 Gkioka M, Schneider J, Kruse A, Tsolaki M, Moraitou D, Teichmann B. Evaluation and effectiveness of dementia staff training programs in general hospital settings: a narrative synthesis with Holton's three-level model applied. *J Alzheimers Dis* 2020; **78:** 1089–108.

168 Corrigan PW, Morris SB, Michaels PJ, Rafacz JD, Rüsch N. Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatr Serv* 2012; **63:** 963–73.

169 Borschmann R, Greenberg N, Jones N, Henderson RC. Campaigns to reduce mental illness stigma in Europe: a scoping review. *Die Psychiatrie Grundlagen & Perspektiven* 2014; **11:** 43–50.

170 Dumesnil H, Verger P. Public awareness campaigns about depression and suicide: a review. *Psychiatr Serv* 2009; **60:** 1203–13.

171 Clement S, Lassman F, Barley E, et al. Mass media interventions for reducing mental health-related stigma. *Cochrane Database Syst Rev* 2013; **7:** CD009453.

172 Rivera KJ, Zhang JY, Mohr DC, Wescott AB, Pederson AB. A narrative review of mental illness stigma reduction interventions among african americans in the United States. *J Ment Health Clin Psychol* 2021; **5:** 20–31.

173 Scior K. Public awareness, attitudes and beliefs regarding intellectual disability: a systematic review. *Res Dev Disabil* 2011; **32:** 2164–82.

174 Hung L, Hudson A, Gregorio M, et al. Creating dementia-friendly communities for social inclusion: a scoping review. *Gerontol Geriatr Med* 2021; **7:** 23337214211013596.

175 Gerritzen EV, Hull MJ, Verbeek H, Smith AE, de Boer B. Successful elements of intergenerational dementia programs: a scoping review. *J Intergenerational Relationships* 2020; **18:** 214–45.

176 Fenton L, White C, Gallant KA, et al. The benefits of recreation for the recovery and social inclusion of individuals with mental illness: an integrative review. *Leis Sci* 2017; **39:** 1–19.

177 Xu Z, Rüsch N, Huang F, Kösters M. Challenging mental health related stigma in China: systematic review and meta-analysis. Interventions among the general public. *Psychiatry Res* 2017; **255:** 449–56.

178 Mascayano F, Toso-Salman J, Ho YCS, et al. Including culture in programs to reduce stigma toward people with mental disorders in low- and middle-income countries. *Transcult Psychiatry* 2020; **57:** 140–60.

179 Nguyen T, Holton S, Tran T, Fisher J. Informal mental health interventions for people with severe mental illness in low and lower middle-income countries: a systematic review of effectiveness. *Int J Soc Psychiatry* 2019; **65:** 194–206.

180 Al Ramiah A, Hewstone M. Intergroup contact as a tool for reducing, resolving, and preventing intergroup conflict: evidence, limitations, and potential. *Am Psychol* 2013; **68:** 527–42.

181 O'Connell J, Pote H, Shafran R. Child mental health literacy training programmes for professionals in contact with children: a systematic review. *Early Interv Psychiatry*2021; **15:** 234–47.

182 Bacsu JD, Johnson S, O'Connell ME, et al. Stigma reduction interventions of dementia: a scoping review. *Can J Aging* 2022; **41:** 203–13.

183 Codjoe L, Barber S, Ahuja S, et al. Evidence for interventions to promote mental health and reduce stigma in black faith communities: systematic review. *Soc Psychiatry Psychiatr Epidemiol* 2021; **56:** 895–911.

184 Bu D, Chung P-K, Zhang C-Q, Liu J, Wang X. Mental health literacy intervention on help-seeking in athletes: a systematic review. *Int J Environ Res Public Health* 2020; **17:** E7263.

185 Castaldelli-Maia JM, Gallinaro JGME, Falcão RS, et al. Mental health symptoms and disorders in elite athletes: a systematic review on cultural influencers and barriers to athletes seeking treatment. *Br J Sports Med* 2019; **53:** 707–21.

186 Griffiths KM, Carron-Arthur B, Parsons A, Reid R. Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials. *World Psychiatry* 2014; **13:** 161–75.

187 Banas JA, Bessarabova E, Massey ZB. Meta-analysis on mediated contact and prejudice. *Hum Commun Res* 2020; **46:** 120–60.

188 Kaur N. Impact of photonovel interventions among people with low levels of health literacy: a literature review. *Educ Inf* 2019; **35:** 21–34.

189 Han A. Interventions for attitudes and empathy toward people with dementia and positive aspects of caregiving: a systematic review and meta-analysis. *Res Aging* 2020; **42:** 72–82.

190 Booth A, Scantlebury A, Hughes-Morley A, et al. Mental health training programmes for non-mental health trained professionals coming into contact with people with mental ill health: a systematic review of effectiveness. *BMC Psychiatry* 2017; **17:** 196.

191 Griffiths KM, Christensen H. Internet-based mental health programs: a powerful tool in the rural medical kit. *Aust J Rural Health* 2007; **15:** 81–87.

192 Morgan AJ, Ross A, Reavley NJ. Systematic review and meta-analysis of Mental health first aid training: effects on knowledge, stigma, and helping behaviour. *PLoS One* 2018; **13:** e0197102.

193 Holmes G, Clacy A, Hermens DF, Lagopoulos J. The long-term efficacy of suicide prevention gatekeeper training: a systematic review. *Arch Suicide Res* 2021; **25:** 177–207.

194 Dalky HF. Mental illness stigma reduction interventions: review of intervention trials. *West J Nurs Res* 2012; **34:** 520–47.

195 Doley JR, Hart LM, Stukas AA, Petrovic K, Bouguettaya A, Paxton SJ. Interventions to reduce the stigma of eating disorders: a systematic review and meta-analysis. *Int J Eat Disord* 2017; **50:** 210–30.

196 Hawke LD, Parikh SV, Michalak EE. Stigma and bipolar disorder: a review of the literature. *J Affect Disord* 2013; **150:** 181–91.

197 Matsumoto H, Maeda A, Igarashi A, Weller C, Yamamoto-Mitani N. Dementia education and training for the general public: a scoping review. *Gerontol Geriatr Educ* 2021; **18:** 1–31.

198 Morgan AJ, Reavley NJ, Ross A, Too LS, Jorm AF. Interventions to reduce stigma towards people with severe mental illness: systematic review and meta-analysis. *J Psychiatr Res* 2018; **103:** 120–33.

199 Morgan AJ, Wright J, Reavley NJ. Review of Australian initiatives to reduce stigma towards people with complex mental illness: what exists and what works? *Int J Ment Health Syst* 2021; **15**: 10.

200 Clay J, Eaton J, Gronholm PC, Semrau M, Votruba N. Core components of mental health stigma reduction interventions in low- and middle-income countries: a systematic review. *Epidemiol Psychiatr Sci* 2020; **29:** e164.

201 Ren Z, Zhao C, Tian F, et al. Meta-analysis of the effect of mental health literacy intervention in Chinese people. *Acta Psychol Sin* 2020; **52:** 497–512.

202 Pirkis J, John A, Shin S, et al. Suicide trends in the early months of the COVID-19 pandemic: an interrupted time-series analysis of preliminary data from 21 countries. *Lancet Psychiatry* 2021; **8:** 579–88.

203 Corrigan P, Michaels PJ, Morris S. Do the effects of antistigma programs persist over time? Findings from a meta-analysis. *Psychiatr Serv* 2015; **66:** 543–46.

204 Maunder RD, White FA. Intergroup contact and mental health stigma: a comparative effectiveness meta-analysis. *Clin Psychol Rev* 2019; **72:** 101749.

205 Herrmann LK, Welter E, Leverenz J, et al. A systematic review of dementia-related stigma research: can we move the stigma dial? *Am J Geriatr Psychiatry* 2018; **26:** 316–31.

206 Schreiber M, McEnany GP. Stigma, American military personnel and mental health care: challenges from Iraq and Afghanistan. *J Ment Health* 2015; **24:** 54–59.

207 Seroalo KB, Du Plessis E, Koen MP, Koen V. A critical synthesis of interventions to reduce stigma attached to mental illness. *Health SA* 2014; **19:** 1–10.

208 Corrigan PE, Larson JE, Michaels PJ. Coming out proud to erase the stigma of mental illness. Collierville, Tennessee: Instant Publisher, 2015.

209 Stuart H. Reducing the stigma of mental illness. *Glob Ment Health (Camb)* 2016; **3:** e17.

210 Thornicroft G, Mehta N, Clement S, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet* 2016; **387:** 1123–32.

211 Rao D, Elshafei A, Nguyen M, Hatzenbuehler ML, Frey S, Go VF. A systematic review of multi-level stigma interventions: state of the science and future directions. *BMC Med* 2019; **17:** 41.

212 Maiorano A, Lasalvia A, Sampogna G, Pocai B, Ruggeri M, Henderson C. Reducing stigma in media professionals: is there room for improvement? Results from a systematic review. *Can J Psychiatry* 2017; **62:** 702–15.

213 Ando S, Clement S, Barley EA, Thornicroft G. The simulation of hallucinations to reduce the stigma of schizophrenia: a systematic review. *Schizophr Res* 2011; **133:** 8–16.

214 Ashton LJ, Gordon SE, Reeves RA. Key ingredients-target groups, methods and messages, and evaluation-of local-level, public interventions to counter stigma and discrimination: a lived experience informed selective narrative literature review. *Community Ment Health J* 2018; **54:** 312–33.

215 Pérez-Flores NJ, Cabassa LJ. Effectiveness of mental health literacy and stigma interventions for Latino/a adults in the United States: a systematic review. *Stigma Health* 2021; **6:** 430–39.

216 Peter L-J, Schindler S, Sander C, et al. Continuum beliefs and mental illness stigma: a systematic review and meta-analysis of correlation and intervention studies. *Psychol Med* 2021; **51:** 716–26.

217 Takada M, Shima S. Characteristics and effects of suicide prevention programs: comparison between workplace and other settings. *Ind Health* 2010; **48:** 416–26.

218 Rüsch N, Kösters M. Honest, Open, Proud to support disclosure decisions and to decrease stigma's impact among people with mental illness: conceptual review and meta-analysis of program efficacy. *Soc Psychiatry Psychiatr Epidemiol* 2021; **56:** 1513–26.

219 Mittal D, Sullivan G, Chekuri L, Allee E, Corrigan PW. Empirical studies of self-stigma reduction strategies: a critical review of the literature. *Psychiatr Serv* 2012; **63:** 974–81.

220 Tsang HW, Ching SC, Tang KH, Lam HT, Law PY, Wan CN. Therapeutic intervention for internalized stigma of severe mental illness: a systematic review and meta-analysis. *Schizophr Res* 2016; **173:** 45–53.

221 Wood L, Byrne R, Varese F, Morrison AP. Psychosocial interventions for internalised stigma in people with a schizophrenia-spectrum diagnosis: a systematic narrative synthesis and meta-analysis. *Schizophr Res* 2016; **176:** 291–303.

222 Yanos PT, Lucksted A, Drapalski AL, Roe D, Lysaker P. Interventions targeting mental health self-stigma: a review and comparison. *Psychiatr Rehabil J* 2015; **38:** 171–78.

223 Larkings JS, Brown PM. Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *Int J Ment Health Nurs* 2018; **27:** 928–41.

224 Büchter RB, Messer M. Interventions for reducing self-stigma in people with mental illnesses: a systematic review of randomized controlled trials. *Ger Med Sci* 2017; **15:** Doc07.

225 Morrison AP, Burke E, Murphy E, et al. Cognitive therapy for internalised stigma in people experiencing psychosis: a pilot randomised controlled trial. *Psychiatry Res* 2016; **240:** 96–102.

226 Winsper C, Crawford-Docherty A, Weich S, Fenton S-J, Singh SP. How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model. *Clin Psychol Rev* 2020; **76:** 101815.

227 Demissie M, Hanlon C, Birhane R, Ng L, Medhin G, Fekadu A. Psychological interventions for bipolar disorder in low- and middle-income countries: systematic review. *BJPsych Open* 2018; **4:** 375–84.

228 Evans M, Barker H, Peddireddy S, et al. Peer-delivered services and peer support reaching people with schizophrenia: a scoping review. *Int J Ment Health* 2021; published online Sept 23. https://doi.org/10.1080/00207411.2021.1975441.

229 Orock AN, Nicette G. A review of literature of peer-based recovery support in substance abuse and the implications for effective implementation in Seychelles. *J Subst Use* 2021; **27:** 115–21.

230 Aguirre Velasco A, Cruz ISS, Billings J, Jimenez M, Rowe S. What are the barriers, facilitators and interventions targeting help-seeking behaviours for common mental health problems in adolescents? A systematic review. *BMC Psychiatry* 2020; **20:** 293.

231 Musiat P, Tarrier N. Collateral outcomes in e-mental health: a systematic review of the evidence for added benefits of computerized cognitive behavior therapy interventions for mental health. *Psychol Med* 2014; **44:** 3137–50.

232 Solli HP, Rolvsjord R, Borg M. Toward understanding music therapy as a recovery-oriented practice within mental health care: a meta-synthesis of service users' experiences. *J Music Ther* 2013; **50:** 244–73.

233 Weetch J, O'Dwyer S, Clare L. The involvement of people with dementia in advocacy: a systematic narrative review. *Aging Ment Health* 2021; **25:** 1595–604.

234 Mills H, Mulfinger N, Raeder S, Rüsch N, Clements H, Scior K. Self-help interventions to reduce self-stigma in people with mental health problems: a systematic literature review. *Psychiatry Res* 2020; **284:** 112702.

235 Nickerson A, Byrow Y, Pajak R, et al. 'Tell Your Story': a randomized controlled trial of an online intervention to reduce mental health stigma and increase help-seeking in refugee men with posttraumatic stress. *Psychol Med* 2020; **50:** 781–92.

236 Xu Z, Huang F, Kösters M, Rüsch N. Challenging mental health related stigma in China: systematic review and meta-analysis. I. Interventions among people with mental illness. *Psychiatry Res* 2017; **255:** 457–64.

237 Ashwood JS, Briscombe B, Collins RL, et al. Investment in social marketing campaign to reduce stigma and discrimination associated with mental illness yields positive economic benefits to California. *Rand Health Q* 2017; **6:** 5.

238 McCrone P, Knapp M, Henri M, McDaid D. The economic impact of initiatives to reduce stigma: demonstration of a modelling approach. *Epidemiol Psichiatr Soc* 2010; **19:** 131–39.

239 Evans-Lacko S, Henderson C, Thornicroft G, McCrone P. Economic evaluation of the anti-stigma social marketing campaign in England 2009–2011. *Br J Psychiatry Suppl* 2013; **55:** s95–101.

240 Mulfinger N, Müller S, Böge I, et al. Honest, open, proud for adolescents with mental illness: pilot randomized controlled trial. *J Child Psychol Psychiatry* 2018; **59:** 684–91.

241 Winkler P, Formánek T, Mladá K, Evans Lacko S. Development of public stigma toward people with mental health problems in Czechia 2013–2019. *Eur Psychiatry* 2021; **64:** e52.

242 Kola L, Kohrt BA, Hanlon C, et al. COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health. *Lancet Psychiatry* 2021; **8:** 535–50.

243 Robertson LJ, Makgoba MW. Mortality analysis of people with severe mental illness transferred from long-stay hospital to alternative care in the Life Esidimeni tragedy. *S Afr Med J* 2018; **108:** 813–17.

244 Potts LC, Henderson C. Evaluation of anti-stigma social marketing campaigns in Ghana and Kenya: time to change global. *BMC Public Health* 2021; **21:** 886.

245 Maulik PK, Devarapalli S, Kallakuri S, Bhattacharya A, Peiris D, Patel A. The systematic medical appraisal referral and treatment mental health project: quasi-experimental study to evaluate a technology-enabled mental health services delivery model implemented in rural India. *J Med Internet Res* 2020; **22:** e15553.

246 Kohrt BA, Turner EL, Rai S, et al. Reducing mental illness stigma in healthcare settings: proof of concept for a social contact intervention to address what matters most for primary care providers. *Soc Sci Med* 2020; **250:** 112852.

247 Li J, Fan Y, Zhong H-Q, et al. Effectiveness of an anti-stigma training on improving attitudes and decreasing discrimination towards people with mental disorders among care assistant workers in Guangzhou, China. *Int J Ment Health Syst* 2019; **13:** 1–10.

248 Maulik PK, Devarapalli S, Kallakuri S, Tripathi AP, Koschorke M, Thornicroft G. Longitudinal assessment of an anti-stigma campaign related to common mental disorders in rural India. *Br J Psychiatry* 2019; **214:** 90–95.

249 Corrigan PW, Michaels PJ, Vega E, et al. Key ingredients to contact-based stigma change: a cross-validation. *Psychiatr Rehabil J* 2014; **37:** 62–64.

250 Evans-Lacko S, Rose D, Little K, et al. Development and psychometric properties of the reported and intended behaviour scale (RIBS): a stigma-related behaviour measure. *Epidemiol Psychiatr Sci* 2011; **20:** 263–71.

251 Evans-Lacko S, Little K, Meltzer H, et al. Development and psychometric properties of the Mental Health Knowledge Schedule. *Can J Psychiatry* 2010; **55:** 440–48.

252 Gabbidon J, Clement S, van Nieuwenhuizen A, et al. Mental Illness: Clinicians' Attitudes (MICA) scale-psychometric properties of a version for healthcare students and professionals. *Psychiatry Res* 2013; **206:** 81–87.

253 Li J, Li J, Thornicroft G, Huang Y. Levels of stigma among community mental health staff in Guangzhou, China. *BMC Psychiatry* 2014; **14:** 231.

254 Henderson C, Robinson E, Evans-Lacko S, et al. Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009-2015. *Acta Psychiatr Scand* 2016; **134** (suppl 446)**:** 23–33.

255 Andreassen CS, Pallesen S, Griffiths MD. The relationship between addictive use of social media, narcissism, and self-esteem: findings from a large national survey. *Addict Behav* 2017; **64:** 287–93.

256 Woods HC, Scott H. #Sleepyteens: social media use in adolescence is associated with poor sleep quality, anxiety, depression and low self-esteem. *J Adolesc* 2016; **51:** 41–49.

257 Lister M, Dovey J, Giddings S, Grant I, Kelly K. New media: a critical introduction. London: Routledge, 2008.

258 Bruhn M, Schoenmueller V, Schäfer D. Are social media replacing traditional media in terms of brand equity creation? *Manag Res Rev* 2012; **35:** 770–90.

259 Odun O, Utulu AU. Is the new media superior to the traditional media for advertising. *Asian Journal of Economic Modelling* 2016; **4:** 57–69.

260 Goulden R, Corker E, Evans-Lacko S, Rose D, Thornicroft G, Henderson C. Newspaper coverage of mental illness in the UK, 1992-2008. *BMC Public Health* 2011; **11:** 796.

261 Thornicroft A, Goulden R, Shefer G, et al. Newspaper coverage of mental illness in England 2008–2011. *Br J Psychiatry Suppl* 2013; **55:** s64–69.

262 Rhydderch D, Krooupa AM, Shefer G, et al. Changes in newspaper coverage of mental illness from 2008 to 2014 in England. *Acta Psychiatr Scand* 2016; **134** (suppl 446)**:** 45–52.

263 Berry N, Lobban F, Belousov M, Emsley R, Nenadic G, Bucci S. #WhyWeTweetMH: understanding why people use Twitter to discuss mental health problems. *J Med Internet Res* 2017; **19:** e107.

264 O'Reilly M, Dogra N, Hughes J, Reilly P, George R, Whiteman N. Potential of social media in promoting mental health in adolescents. *Health Promot Int* 2019; **34:** 981–91.

265 Ross AM, Morgan AJ, Jorm AF, Reavley NJ. A systematic review of the impact of media reports of severe mental illness on stigma and discrimination, and interventions that aim to mitigate any adverse impact. *Soc Psychiatry Psychiatr Epidemiol* 2019; **54:** 11–31.

266 Niederkrotenthaler T, Reidenberg DJ, Till B, Gould MS. Increasing help-seeking and referrals for individuals at risk for suicide by decreasing stigma: the role of mass media. *Am J Prev Med* 2014; **47** (suppl 2)**:** S235–43.

267 Brandt Sørensen J, Pearson M, Armstrong G, et al. A qualitative analysis of self-harm and suicide in Sri Lankan printed newspapers. *Crisis* 2021; **42:** 56–63.

268 Muñoz M, Pérez-Santos E, Crespo M, Guillén AI, Izquierdo S. La enfermedad mental en los medios de comunicación: un estudio empírico en prensa escrita, radio y televisión. *Clin Salud* 2011; **22:** 157–73.

269 Calhoun AJ, Gold JA. "I Feel Like I Know Them": the positive effect of celebrity self-disclosure of mental illness. *Acad Psychiatry* 2020; **44:** 237–41.

270 Hoffner CA. Responses to celebrity mental health disclosures: parasocial relations, evaluations, and perceived media influence. In: Lippert LR, Hall RD, Miller-Ott AE, Davis DC, eds. Communicating mental health: history, contexts, and perspectives. Washington, DC: Lexington Books, 2019: 125–146.

271 Hoffner CA, Cohen EL. Mental health-related outcomes of Robin Williams' death: the role of parasocial relations and media exposure in stigma, help-seeking, and outreach. *Health Commun* 2018; **33:** 1573–82.

272 Lee SY. The effect of media coverage of celebrities with panic disorder on the health behaviors of the public. *Health Commun* 2018.

273 Corrigan PW, Powell KJ, Michaels PJ. The effects of news stories on the stigma of mental illness. *J Nerv Ment Dis* 2013; **201:** 179–82.

274 Reavley NJ, Jorm AF, Morgan AJ. Beliefs about dangerousness of people with mental health problems: the role of media reports and personal exposure to threat or harm. *Soc Psychiatry Psychiatr Epidemiol* 2016; **51:** 1257–64.

275 Morgan AJ, Jorm AF. Recall of news stories about mental illness by Australian youth: associations with help-seeking attitudes and stigma. *Aust N Z J Psychiatry* 2009; **43:** 866–72.

276 Angermeyer MC, Matschinger H. The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. *Soc Sci Med* 1996; **43:** 1721–28.

277 Alvarez-Mon MA, Llavero-Valero M, Sánchez-Bayona R, et al. Areas of interest and stigmatic attitudes of the general public in five relevant medical conditions: thematic and quantitative analysis using Twitter. *J Med Internet Res* 2019; **21:** e14110.

278 Miles S. A dual-process approach to stigma reduction using online, user-generated narratives in social media messages. PhD thesis, University of Iowa, 2016.

279 Francis DB. "Twitter is really therapeutic at times": examination of black men's twitter conversations following hip-hop artist Kid Cudi's depression disclosure. *Health Commun* 2021; **36:** 448–56.

280 Jakubowska A, Kaselionyte J, Priebe S, Giacco D. Internet use for social interaction by people with psychosis: a systematic review. *Cyberpsychol Behav Soc Netw* 2019; **22:** 336–43.

281 Goepfert NC, Conrad von Heydendorff S, Dreßing H, Bailer J. Effects of stigmatizing media coverage on stigma measures, self-esteem, and affectivity in persons with depression—an experimental controlled trial. *BMC Psychiatry* 2019; **19:** 138.

282 Collins RL, Wong EC, Breslau J, Burnam MA, Cefalu M, Roth E. Social marketing of mental health treatment: California's mental illness stigma reduction campaign. *Am J Public Health* 2019; **109:** S228–35.

283 WHO. Preventing suicide: a resource for media professionals, 2017 update. Geneva: World Health Organization, 2017.

284 Ganesh R, Singh S, Mishra R, Sagar R. The quality of online media reporting of celebrity suicide in India and its association with subsequent online suicide-related search behaviour among general population: an infodemiology study. *Asian J Psychiatr* 2020; **53:** 102380.

285 Sumner SA, Burke M, Kooti F. Adherence to suicide reporting guidelines by news shared on a social networking platform. *Proc Natl Acad Sci USA* 2020; **117:** 16267–72.

286 Creed M, Whitley R. Assessing fidelity to suicide reporting guidelines in Canadian news media: the death of Robin Williams. *Can J Psychiatry* 2017; **62:** 313–17.

287 Duncan S, Luce A. Using the Responsible Suicide Reporting Model to increase adherence to global media reporting guidelines. *Journalism* 2020; 1464884920952685.

288 Carmichael V, Adamson G, Sitter KC, Whitley R. Media coverage of mental illness: a comparison of citizen journalism *vs* professional journalism portrayals. *J Ment Health* 2019; **28:** 520–26.

289 Dare AJ, Andriessen KA, Nordentoft M, Meier M, Huisman A, Pirkis JE. Media awards for responsible reporting of suicide: experiences from Australia, Belgium and Denmark. *Int J Ment Health Syst* 2011; **5:** 15.

290 Yuen ASY, Mak WWS. The effects of immersive virtual reality in reducing public stigma of mental illness in the university population of Hong Kong: randomized controlled trial. *J Med Internet Res* 2021; **23:** e23683.

291 Brown S. The effectiveness of two potential mass media interventions on stigma: video-recorded social contact and audio/visual simulations. *Community Ment Health J* 2020; **56:** 471–77.

292 Yamaguchi S, Ojio Y, Ando S, et al. Long-term effects of filmed social contact or internet-based self-study on mental health-related stigma: a 2-year follow-up of a randomised controlled trial. *Soc Psychiatry Psychiatr Epidemiol* 2019; **54:** 33–42.

293 Amsalem D, Yang LH, Jankowski S, Lieff SA, Markowitz JC, Dixon LB. Reducing stigma toward individuals with schizophrenia using a brief video: a randomized controlled trial of young adults. *Schizophr Bull* 2021; **47:** 7–14.

294 Neubaum G, Sobieraj S, Raasch J, Riese J. Digital destigmatization: how exposure to networking profiles can reduce social stereotypes. *Comput Human Behav* 2020; **112:** 106461.

295 Vyncke B, Van Gorp B. Using counterframing strategies to enhance anti-stigma campaigns related to mental illness. *Soc Sci Med* 2020; **258:** 113090.

296 Luty J, Rao H, Arokiadass SMR, Easow JM, Sarkhel A. The repentant sinner: methods to reduce stigmatised attitudes towards mental illness. *Psychiatr Bull* 2008; **32:** 327–32.

297 Quintero Johnson JM, Riles J. "He acted like a crazy person": exploring the influence of college students' recall of stereotypic media representations of mental illness. *Psychol Pop Media Cult* 2018; **7:** 146–63.

298 Scarf D, Zimmerman H, Winter T, Boden H, Graham S, Riordan BC, et al. Association of viewing the films *Joker* or *Terminator: Dark Fate* with prejudice toward individuals with mental illness. JAMA Netw Open 2020; **3:** e203423.

299 Stern SC, Barnes JL. Brief report: does watching the good doctor affect knowledge of and attitudes toward autism? *J Autism Dev Disord* 2019; **49:** 2581–88.

300 Ta Park VM, Olaisen RH, Vuong Q, Rosas LG, Cho MK. Using Korean dramas as a precision mental health education tool for Asian Americans: a pilot study. *Int J Environ Res Public Health* 2019; **16:** 2151.

301 Naslund JA, Aschbrenner KA, Marsch LA, Bartels SJ. The future of mental health care: peer-to-peer support and social media. *Epidemiol Psychiatr Sci* 2016; **25:** 113–22.

302 WHO. Preventing suicide: a global imperative. Geneva: World Health Organization, 2014.

303 Oquendo MA, Porras-Segovia A. Barriers for the research, prevention, and treatment of suicidal behavior. *Curr Top Behav Neurosci* 2020; **46:** 25–40.

304 Côté D, Williams M, Zaheer R, Niederkrotenthaler T, Schaffer A, Sinyor M. Suicide-related Twitter content in response to a national mental health awareness campaign and the association between the campaign and suicide rates in Ontario. *Can J Psychiatry* 2021; **66:** 460–67.

305 Domaradzki J. The Werther effect, the Papageno effect or no effect? A literature review. *Int J Environ Res Public Health* 2021; **18:** 2396.

306 Chesin M, Cascardi M, Rosselli M, Tsang W, Jeglic EL. Knowledge of suicide risk factors, but not suicide ideation severity, is greater among college students who viewed *13 Reasons Why*. *J Am Coll Health* 2020; **68:** 644–49.

307 Rosa GSD, Andrades GS, Caye A, Hidalgo MP, Oliveira MAB, Pilz LK. T*hirteen Reasons Why*: the impact of suicide portrayal on adolescents' mental health. *J Psychiatr Res* 2019; **108:** 2–6.

308 Mueller AS. Why *Thirteen Reasons Why* may elicit suicidal ideation in some viewers, but help others. *Soc Sci Med* 2019; **232:** 499–501.

309 D'Agati D, Beaudry MB, Swartz K. *Thirteen Reasons Why* revisited: a monograph for teens, parents, and mental health professionals. *J Med Humanit* 2021; **42:** 345–53.

310 Vijayakumar L, Shastri M, Fernandes TN, et al. Application of a scorecard tool for assessing and engaging media on responsible reporting of suicide-related news in India. *Int J Environ Res Public Health* 2021; **18:** 620–26.

311 Jang J, Myung W, Kim S, et al. Effect of suicide prevention law and media guidelines on copycat suicide of general population following celebrity suicides in South Korea, 2005–2017. *Aust N Z J Psychiatry* 2022; **56:** 542–50.

312 Naderifar M, Goli G, Ghaljaie F. Snowball sampling: a purposeful method of sampling in qualitative research. *Strides in Development of Medical Education* 2017: **14:** e67670.

313 Braun V, Clarke V, Boulton E, Davey L, McEvoy C. The online survey as a qualitative research tool. *Int J Soc Res Methodol* 2021; **24:** 641–54.

314 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; **3:** 77–101.

315 WHO. Comprehensive Mental Health Action Plan 2013–2020. Geneva: World Health Organization, 2021.

316 Ran MS, Peng MM, Yau YY, et al. Knowledge, contact and stigma of mental illness: comparing three stakeholder groups in Hong Kong. *Int J Soc Psychiatry* 2022; **68:** 365–75.

317 WHO. Guidelines on work and mental health. Geneva: World Health Organization, 2022.