

**A COMPARISON OF THE MENTAL HEALTH LITERACY OF AUSTRALIAN
NEWSPAPER JOURNALISTS WITH A SAMPLE OF THE AUSTRALIAN PUBLIC
AND THE PUBLIC'S RECALL OF STORIES ABOUT DEPRESSION FROM THE
MEDIA**

A thesis submitted for the degree of Doctor of Philosophy
at The Australian National University

by
Lara Marguerite Bishop
May 2011

The Centre for Mental Health Research



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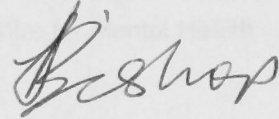
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by
Lisa Margaret Dillip
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The Centre for Mental Health Research

STATEMENT OF CANDIDACY FOR THE DEGREE OF DOCTOR OF PHILOSOPHY
DECLARATION

I declare that this thesis reports original work and that no part has been previously presented for any degree. All sources that were consulted are acknowledged in the references.



Lara Bishop

STATEMENT OF CANDIDATE'S CONTRIBUTION TO THE RESEARCH

Research undertaken for this thesis was based on data obtained in two surveys. The first survey was developed and administered by the candidate to print media journalists in Australia in 2003/2004. The second data set was extracted from a national survey of the Australian and Japanese public undertaken by the Centre for Mental Health Research in 2003/2004.

The candidate independently drafted all chapters of this thesis and revised them following suggestions and comments by her supervisors, in particular Professors Helen Christensen and Kathy Griffiths. Professor Anthony Jorm, Dr Ruth Parslow and Professor Andrew MacKinnon also provided guidance and direction at various stages of the research.

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ABSTRACT

The literature suggested that the media plays an important role in influencing social attitudes towards, and knowledge and perceptions of, mental disorders. Informed representations of mental disorders by the media have been linked to increased help-seeking by people with mental disorders and play an important role in the formation of national mental health literacy rates, which have previously been described as poor. However, the knowledge, attitudes and beliefs about mental disorders held by Australian journalists themselves – their mental health literacy – has not been systematically measured and evaluated. The aims of the present thesis are to assess Australian newspaper journalists' mental health literacy, compare their mental health literacy with a representative sample of Australians, identify similarities and differences in mental health literacy within the journalist group and document the messages Australians recall from the media.

Data for this study were derived from two mental health literacy surveys. The first study was conducted by researchers from the Centre for Mental Health Research at the Australian National University, Canberra in 2003/2004 and involved a survey of 3998 members of the Australian general public. The second study was conducted by the present author in 2003/2004 and measured the mental health literacy of 636 Australian newspaper journalists. Participants in both surveys were presented with a vignette describing a person with major depressive disorder with suicidal ideation (suicidal depression) or early onset schizophrenia (early schizophrenia). Both surveys sought to determine the respondents' ability to recognise a mental disorder from an unlabelled vignette, their knowledge about various treatments and sources of help or information, knowledge about causes and risk factors, beliefs about recovery, stigmatising attitudes and social distance. Both surveys used a number of different scales and were drawn from a variety of sources, but derived mainly from the Jorm and colleagues seminal adult survey in 1997. The journalists' survey included an additional vignette of a person experiencing postnatal depression. The Australian public survey included an additional comment on what they recalled having seen or read in the media about depression.

The results demonstrated that journalists generally held more sophisticated views about many aspects of mental health literacy than the Australian public. For example, journalists were more likely to correctly identify the mental disorders from the vignettes, were more likely to nominate evidence-based treatments for the disorders and were less stigmatising. Specifically, compared with the sample of Australians (77.3%), journalists (88.8%) demonstrated better recognition of suicidal depression from an

unlabelled vignette. Although journalists' (49.4%) ability to recognise early schizophrenia from an unlabelled vignette was similar to the sample of Australians (42.6%), they were much better than the Australian sample in recognising evidence-based treatments for both disorders and more similar to health professionals in their treatment beliefs. Respondents from both samples recognised that the person in the vignette needed treatment and agreed that the prognosis for recovery was better if appropriate treatment was accessed.

Both the Australian public and journalists had a good knowledge of the causes and risk factors of suicidal depression and early schizophrenia. Respondents from both samples accurately endorsed common social environmental factors as causes of suicidal depression. Journalists were less likely to nominate personal vulnerability traits as playing a role in the development the disorders and were better at identifying the potential role of genetic factors. Journalists rejected the notion that 'weakness of character' was a cause of suicidal depression or early schizophrenia.

Journalists demonstrated significantly lower personal stigma scores than the sample of Australians and were significantly less likely to endorse several negative statements from the personal stigma scale, indicating that they were less likely to stigmatise people with mental disorders.

The level of social distance (self-reported willingness to interact with a person with a mental disorder) increased as a function of the degree of intimacy of the interaction. In particular, both journalists and the general public displayed greater reluctance to interact with people with suicidal depression or early schizophrenia for closer compared to more casual social contacts. In addition, both stigma and social distance were greater for the person with early schizophrenia compared to suicidal depression.

Ninety-six percent of journalists recognised postnatal depression from the unlabelled vignette. General practitioners, close friends and counsellors were nominated as the three most helpful people for postnatal depression. Lifestyle/psychosocial interventions received the highest helpfulness ratings whilst antidepressant medication, an evidence-based intervention for the disorder, was only endorsed by around half of the journalists (56.5%). Journalists were not adept at identifying groups in the population who were more likely to experience postnatal depression – only 55.5% of journalists thought that women, who are the prime candidates for postnatal depression, would be more likely than other groups in the population to experience the disorder. As with the suicidal depression vignette, journalists endorsed common social environmental factors as

causes of postnatal depression, recognised that the person in the vignette would achieve a better outcome if they sought treatment, had low personal stigma and expressed a willingness to interact socially with the person in the vignette. The exception to this was that only 31.9% of respondents would be willing to allow a person with postnatal depression to babysit their children.

The factors that predicted the types of treatment journalists believed would be most helpful for suicidal depression, early schizophrenia and postnatal depression were also investigated. Treatments nominated varied as a function of vignette and participant characteristics including type of vignette, age, gender, level of education, previous experience with a mental disorder and level of personal stigma. For example, journalists aged over 40 years nominated some lifestyle/psychosocial interventions, such as psychotherapy or having an occasional alcoholic drink, as significantly more helpful for mental disorders than journalists who were aged 39 years or younger. Compared to younger respondents, this group also thought that help from professionals, such as a counsellor, social worker or naturopath or information sources, such as consulting a book or a health educator would be less helpful for mental disorders. Female journalists, rather than male journalists, suggested a range of different, non evidence-based interventions and especially endorsed dealing with mental disorders naturally. Journalists with a Bachelor's degree or higher level of education and those with previous experience of mental disorders were more likely to nominate lifestyle/psychosocial interventions as being helpful than journalists without a Bachelor's degree or experience of mental disorders. This group nominated the most diverse range of treatments and appeared to favour a holistic approach to managing mental disorders. Journalists with high personal stigma rejected medications and health professionals and suggested that lifestyle/psychosocial interventions and dealing with it alone would be more helpful than people with low personal stigma.

The general public recalled a variety of stories about depression from the media. Seventy-one percent of respondents recalled a media story on depression. This may reflect the large number of media articles on the topic of depression as well as a high level of public interest in depression. Overall, the most common items recalled by respondents in this study related to stories about causes, symptoms and treatments of depression (27.9%). The content that was recalled, however, varied as a function of characteristics such as age, education, experience of a mental disorder, stigma and vignette received. When compared with data from previous research of the actual stories that appeared in newspapers by Pirkis and colleagues (2001), it was clear that the general public's pattern of recall did not reflect the frequency with which themes

were presented in the media. The findings suggested that more work is needed to elucidate the relationship between the types of stories presented in the media and the recall of stories by the general public.

STATEMENT OF CONTRIBUTOR'S CONTRIBUTION TO THE RESEARCH

In conclusion, the present project revealed that the overall mental health literacy of journalists is superior to that of the Australian public. However, the mental health knowledge of journalists was not faultless. Their knowledge might be further enhanced by developing and implementing interventions to raise their mental health literacy in some areas. For example, improving their ability to recognise early schizophrenia, improving their knowledge of some evidence-based treatments for mental disorders and implementing stigma reduction programs in their workplaces would be appropriate. These interventions would enhance their skills and further increase their mental health literacy.

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CHAPTER ONE

GENERAL AIMS AND OVERVIEW OF THE THESIS

1.1 Introduction

Mental disorders¹ are highly prevalent in Australia. The 2007 National Survey of Mental Health and Wellbeing demonstrated that 20% of Australian adults had experienced an anxiety, affective, or substance use disorder (or more than one of these disorders) in the 12 months prior to the survey, and only 35% of people with a mental disorder accessed services for mental disorders (Australian Bureau of Statistics, 2008).

Although service use for mental disorders is low, members of the public commonly seek to acquire information about mental disorders from a variety of other sources (Powell & Clarke, 2006) including the media², personal experience, anecdotal evidence from family and friends, books, libraries, the Internet and courses of study (Jorm, 2000).

This thesis examines one important source of mental health information in Australia – the newspaper media. Newspapers have a significant influence on the news products of other media in that they are usually the first to ‘break news,’ and serve as key reference material for other media (Pearson & Brand, 2001). The print media also play a role in the provision of information about issues related to mental health and illness in Australia (SANE, 2005a) and in community education about mental health in the country (Australian Government Department of Health and Aged Care, 2000). The media has also been cited as an important source of mental health information in other countries such as the United States of America (Granello, Pauley, & Carmichael, 1999; Lopez, 1991), Germany (Benkert, Graf-Morgenstern, Hillert, Sandman, Ehmig, Weissbecker, Kepplinger, & Sobota, 1997), Scotland (Philo, 2004) and the United Kingdom (Powell & Clarke, 2006; Wolffe, Pathare, Craig, & Leff, 1996).

Representations of mental disorders by the Australian media have received increasing attention from researchers over the past decade (Pirkis, Blood, Francis, Putnis, Burgess, Morley, Stewart, & Payne, 2001a). One reason for this growing focus on the media is due to the fact that the media plays an important role in influencing social attitudes towards, and knowledge and perceptions of, mental disorders (Hunter Institute for Mental Health, 2007). In particular, informed representations of mental

¹ The terms ‘mental disorder’ and ‘mental illness’ are used interchangeably throughout this thesis.

² The term ‘media,’ from medium, refers to the group of journalists and others who constitute the communications industry and profession.

illness by the media may promote help-seeking behaviour by people with mental disorders (Milson & Skehan, 2007) and may also play a key role in the formation of national mental health literacy rates, which have previously been described as poor (Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997a; Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997b; Jorm, Korten, Jacomb, Rodgers, Pollitt, Christensen, & Henderson, 1997d; Jorm, Korten, Rodgers, Pollitt, Jacomb, Christensen, & Jiao, 1997e), although more recent research has demonstrated an increase in the mental health literacy of Australians over the past decade (Goldney, Fisher, & Dal Grande, 2005; Jorm, Christensen, & Griffiths, 2005d; Jorm, Christensen, & Griffiths, 2006d).

Conversely, inappropriate or negative media portrayals of mental disorders have been shown to adversely influence community attitudes toward mental disorders, and these attitudes are not necessarily altered, even after exposure to positive stories (Domino, 1983; Wahl & Lefkowitz, 1989).

The Australian government has acknowledged the important role of the media in influencing social attitudes and national mental health literacy rates through their portrayal of mental disorders noting that:

Media coverage and reporting is critical to mental health literacy, particularly through forming community attitudes to mental health and mental illness, and to people affected by mental illness (Australian Government Department of Health and Aged Care, 2000 p.43).

The Australian government funds a comprehensive *Mindframe* National Media Initiative (Hunter Institute for Mental Health, 2007) which aims to encourage responsible, accurate and sensitive portrayal of mental disorders through the development of guidelines on the appropriate reporting and portrayal of mental illness and suicide (Commonwealth Department of Health and Ageing, 2006; Hunter Institute for Mental Health, 2007).

Despite the acknowledgement of the importance of the media's role in influencing social attitudes towards mental illness, and the establishment of a national initiative to encourage responsible reporting of these issues, the knowledge, attitudes and beliefs about mental disorders held by Australian journalists themselves – their mental health literacy – has not been systematically measured and evaluated. In addition, it is not known how the mental health literacy of journalists compares with the rest of the Australian community.

In response to this gap in evidence, the current thesis aims to document the knowledge, attitudes and beliefs about mental disorders held by Australian newspaper journalists (hereafter referred to as journalists), and to describe how their mental health literacy compares with a sample of the Australian public. More specifically, it focuses on journalists' knowledge and attitudes to major depressive disorder with suicidal ideation (hereafter referred to as suicidal depression), early schizophrenia and postnatal depression.

This chapter describes the prevalence and burden of the three mental disorders that are the subject of this thesis, the definition and nature of mental health literacy and the size and influence of the media in Australia. This chapter concludes with a brief description of the aims and structure of the thesis.

1.2 Prevalence and burden of mental disorders

1.2.1 Prevalence

The prevalence of mental disorders in Australia has been measured in two large national surveys. In 1997 the Australian Bureau of Statistics (ABS) conducted the first National Survey of Mental Health and Wellbeing of adults aged over 18 years (Australian Bureau of Statistics, 1998) and in 2007 the ABS conducted the second National Survey of Health and Wellbeing (Australian Bureau of Statistics, 2008). The prevalence of selected lifetime and 12-month mental disorders (affective disorders, anxiety disorders and substance use disorders) were measured for 8,841 people aged 16 to 85 years in 2007 and prevalence rates reported in this thesis correspond to the 12-month prevalence rates reported in the 2007 survey. The diagnostic component of the survey was based on the Composite International Diagnostic Interview (CIDI), which is a standardised questionnaire developed by the World Health Organisation (World Health Organisation, 1990) and which is an expansion of the Diagnostic Interview Schedule (DIS) developed by Robins and colleagues in association with the National Institutes of Health (Robins, Wing, Wittchen, Helzer, Babor, Burke, Farmer, Jablensky, Pickens, Regier, Sartorius, & Towle, 1989). Results from the survey demonstrated that 20% of Australians aged 16-85 years had experienced a mental disorder in the 12 months prior to the interview (Australian Bureau of Statistics, 2008).

The second National Survey of Health and Wellbeing also reported that 4.1% of the population had experienced a depressive disorder during the 12 months prior to the survey and that the condition was more prevalent among females (5.1%) than males (3.1%) (Australian Bureau of Statistics, 2008).

The prevalence of postnatal depression was not measured in the National Survey of Mental Health and Wellbeing of adults. However, it was estimated to affect around 14%-16% of postpartum Australian women, with onset at any time during the first year after the birth of a child (Bishop, 1999; Buist, Speelman, Hayes, Reay, Milgrom, Meyer, & Condon, 2007). Recent research has suggested that men may also experience higher rates of anxiety and depression both antenatally and postnatally (Matthey, Barnett, Howie, & Kavanagh, 2003).

The prevalence of schizophrenia was not measured in the National Survey of Mental Health and Wellbeing of adults. However, an Australian study of low prevalence psychotic disorders demonstrated that

between 4 and 7 persons per every 1000 adults resident in urban areas (a weighted mean of 4.7 per 1000) are in contact with mental health services during any given month because of symptoms of a psychotic disorder. Schizophrenia and schizoaffective disorder account for over 60% of the prevalence of psychotic disorders four and seven people per thousand adults resident in urban areas (Jablensky, McGrath, Herrman, Castle, Gureje, Morgan & Korten, 1999 p.3).

Although schizophrenia has a lower prevalence than depressive disorders, it places a greater burden on medical services and resulted in 17731 hospitalisations in Australia in 2001-02 (Australian Institute of Health and Welfare, 2004).

1.2.2 Burden

Mental health was designated a National Health Priority Area in 2004 after it was identified as one of the leading causes of non-fatal burden of disease and injury in Australia (Australian Institute of Health and Welfare, 2004). Burden of disease analysis integrates fatal and non-fatal outcomes and thus represents a deviation from previous methods which examined burden with respect to mortality alone (Mathers, Vos, Stevenson, & Begg, 2000). Specifically, the Global Burden of Disease study uses

disability adjusted life years (DALYs)—to quantify the burden of diseases, injuries and risk factors with a single currency based on years of life lost due to premature mortality (YLL) and years of life lived in less than full health (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006 p.1747; Murray & Lopez, 1996).

Based on this metric, mental disorders were established as the third leading cause of disease burden in Australia, after cardiovascular disease and cancers (Mathers, Vos, & Stevenson, 1999). Future predictions indicate that by the year 2020, depression will be the second major cause of disability worldwide (Murray & Lopez, 1996).

1.3 The nature and definition of mental health literacy

Australian researchers first adopted the term mental health literacy in 1997 to refer to:

Knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking (Jorm, et al., 1997a p.182).

From this definition it is clear that mental health literacy includes both knowledge about mental disorders and attitudes toward mental disorders and the people who have them.

A thorough review of mental health literacy literature is provided in Chapter 2.

1.4 Australian newspapers as a source of information

Australians have access to an extensive range of national, state and local newspapers. There are more than 600 newspapers in Australia, including online newspapers, and Australia reports one of the highest per capita based circulation rates in the world (Australian Government Department of Foreign Affairs and Trade, 2005).

While the general role and influence of the Australian media continues to be debated, some specific research about the role of the media in influencing people's views about mental illness has been undertaken. This issue is addressed briefly here, and considered in more detail in Chapter 3.

The community obtains much of its information about mental illness from the media. Research from Australia and overseas has consistently found that the media, especially newspaper and television reports, are a primary source of information about mental illness for the public (Benkert, et al., 1997; Granello, et al., 1999; Lopez, 1991; Philo, 2004; Powell & Clarke, 2006; Wolffe, et al., 1996). SANE Australia explored the views of a sample of the Australian public, comprising people who had previously experienced a mental disorder (sometimes called consumers), carers and community members, between March and May 2005, via 131 online surveys and six focus groups, to determine their views on media representations of mental health information (SANE, 2005a). SANE concluded that the media was an important source of mental health information for the general public. Specifically, 62.3% of respondents cited television dramas as a source of information about mental illness and more than 99% believed that television dramas influence their attitude to mental illness (SANE, 2005a). A survey of the general public in the United Kingdom found that 32% of respondents cited the media, including journalists' reports and television and cinema dramas, as their

main source of information about mental disorders (Wolffe, et al., 1996). A Scottish study of the general public undertaken in 1993 found that over 40% of people surveyed believed that mental illness was associated with violence and identified the media as the source of their beliefs (Philo, 2004). These reports suggest that the media are very influential in shaping people's perceptions about mental illness (Cutcliffe & Hannigan, 2001).

An online survey of 1006 Australians in 2006 described the top ten sources of health information, as nominated by respondents (Roesler, 2006). Media sources featured highly, with the Internet, television documentaries, magazines, newspapers and radio talkback all nominated in the top ten sources of health information (Roesler, 2006).

Consistent with public reports that the media is an important source of mental health information, there is evidence that mental health articles are common in the media. A large Australian study of all national radio and television stations, major metropolitan daily newspapers, suburban and regional newspapers in Victoria, and major suburban and regional newspapers in all other states and territories (the Media Monitoring Project) was conducted over a 12 month period from March 2000 to March 2001 (Pirkis, et al., 2001a). The study identified 12338 articles on mental health in the Australian media, 3762 items on suicide and 1051 on suicide and mental health/illness in combination (Pirkis, et al., 2001a). Specifically, there were 4351 newspaper articles on these topics (Pirkis, et al., 2001a). A second phase of the Media Monitoring Project by Pirkis and colleagues was conducted in 2006/2007 (Pirkis, Blood, Dare, Holland, Rankin, Williamson, Burgess, Jolley, Hogan, & Chandler (2008).

The above studies have highlighted the importance of the media as a source of mental health information at both a national and international level and are further explored in Chapter 3.

1.5 Aims of the thesis

To date, no comprehensive studies have considered the mental health literacy of newspaper journalists. Although several studies have investigated the potential impacts of various media reports on public attitudes towards mental illness and suicide, the individual views of journalists themselves have not been examined. This thesis attempts to fill this gap by investigating journalists' attitudes and beliefs about mental disorders. Understanding the limitations of journalists' knowledge of mental health problems has the potential to guide interventions to improve literacy.

The study reported in this thesis has therefore emerged in response to growing recognition of the importance of newspaper media in reporting stories about mental illness and mental health. Using survey methodology, the mental health literacy of Australian journalists is assessed and compared to the mental health literacy of a representative sample of the Australian public. Similarities and differences in mental health literacy between newspaper journalists and the Australian public are reported. The similarities and differences in mental health literacy within the journalist group are also investigated.

In addition to the quantitative analyses, this thesis contains a qualitative analysis of the content of media stories about depression that are recalled by a national sample of the Australian public.

Specifically, the aims of this thesis are to:

1. Compare the mental health literacy of Australian newspaper journalists to the mental health literacy of a national Australian public. This will include a comparison of their ability to recognise suicidal depression and early schizophrenia from an unlabelled vignette, their knowledge of treatments available, knowledge of causes and risk factors, levels of stigma and social distance and attitudes that facilitate appropriate help-seeking;
2. Within the journalist group, investigate and examine the levels of mental health literacy for three types of mental disorders – postnatal depression, depression with suicidal ideation and early schizophrenia. In particular, the thesis examines the ability of journalists to recognise the disorders from unlabelled vignettes, their knowledge of treatments available, knowledge of causes/risk factors³, levels of stigma and social distance and attitudes that facilitate appropriate help-seeking; and
3. Document the messages Australians recall from the media.

1.6 Hypotheses of the thesis

The hypotheses are briefly outlined below and are discussed in more detail in the corresponding chapters of this thesis.

³ The terms 'causes' and 'risk factors' are used interchangeably throughout this thesis. When applied to mental disorders, they refer to the factors that are believed to contribute to the development of these disorders. Some researchers prefer one term over another, and where a study has been reviewed or quoted, the term used by the original researchers has been retained and used in this thesis.

The following hypotheses were investigated. First, the mental health literacy of journalists will be at a higher level than that of the general public. In particular, when compared with the general public, it is hypothesised that journalists will demonstrate:

- a. Greater capacity to recognise depression and schizophrenia from an unlabelled vignette;
- b. Better knowledge of evidence-based treatments for these conditions;
- c. Better knowledge of known causes and risk factors;
- d. More optimistic views about the prognosis and recovery of these conditions in circumstances where appropriate treatment is provided;
- e. Lower stigma; and
- f. Less social distance.

It is hypothesised that the factors predicting journalists' responses regarding helpful treatments for mental disorders will be influenced by the vignette they were shown, their age, gender, level of education, stigma and previous experience with a mental disorder.

It is also hypothesised that participants' recall of specific items from the media will be influenced by:

- a. The vignette they received;
- b. Sociodemographic variables including their age, gender and level of education;
- c. Previous experience of a mental disorder; and
- d. Level of personal stigma.

1.7 Structure of the thesis

This thesis is organised into nine chapters. The current chapter has described the research objectives and defined the issues that this thesis will address.

Chapter 2 reviews previous mental health literacy research. Australian and international studies that have been conducted since mental health literacy was first described in the literature in 1997 are reviewed for the ten-year period to 2007.

Chapter 3 describes the media in Australia and its role in reporting stories about mental health and mental illness. It considers the role the media may play in influencing attitudes and perceptions about mental disorders through fictional and non-fictional media portrayals of mental disorders.

Chapter 4 provides a description of the study and describes the methodology employed in the study. Chapter 5 then presents the results of the mental health literacy surveys of newspaper journalists and compares these with those obtained from a sample of the Australian public. The study compares the samples in terms of accuracy of recognition of suicidal depression and early schizophrenia, and knowledge of treatments, causes, risk factors, levels of stigma, social distance and attitudes that facilitate appropriate help-seeking for these conditions. No previous studies of the Australian public's views about postnatal depression have been conducted to enable a comparison with journalists. Therefore chapter 6 describes journalists' mental health literacy with respect to their knowledge of, and attitudes to, postnatal depression.

Whilst Chapter 5 compares the mental health literacy between the two groups – journalists and the Australian public – and Chapter 6 presents the descriptive data regarding journalists knowledge and beliefs about postnatal depression, Chapter 7 compares the mental health literacy of individuals within the journalist group regarding treatments for the three disorders. Chapter 8 then describes what the Australian public recall from the media about depression.

The final chapter summarises the research findings, describes the contribution of the research to the field of mental health literacy, discusses the practical implications of the findings, describes the limitations of the study and suggests areas for future research.

CHAPTER TWO

MENTAL HEALTH LITERACY – A REVIEW OF THE LITERATURE

2.1 Introduction

This chapter presents a review of Australian and international mental health literacy studies. It defines mental health literacy, describes the components that make up the construct of mental health literacy and provides a summary of the key mental health literacy studies conducted with adults in Australia and overseas. Methods of increasing mental health literacy, such as public health campaigns and Internet interventions, are also briefly reviewed.

2.2 Definition of mental health literacy

The concept of mental health literacy was introduced in Chapter 1. To reiterate, Australian researchers invented the term mental health literacy in 1997 to refer to Knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking (Jorm, et al., 1997a p.182).

Mental health literacy is an extension of the concept of 'health literacy,' which is defined as the ability to gain access to, understand, and use information in ways which promote and maintain good health (Nutbeam, Wise, Bauman, Harris, & Leeder, 1993). Health literacy, as a discrete form of literacy, is increasingly recognised as important for social, economic and health development (Kickbusch, 2001). Good health literacy may help support health promoting behaviours both at an individual and population level (Kickbusch, 2001). However, the degree to which an individual's expressed attitude translates into behaviour when faced with a mental disorder remains largely unknown. Recent Australian research suggested that attitudes regarding appropriate help-seeking for mental disorders may not predict actual help-seeking behaviour or outcomes for people with common psychiatric symptoms (Jorm, Medway, Christensen, Korten, Jacomb, & Rodgers, 2000a).

Two key constructs, stigma and social distance, are also important components of mental health literacy and are defined below.

Stigma was originally derived from the work of Goffman (1968), who defined it as "an attribute that is deeply discrediting" and that a person with such an attribute is "reduced in our minds from a whole and usual person to a tainted, discounted one"

(Goffman, 1963 p.3). A more contemporary definition of stigma has been suggested. Stigma is defined as “the co-occurrence of its components – labelling, stereotyping, separation, status loss, and discrimination” and that for this stigmatisation to occur “power must be exercised” (Link & Phelan, 2001 p.363).

With respect to mental disorders, stigma has been classified into several types: personal stigma, perceived stigma, self-stigma and structural stigma. Personal stigma, is said to reflect the respondents’ own personal attitudes about people with mental disorders (Griffiths, Christensen, Jorm, Evans, & Groves, 2004). People with high personal stigma display negative attitudes and discriminatory behaviours (Corrigan, Watson, Gracia, Slopen, Rasinski, & Hall, 2005). Perceived stigma reflects respondents’ beliefs about the attitudes of others toward people with mental disorders (Griffiths, et al., 2004). Self-stigma relates to a person’s negative attitudes to their own mental disorder. Structural stigma occurs when an institution, rather than an individual, disseminates stigmatising messages about mental disorders that restrict the opportunities of the groups that are stigmatised (Corrigan, et al., 2005). This thesis is concerned with the first two types of stigma: personal and perceived.

Stigma is an important attitudinal component of mental health literacy. In particular, stigmatising views among journalists, if they exist, have the potential to increase or reinforce public stigma through inappropriate media representations.

For this thesis, social distance is defined as “the willingness to engage in relationships of varying intimacy with a person” (Jorm, et al., 1997a p.265) and is a proxy measure of discrimination.

2.3 Measuring mental health literacy

Mental health literacy is often assessed by presenting respondents with a questionnaire, which includes a case vignette depicting a person with a mental disorder (such as major depressive disorder, early schizophrenia or postnatal depression), and asking them to respond to open-ended or forced-choice questions about the person in the vignette. Alternatively, studies may use diagnostic labels as a stimulus for determining beliefs about mental disorders. In the latter case, respondents are either provided with the diagnosis of the person in a vignette, or they are asked about a named mental disorder, and required to answer a series of questions related to the disorder.

Respondents are usually asked to identify the problem described in unlabelled vignettes and may be asked to nominate the best sources of help for a person in a vignette or with a labelled problem. They may also be asked to rate whether various treatments would be helpful, to indicate their beliefs about risk factors, to provide their views about prognosis, to indicate their willingness to relate to, and attitudes toward, a person with the problem, to describe any personal contact they may have had with persons with similar symptoms to those described in the vignette or labelled condition, and to say whether they themselves had experienced such a problem.

Mental Health Literacy is a relatively new scientific concept. Consequently, there are no published gold standards by which to establish the accuracy of an individual's mental health literacy. The approach of this thesis is to compare two groups of respondents to determine relative differences between their views.

2.4 Key mental health literacy studies

A large number of mental health literacy studies have been conducted and reported on in the literature since the term mental health literacy was first introduced in February 1997. In this chapter, a review of studies for the ten-year period to March 2007 is presented. To limit the review to key studies, papers were only included if they were written in English, their sample size exceeded 500, their focus was on schizophrenia, anxiety, depression, or postnatal depression and if they were solely concerned with adults. Qualitative studies, mental health literacy studies exclusively related to children or youth, and mental health literacy studies of eating disorders were excluded. Australian studies are presented in Appendix 1 and international studies are presented in Appendix 2. Multiple papers reporting results from the same survey are grouped together. The methodology, the type of disorder, the stimulus used to elicit the information, the main focus of the study and the key findings are described for each study. Key findings with respect to recognition of a mental disorder, risk factors/causes, treatment, recovery, social distance, stigma and the respondent's own health and its relationship to mental health literacy are noted. Findings from the international studies accord strongly with those findings from the Australian studies. For this reason, the findings from the Australian studies were described in detail in the text, and those from the International studies were only briefly summarised in the text.

2.5 Findings from the Australian studies

Twenty-five papers described the findings from national surveys of the Australian public (Goldney, et al., 2005; Goldney, et al., 2001; Goldney, et al., 2002; Highet, et al., 2002; Jorm, 2000; Jorm & Butterworth, 2006; Jorm, et al., 2006a; Jorm, et al., 2005b; Jorm, et al., 2005d; Jorm, Christensen, & Griffiths, 2006c; Jorm, et al., 2006d; Jorm, et al., 1999; Jorm, et al., 1997a; Jorm, et al., 1997b; Jorm, et al., 1997d; Jorm, et al., 1997e; Jorm, et al., 2005e; Jorm, et al., 2000a; Jorm, et al., 2000b; Jorm, et al., 2005f), rural dwelling Australians (Bartlett, et al., 2006), samples of health professionals (Caldwell & Jorm, 2000; Jorm, et al., 1997d), women who were pregnant or had recently given birth (antenatal/postnatal women), midwives and antenatal nurses (Buist, et al., 2006; Buist, et al., 2007). Additionally, there were two major cross cultural studies, one compared the mental health literacy of the Australian public with that of the Japanese public (Griffiths, et al., 2006; Jorm, et al., 2006d; Jorm, et al., 2005e; Jorm, et al., 2005f), and the second compared the mental health literacy of Australian general practitioners with those in Singapore (Parker, et al., 2001).

A number of longitudinal studies have investigated public beliefs using the same survey at different time periods to determine if attitudes and knowledge have changed with time. For example, Jorm and colleagues carried out a national household mental health literacy survey in 1995 and again in 2003/2004 using the same survey items and methodology (Jorm, et al., 2006d; Jorm, et al., 1997a; Jorm, et al., 2005e; Jorm, et al., 2005f). The authors sought to determine whether there had been improvements in the Australian public's recognition of mental disorders and their knowledge and beliefs about causes/risk factors, symptoms, treatments, outcomes, social distance and stigmatising beliefs. Similarly, Goldney and his colleagues investigated the mental health literacy of South Australians at two time points to identify any changes between 1998 and 2004 (Goldney, et al., 2005; Goldney, et al., 2001; Goldney, et al., 2002). As noted above, another theme has been to compare the mental health literacy of the Australian public with that of health professionals to determine the similarities and differences in their beliefs about mental disorders (Buist, et al., 2006; Caldwell & Jorm, 2000; Jorm, et al., 1997d).

The following sections briefly describe the outcomes of these Australian studies in terms of recognition of disorders, knowledge of causes and risk factors, recommendations for help-seeking, prognosis/outcome, stigma/social distance and self-rated health.

2.5.1 Recognition of mental disorder

The percentage of the Australian public able to accurately recognise depression ranges from 39% to 81% and from 27% to 42% for schizophrenia. Rates for postnatal depression vary from 32% to 60%.

Differences in the reported rates of recognition of mental disorders may be explained by the different methodologies employed in the research studies. For example, a study in rural Queensland towns found that a high proportion of respondents correctly identified depression (81%) (Bartlett, et al., 2006). However, the response rate (36%) was lower than that reported in many other studies raising the possibility that those with an interest in mental health issues were over-represented in the sample.

Differences between studies may also be due to differences in the date the studies were conducted. There is evidence that the Australian public's recognition of mental disorders has been improving since 1995. In South Australia, 49.5% of respondents correctly identified depression in 1998 compared to 68.1% in 2004 (Goldney, et al., 2005). In the Australia-wide survey in 1995, 72% and 84% of respondents who received the depression and schizophrenia vignettes respectively recognised them as depicting a mental disorder (Jorm, et al., 1997a). However, respondents were markedly poorer at labelling the specific disorder: 39% (depression) and 27% (schizophrenia) (Jorm, et al., 1997a). By contrast, in 2003/2004, 67% of the public correctly labelled depression and 42% correctly labelled schizophrenia (Jorm, et al., 2006d), indicating a significant improvement over the intervening eight years.

In contrast to the findings from the general public, the recognition of specific mental disorders by health professionals in Australia is relatively high being 98.5% for depression (Caldwell & Jorm, 2000), 92% for schizophrenia (Caldwell & Jorm, 2000) and ranging from 79% to 95% for postnatal depression (Buist, et al., 2006).

2.5.2 Recommendations for help-seeking and treatment

A number of studies have investigated the general public's perception of the helpfulness of different treatments, including professionals and lay people in treating mental disorders. These studies have yielded consistent findings. Psychological treatments, such as visiting a psychologist or counsellor, visiting general practitioners (GPs) and some lifestyle interventions have typically been seen by the public as helpful. However some evidence-based treatments, such as the use of antidepressant medication for depression and antipsychotic medication for schizophrenia, were often rated as harmful. In addition, some non-standard treatments, such as vitamins and

minerals and special diets were rated highly by the Australian public. Although, over the 10-year period of this review, there has been a trend towards greater endorsement of evidence-based treatments, endorsement rates of many of these interventions are still low.

Respondents to the 1995 Australian survey were asked to rate the helpfulness of various professional and non-professional treatments for the mental disorders described in the vignettes (Jorm, et al., 1997d; Jorm, et al., 1997e). A factor analysis of helpfulness ratings identified three factors for both depression and schizophrenia: a medical factor, a psychological factor and a lifestyle factor. The medical factor had high loadings on all drug treatments (but excluded vitamins), admission to a psychiatric ward and electroconvulsive therapy (ECT). The psychological factor had high loadings on counsellor, social worker, phone counselling, psychiatrist, psychologist, psychotherapy and hypnosis. The lifestyle factor had high loadings on close family, close friends, naturopath, physical activity and getting out more (Jorm, et al., 1997e). Using scales constructed from the items with high loadings the authors demonstrated that the Australian public had a negative view of medical treatments and a positive view of psychological and lifestyle treatments (Jorm, et al., 1997e). Medical treatments were rated more negatively for depression than schizophrenia, whilst lifestyle treatments were rated more positively for depression than schizophrenia. Conversely, psychological treatments were rated as more helpful for schizophrenia than depression (Jorm, et al., 1997e).

With respect to people who could help with mental disorders, GPs (83%) and counsellors (74%) were most often rated as helpful for the depression vignette, with psychiatrists (51%) and psychologists (49%) less so (Jorm, et al., 1997e). With respect to the schizophrenia vignette, respondents rated counsellors (81%), GPs (74%), psychiatrists (71%) and psychologists (62%) as helpful (Jorm, et al., 1997e).

There is evidence that public knowledge about help sources has improved over time. Jorm and colleagues demonstrated an increase over eight years in the endorsement of mental health professionals, medication, psychotherapy and psychiatric ward admission for mental disorders (Jorm, Christensen, & Griffiths, 2006b). In addition, there was an increased belief in the harmfulness of dealing with depression and schizophrenia alone. For depression, the greatest changes were an increase in the belief about the helpfulness of social workers, telephone counsellors, psychiatrists, psychologists, antidepressants, antipsychotics, physical activity, reading about the problem, psychotherapy, and admission to a psychiatric ward (Jorm, et al., 2006b). For

the early schizophrenia vignette, the greatest changes in beliefs were that social workers, psychiatrists, psychologists, naturopaths/herbalists, antidepressants, antipsychotics, hypnosis, admission to a psychiatric ward and going on a special diet were more often reported to be helpful (Jorm, et al., 2006b). There was also a decrease in the belief that antidepressants and admission to a psychiatric ward would be harmful (Jorm, et al., 2006b). Although admission to a psychiatric ward was considered more helpful in 2003/2004 than in the 1995 survey, harmful ratings were still more common than helpful ratings (Jorm, et al., 2006b). Similarly, although there was an increase in the belief about the helpfulness of antidepressants for depression (28.7% in 1995 to 47.8% in 2003/2004) and schizophrenia (38.5% in 1995 to 50.5% in 2003/2004), the public still endorsed vitamins, minerals or tonics and herbal medicines as a treatment for depression in 2003/2004 (50.4 %) (Jorm, et al., 2005e).

The public's beliefs about antidepressants in 2003/2004 were also assessed. Specifically, responses from the 999 adults who received a vignette depicting depression with suicidal thoughts were analysed to assess beliefs about the helpfulness or harmfulness of antidepressants (Jorm, et al., 2005b). Results showed that 27.5% of respondents believed that antidepressants would be harmful for the person with suicidal depression (Jorm, et al., 2005b).

This group was less educated, had less exposure to depression, showed poorer recognition of depression, was less favourable about other standard interventions including psychological ones, was less pessimistic about the long-term outcome if the person did not have treatment, and was more likely to see depression as due to weakness and to be under the individual's control (Jorm, et al., 2005b p.47).

A factor analysis was performed on the 2003/2004 helpfulness ratings. Whereas the analysis of the 1995 data yielded a three factor solution (Jorm, et al., 2005e), analysis of the 2003/2004 data produced a four factor solution (Jorm, et al., 1997e). The first three factors for the 2003/2004 data corresponded substantially to those described earlier (Jorm, et al., 2005e) for depression and schizophrenia and included: medical, psychological and lifestyle factors. However, a number of additional items were included in the 2003/2004 survey. These were responsible for a fourth factor, termed 'information seeking' (Jorm, et al., 2005e). Items loading on this fourth factor included visiting a relevant web site, consulting an expert via email or the Internet, reading a book containing information about the individual's health problem, receiving information from a health educator and reading about people with similar problems and how they dealt with them (Jorm, et al., 2005e). There is little evidence concerning the effectiveness of these actions.

Women rated lifestyle and psychological factors as more helpful than men, but no significant gender effect was observed on the medical and information-seeking scales (Jorm, et al., 2005e). Information-seeking interventions were rated as more helpful by younger respondents while psychological interventions were rated as more helpful in middle age (Jorm, et al., 2006d).

Mean ratings of interventions forming the Lifestyle, Psychological and Information-seeking dimension were located between the neutral and helpful response categories, while those of the Medical factor lay between the harmful and neutral points. This further reinforces the notion that the dimensions found relate to attitudes to treatment rather than reflecting knowledge-based appraisal (Jorm, et al., 2005e p.882)

Between 1998 and 2004 there were also some changes in the endorsement of treatments for mental disorders among the South Australian public. Although different members of the public were sampled at each point in time, more respondents recommended seeing a doctor or counsellor or talking their problems over with friends in 2004. There were no significant changes in the reported helpfulness of seeing a psychiatrist or psychologist or taking medications (Goldney, et al., 2005). However, significantly fewer respondents assigned harmful ratings to consulting psychiatrists and psychologists, as well as pharmacists, counsellors, social workers, and telephone counsellors (Goldney, et al., 2005). In terms of pharmacological treatments, significantly more of the 2004 sample considered antidepressants, sleeping pills and tranquilisers as helpful and significantly fewer considered them harmful (Goldney, et al., 2005). The authors concluded that there had been a significant improvement in mental health literacy for depression between 1998 and 2004 (Goldney, et al., 2005).

In a study of rural dwelling Queenslanders, assistance from a GP was considered helpful for depression by most respondents (86.4%). Assistance from a counsellor was also rated as helpful by respondents (88.2%), with women significantly more likely to endorse seeing a counsellor (Bartlett, et al., 2006). In contrast, more than half of the respondents (55.2%) thought it would be harmful for the person in the vignette to deal with the problem on their own (Bartlett, et al., 2006). The strategies most likely to be seen as helpful for the person in the vignette were attending courses on relaxation, stress management, meditation or yoga (84%) or becoming more physically active (82.3%). The strategies most likely to be seen as harmful were undergoing ECT (65.8%) or being admitted to the psychiatric ward of a hospital (55.8%) (Bartlett, et al., 2006).

Although beliefs about the helpfulness of interventions for mental disorders have been measured, little research has focused on whether the public's beliefs actually influence

their help-seeking behaviour when they experience a mental disorder. However, one study did investigate whether beliefs about the helpfulness of interventions predicted subsequent actual help-seeking behaviours for these disorders (Jorm, et al., 2000b). In this study of 3109 individuals on the electoral role of Farrer (encompassing Albury and surrounding areas), the five most commonly endorsed interventions for depression were: seeing a counsellor, physical activity, learning relaxation and getting help from friends and family. A sub-group of 422 people who had reported a high level of depressive symptoms in the abovementioned survey were then sent a second survey 6 months later which asked about the actual interventions they had used to manage their depressive symptoms. The five most used interventions at follow-up were having an occasional alcoholic drink to relax, taking pain relievers, physical activity, getting help from close friends, and getting help from family (Jorm, et al., 2000b). The authors concluded that there were discrepancies between what people ranked as helpful and the interventions they subsequently used. Self-help interventions which are inexpensive and accessible were frequently used, even though the public rated professional sources of help as likely to be helpful (Jorm, et al., 2000b). Predictors of the use of self-help interventions were gender, history of treatment, current symptoms and belief in a particular treatment. Thus, this study demonstrated that the respondents attitudes about the help that they would seek, did not predict the actual actions taken when experiencing symptoms of depression or anxiety (Jorm, et al., 2000b).

2.5.3 Knowledge about causes and risk factors

The terms 'causes' and 'risk factors' were used interchangeably in the mental health literacy literature that was reviewed for this thesis, and are subsequently used interchangeably in this thesis. Although risk factors and causes are different entities, that is, risk factors are variables associated with a particular outcome, while causes are the agent by which an outcome comes to be, most of the public were considered unlikely to make this distinction.

A number of studies have investigated the beliefs of the Australian public about causes and risk factors for mental disorders (Bartlett, et al., 2006; Goldney, et al., 2005; Jorm, et al., 2005d; Jorm, et al., 1997b). Typically, respondents have been asked to rate whether various factors are likely causes of the problems described in depression or schizophrenia vignettes and which of a range of groups were at higher or lower risk of these disorders (Jorm, et al., 1997b). Changes over time in beliefs about the causes and risk factors for depression and schizophrenia have also been documented (Goldney, et al., 2005; Jorm, et al., 2005d).

In the late 1990's social environmental factors, such as day-to-day problems, traumatic events, the death of someone close, and childhood environment were seen as likely causes for depression and schizophrenia. Genetic factors were often seen as a cause of schizophrenia (60%) and less so for depression (50%) (Jorm, et al., 1997b). The authors also found that half the population endorsed weakness of character as a likely cause of depression (Jorm, et al., 1997b). Unemployment, divorce/separation and poverty were frequently rated as risk factors for depression (Jorm, et al., 1997b).

In 2003/2004, social factors were again widely nominated as causes of the disorders (Jorm, et al., 2005d). More than 85% of respondents nominated day-to-day problems, death of someone close, traumatic events and problems from childhood as causes of depression and schizophrenia, findings similar to those from the earlier survey (Jorm, et al., 2005d). In addition, there was an increase in genetic causal attributions for depression and schizophrenia, and an increase in the belief that depression was caused by childhood problems and the death of someone close (Jorm, et al., 2005d). There was a decrease in the belief that weakness of character is a cause of schizophrenia. Unemployment and divorce/separation were again nominated as key risk factors for depression and schizophrenia (Jorm, et al., 2005d).

These findings were consistent with a telephone-based community survey which used a labelled depression vignette (Highet, et al., 2002). Respondents nominated unemployment (97%), having a severe medical condition (95%) and the birth of a child (72%), as risk factors for depression (Highet, et al., 2002). However, there was less consistency regarding other risk factors and protective factors for depression. For example, the researchers reported that being married or in a de-facto relationship, which is a known protective factor for depression, was incorrectly nominated as a likely risk factor by 55% of respondents (Highet, et al., 2002).

2.5.4 Beliefs about recovery

Australian research indicates that the general public believes that depression and schizophrenia are treatable (Jorm, et al., 1997b) and that people with these conditions require professional help (Bartlett, et al., 2006).

In the 1995 national survey (Jorm, et al., 1997b), 80% of people who received the depression vignette and 69% of people who received the schizophrenia vignette were optimistic that full recovery was possible with professional help, although some believed that future relapses were possible. In 2005 these figures were similar – 80.9% for depression and 72.1% for schizophrenia (Jorm, et al., 2005f). Without professional

help, the general public were not optimistic about full recovery. Similar findings were reported in a study of public beliefs among rural Queenslanders: 79% of respondents were optimistic that with professional help, a full recovery from depression, with possible future relapses, was possible (Bartlett, et al., 2006). However, half of the respondents (50.3%) thought that without professional help, the person in the vignette would get worse (Bartlett, et al., 2006).

When viewed as a single group, health professionals in Australia (GPs, psychiatrists and psychologists), reported more negative views about long-term outcomes than the general public, even with appropriate treatment (Jorm, et al., 1999). For example, health professionals were more likely than the general public to believe that in the long term, a person with depression or schizophrenia, would attempt suicide, drink too much, take illegal drugs, be violent and have poorer friendships. As noted by Jorm et al. (1999), this may reflect greater knowledge of the course of mental disorders, or more contact with people experiencing recurrent or chronic disorders, which may lead to an overly negative attitude.

2.5.5 Stigma

It has been argued that the stigma attached to mental disorders is one of the greatest obstacles facing people with mental disorders (Goffman, 1963). As a result of this stigma, some people may be reluctant to seek help for their disorder, may be less likely to cooperate with treatment, and may be slower to recover self-esteem and confidence (Hocking, 2003). In 2003/2004, schizophrenia (especially chronic schizophrenia) attracted greater personal stigma and perceived stigma than depression in Australia (Griffiths, et al., 2006). The stigma item most frequently endorsed by Australian respondents was 'people with the problem are unpredictable' (range 42.2% for depression to 67.5% for chronic schizophrenia) (Griffiths, et al., 2006). Perceived stigma was consistently higher than personal stigma for both conditions. An earlier Australian survey also demonstrated more negative attitudes toward people with schizophrenia than depression (Jorm, et al., 1999). Some specific findings were that health professionals generally held more negative attitudes than the general public for both disorders, but that both health professionals and the general public who had personally experienced a mental disorder displayed more favourable attitudes (Jorm, et al., 1999). Interestingly, having family or friends with depression or schizophrenia was not associated with attitudes in either direction, but higher levels of education were associated with more negative attitudes toward a person with schizophrenia (Jorm, et al., 1999).

2.5.6 Social distance

Social distance refers to the self-reported willingness of respondents to relate to people with a mental illness. It should be noted that social distance refers to stated intentions concerning interpersonal behaviour and as such is a proxy measure of discrimination rather than a measure of actual discriminatory behaviour (Schulze & Angermeyer, 2003)

Only one Australian study has measured social distance among the Australian public (Griffiths, et al., 2006). The main findings were that social distance was greater for schizophrenia than depression and that both personal stigma and social distance were greater among the Japanese public than the Australian public. However, when respondents were asked about their perceptions of the attitudes and discriminatory behaviour of others, a large percentage of Australians believed that most other people would think that the person in the vignette would be discriminated against by others in the community (range: 53.5% for the depression vignette to 83.2% for the chronic schizophrenia vignette) (Griffiths, et al., 2006).

2.5.7 Other

In 2003/2004, the Australian public's mental health first aid responses to hypothetical cases of people with mental disorders were also measured (Jorm, et al., 2005a). Verbatim responses to an open-ended question seeking to determine what the respondent would do if the person described in the vignette was someone they cared about were coded into at least one of six possible categories (Jorm, et al., 2005a). Encouraging professional help-seeking (range 57.5%-66.0%) and listening/talking/supporting the person (range 65.6%-73.4%) were found to be the most common first aid responses for all vignettes and the most commonly mentioned professional that could potentially help the person in the vignette was a GP/doctor (range 26.9%-40.1%) (Jorm, et al., 2005a). However, 32%-44% of respondents did not mention professionals as potential sources of help or listening/talking/supporting the person (27%-34%) (Jorm, et al., 2005a). Less common responses were to assess the problem of risk or harm, to give or seek information, to encourage self-help or to support the family of the person with the mental disorder (Jorm, et al., 2005a). The authors also reported that first aid responses were generally more appropriate in respondents who correctly identified the disorder, women, and those with less stigmatising attitudes (Kitchener & Jorm, 2004).

2.6 General public versus professionals in Australia

One of the most striking findings from the mental health literacy research is the differences between health professionals and the general public (Buist, et al., 2005; Caldwell & Jorm, 2000; Jorm, et al., 1999; Jorm, et al., 1997c). Although these differences have already been described above, the issue warrants some additional discussion here. The public's attitudes and beliefs about effective treatments are often different to those of health experts, and are inconsistent with the available scientific evidence (Jorm, et al., 1997d). For example, in contrast to health professionals they hold negative views about the use of antidepressant medication for depression. In addition, in contrast to health professionals, the public does not discriminate between the antidepressant medications and addictive medications such as the benzodiazepines (Jorm, et al., 1997d). The public favoured natural therapies, whilst mental health professionals favoured more of the evidence-based treatments (Jorm, et al., 1997d). Health professionals rated psychiatrists, psychologists, antidepressants, and various forms of psychotherapy more highly for depression than the general public whereas the latter gave higher ratings of helpfulness to close friends, a naturopath or herbalist, vitamins and minerals, courses on relaxation and a special diet (Jorm, et al., 1997d). For the schizophrenia vignette, psychiatrists, antipsychotic medication and admission to a psychiatric ward were rated more highly by health professionals, whereas the public rated counsellors, close friends, naturopaths, vitamins, physical activity, self-help books, getting out more, courses on relaxation, a special diet and hypnosis more highly (Jorm, et al., 1997d). In terms of a prognosis for the person depicted in the vignettes, both the public and health professionals agreed that the prognosis was better with professional help (Jorm, et al., 1997d).

The results of these surveys demonstrate clear discrepancies between the views of health professionals and the views of the general public with regard to helpfulness of interventions (Caldwell & Jorm, 2000). Such differences were also reflected in a study of mental health nurses' beliefs about interventions for schizophrenia and depression (Caldwell & Jorm, 2000). Nurses' views about the most helpful interventions were more closely aligned with those of psychiatrists than the general public. For the schizophrenia vignette, nurses and psychiatrists agreed that the most helpful interventions were seeing a psychiatrist, taking antipsychotic medication and being admitted to a psychiatric ward (Caldwell & Jorm, 2000). For the depression vignette, psychiatrists and nurses agreed that seeing a GP, psychiatrist or clinical psychologist and taking antidepressants were helpful interventions (Caldwell & Jorm, 2000). However, there were also areas of disagreement between psychiatrists and nurses about the helpfulness of interventions. Nurses tended to rate lifestyle factors (such as

vitamins and naturopaths) and psychological factors (such as seeking counselling) as helpful more often than psychiatrists (Caldwell & Jorm, 2000). Antidepressants and antipsychotics were rated as more helpful by nurses for depression and schizophrenia respectively, when compared to the Australian public (Caldwell & Jorm, 2000). There were also some other differences of interest. Certain non-standard interventions such as vitamins, minerals and visiting a naturopath were rated as more helpful by nurses than psychiatrists, and nurses also rated significantly more interventions as helpful than psychiatrists, both for depression and schizophrenia (Caldwell & Jorm, 2000). Another interesting finding was that whereas dealing with problems by oneself was most often seen as harmful by nurses and psychiatrists for the schizophrenia vignette, undergoing ECT was seen as the most harmful by the general public for the same condition (Caldwell & Jorm, 2000). Overall, it appeared that the beliefs of mental health nurses lay somewhere between those of psychiatrists and the general public (Caldwell & Jorm, 2000). The authors concluded that attempts to reconcile the differences between public and professional beliefs deserve serious consideration (Jorm, 2000).

A comparative study of the mental health literacy of the public and health professional has also been undertaken for the conditions of postnatal and antenatal depression (Buist, et al., 2005). Years of experience as a GP positively influenced treatment choices for postnatal depression; 77% of GPs endorsed the usefulness of antidepressant medication for women who were depressed during pregnancy and 97% endorsed antidepressants as a useful intervention for women with postnatal depression (Buist, et al., 2005). Whilst the use of antidepressant medication during pregnancy and breastfeeding remains a controversial topic, the risks of untreated depression need to be weighed up against the risks of foetal and infant exposure to these medications (Black Dog Institute, 2008). Counselling was also endorsed by GPs as a useful intervention both antenatally (95%) and postnatally (86%) and assistance from the woman's partner was believed to be useful antenatally (97%) and postnatally (82%) (Buist, et al., 2005). However women in the post partum period were significantly less likely than GPs to view antidepressants as useful antenatally (22%) or postnatally (54%), although they were as likely as GPs to rate assistance from partner and counselling as useful both antenatally and postnatally (Buist, et al., 2005). Compared to GPs, women who had recently given birth were significantly more likely to rate vitamins and minerals as helpful for depression during the antenatal (86%) and postnatal periods (78%), visiting a naturopath as helpful antenatally (55%) and postnatally (49%) or going on a special diet for depression antenatally (40%) or postnatally (45%) (Buist, et al., 2005). These results suggest that compared to GPs, women have different ideas about how depression should be treated in the antenatal and postnatal periods and that women

generally favour natural remedies whereas GPs prefer antidepressant medication (Buist, et al., 2005). This result mirrors findings of earlier studies where health professionals and the general public held differing views on treatment for major depression (Jorm, et al., 1997d). Buist et al., (2005) also measured women's actual help-seeking behaviour for issues such as crying babies, not coping, sleep problems for themselves or their babies and general advice. They found that women primarily sought help from their family (50%), partner (29%), GP (29%) or maternal and child health nurse (28%) for these issues (Buist, et al., 2006).

GPs (91.1%) were significantly more likely than Maternal and Child Health Nurses (MCHNs) (81.7%) and midwives (79.3%) to diagnose depression both antenatally and postnatally. GPs were also significantly more likely to choose antidepressants antenatally than MCHNs and midwives, and significantly more likely than midwives but not MCHNs to choose antidepressants postnatally (Buist, et al., 2006). Midwives were more likely than GPs to select inappropriate medications, such as antibiotics, analgesics or antipsychotics for postnatal depression (Buist, et al., 2006). In summary, knowledge and awareness of postnatal depression amongst these health professionals was high, but further education to increase the awareness of antenatal depression, and the safety risks and alternatives to medication is needed, especially in midwives (Buist, et al., 2006).

2.7 International studies

The literature presented thus far relates to mental health literacy studies that have been conducted in Australia. However, many surveys have been undertaken of the mental health literacy of the general public and health professionals in other countries. The resulting papers are described in Appendix 2.

Forty-seven papers described the findings from international studies conducted in fourteen countries. The findings from these studies were broadly similar to those reported for Australian studies. The following sections briefly describe the outcomes of these international studies in terms of recognition of disorders, recommendations for help-seeking, knowledge of causes and risk factors, beliefs about recovery and stigma/social distance

2.7.1 Recognition of mental disorder

The international literature demonstrated that mental disorders were not well recognised by the general public, although recognition appeared to have improved over the past ten years.

For example, in a 1990 mental health literacy survey of 3098 members of the German general public, only 28% of West German respondents and 21.8% of East German respondents were able to correctly identify depression from an unlabelled vignette (Angermeyer & Matschinger, 1999). When respondents in the survey were asked to identify schizophrenia from an unlabelled vignette, even fewer respondents from West (22.0%) and East (19.2%) Germany correctly identified the disorder (Angermeyer & Matschinger, 1999). When 5025 members of the German public were surveyed in 2001, the majority of respondents identified the symptoms depicted in the schizophrenia (70.2%) and depression (62.2%) vignettes as an indication of mental illness but still had difficulty actually labelling the vignettes correctly (Angermeyer & Matschinger, 2003), although no actual data on identification rates were presented in the article..

Similar to the 2001 German study cited above, a mental health literacy survey of 1737 members of the Swiss general public in 1998/1999 demonstrated that unlabelled schizophrenia and depression vignettes were recognised as mental disorders. However the general public had difficulty actually naming the disorders. Schizophrenia (73.6%) was more often recognised as a mental illness than depression (39.8%). In contrast to the previous studies, depression was more often viewed as a normal psychological state and designated as a 'life crisis', rather than an actual mental disorder (Lauber, Nordt, Falcato, & Rössler, 2003b.).

In 2004, Magliano and colleagues conducted a nationwide mental health literacy survey of 1888 people, including members of the general public, mental health professionals and relatives of people with schizophrenia in Italy (Magliano, De Rosa, Fiorillo, Malangone, Maj, & National Mental Health Project Working Group (2004b). The researchers found that between 46% and 54% of respondents correctly identified schizophrenia from the vignette.

2.7.2 Recommendations for help-seeking and treatment

The international literature demonstrated that the lay system (e.g. friends and family), GPs and counsellors were often viewed positively as a source of help. Psychiatrists and psychologists were less likely to be endorsed. However, there is evidence of an increase over the past 10 years in the endorsement of psychiatrists and psychologists for the treatment of the disorders. The general public often did not endorse commonly used psychiatric interventions, such as antidepressants or psychotherapy for depression, and antipsychotics or admission to a psychiatric ward for schizophrenia. There was a strong belief in using non-standard treatments, such as vitamins and

minerals, for the treatment of depression. Psychological treatments (such as counselling) were viewed more positively than psychiatric medications, which were often seen as being more harmful than helpful for psychiatric disorders (Angermeyer & Matschinger, 1999; Angermeyer, Matschinger, & Riedel-Heller, 2001; Lauber, Carlos, & Wulf, 2005; Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004c; Ozmen, Ogel, Aker, Sagduyu, Tamar, & Boratav, 2005)

There was a considerable discrepancy between the general public and mental health professionals in their beliefs about mental disorders, especially with regard to treatments. Mental health professionals exhibited higher levels of mental health literacy than the general public however, the public have moved closer to the beliefs of professionals in the last ten years (Magliano et al 2004c; Magliano, De Rosa, Fiorillo, Malangone, Guarneri, Marasco, Maj, & The Working Group of the Italian National Study on Families of Persons with Schizophrenia, 2004a.; Parker, Lee, Chen, Kua, Loh, & Jorm, 2001).

2.7.3 Knowledge about causes and risk factors

The general public frequently endorsed psychosocial stress as a causal explanation for both depression and schizophrenia. Biological causal explanations were also frequently endorsed for schizophrenia, but much less frequently endorsed for depression (Lauber, Nordt, Falcato, & Rössler, 2004; Magliano et al 2004a; Schomerus, Borsche, Matschinger, & Angermeyer, 2006a and b; Stip, Caron, & Lane, 2001; Stuart & Arboleda-Florez, 2001)

2.7.4 Beliefs about recovery

International mental health literacy studies demonstrated that the general public were generally optimistic about the outcome for people with mental disorders who received appropriate treatment, but were not optimistic about outcomes for people who did not receive treatment for their disorder. The public were more optimistic about the outcomes for depression than schizophrenia (Angermeyer & Matschinger, 2003; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Parker, Lee, Chen, Kua, Loh, & Jorm, 2001).

2.7.5 Stigma and social distance

Portions of the general public perceived people with mental disorders as dangerous and unpredictable and reacted with fear and increased desire for social distance. This was particularly true for people with schizophrenia, who were more frequently considered violent and unpredictable compared to people with depression. High levels of dangerousness and unpredictability were associated with greater social distance,

especially toward people with schizophrenia and in relationships where greater closeness was implied (e.g. having a person with a mental disorder marry into the family) (Angermeyer & Matschinger, 2005c; Angermeyer & Matschinger, 2004a and b; Dietrich, Matschinger, & Angermeyer, 2006; Gaebel, Bauman, Witte, & Zaeske, 2002; Lauber, et al 2004; Ozmen, Ogel, Aker, Sagduyu, Tamar, & Boratav (2004); Stuart & Arboleda-Florez, 2001; Tanaka, Inadomi, Kikuchi, & Ohta, 2005).

The conclusion from other recent reviews of mental health literacy studies (see Angermeyer & Dietrich, 2006; Jorm & Kelly, 2007) are consistent with these conclusions.

2.8 Interventions aimed at increasing mental health literacy

A range of programs from large national campaigns to small group educational interventions have been used to improve mental health literacy.

National campaigns aimed at increasing awareness of mental disorders, especially depression, have been undertaken in many different countries around the world. For example, the Defeat Depression Campaign in the United Kingdom carried out a media campaign between 1991 and 1996, with the aim of educating the public about depression and its treatment and the importance of early help-seeking, in addition to stigma reduction (Paykel, Hart, & Priest, 1998). In order to assess the effectiveness of the campaign, surveys of public attitudes in Great Britain were conducted in 1991, 1995 and 1997 (Paykel, et al., 1998). About 2000 people were surveyed each time and structured interviews were undertaken to determine respondent's attitudes and views on depression and its treatment, and to collect information about participant's stigmatising attitudes and views about GPs. Because this was a national campaign, it was not possible to have control groups (Paykel, et al., 1998).

There were significant positive changes in attitudes to depression, reported experience of it and attitudes toward antidepressants. Most of the analyses demonstrated a positive shift in views of between 5% and 10% (Paykel, et al., 1998). Interestingly, although the views on the use of antidepressants for the treatment of depression improved over time, many still regarded antidepressants as addictive. These views were in line with other evidence of poor compliance with medication (Paykel, et al., 1998). The authors concluded that although they could not state with certainty that the Defeat Depression Campaign was responsible for these changes, since there were other independent medical initiatives during the five years of the campaign (generally targeted to medical professionals), the campaign coincided with significant adverse

publicity about murders by people with schizophrenia and that without the campaign, would most likely have had a negative impact on attitudes to psychiatry (Paykel, et al., 1998).

Other community education campaigns have been undertaken in the United States (Johannessen, McGlashan, Larsen, Horneland, Joa, Mardal, Kvebaek, Friis, Melle, & Opjordsmoen, 2001) and in Norway (Regier, Hirschfeld, Goodwin, Burke, Lazar, & Judd, 1988). The Depression Awareness Recognition and Treatment (DART) program in the USA was designed as a multi-phase project to educate the American public and health professionals that mood disorders, specifically major depression, bipolar disorder and dysthymic disorder, are common, serious and treatable (O Hara, Gorman, & Wright, 1996). In developing the program, researchers contacted both professional and public representatives, conducted literatures searches, ran focus groups and surveyed 500 households (O Hara, et al., 1996). The research demonstrated that respondents were reasonably knowledgeable about the mood symptoms of depression, but were less likely to know about the physical symptoms, changes in psychomotor state, energy or sleep. Moreover, most believed that the person experiencing depression could recover through their own efforts (O Hara, et al., 1996).

The DART program supported professional training and development of health professionals in addition to a large campaign aimed at the general public. Eighteen, two-day educational training programs were held in 1996 with 1221 health, mental health and social service professionals who were responsible for providing services to rural residents in the American Midwest. The training program included education about the identification and treatment of depression (O Hara, et al., 1996). Participant knowledge was assessed prior to commencing the course, at the completion of the program and six months post intervention. Results demonstrated significant increases in levels of knowledge about depression, which were sustained at the six-month follow-up (O Hara, et al., 1996). In addition, several of the follow-up questions asked respondents about changes in their professional behaviour and knowledge base that may have resulted from the training. There was evidence of positive changes in these areas, but the efficacy of the intervention is difficult to assess in the absence of a control group (Johannessen, et al., 2001).

The early treatment and intervention program (TIPS) project in Norway for first-episode schizophrenia was designed to test whether early treatment of first-episode psychosis could improve the course of the disorder (Johannessen, et al., 2001). Of particular interest was the impact of information and education about early psychosis on the

general public, health care professionals and schools. The program aimed to change the help-seeking behaviour of the general public by focusing on available help and positive outcomes associated with earlier help-seeking, as well as reducing the stigma associated with schizophrenia and psychiatry in general (Johannessen, et al., 2001). In an attempt to achieve this goal, 110,000 households in Norway received a brochure about the project, and mass media campaigns, advertisements, merchandise (such as t-shirts advertising the campaign and mugs distributed to businesses), brochures, educational booklets and public meetings about psychosis were distributed (Johannessen, et al., 2001). Health professionals received educational programs tailored to meet their specific needs, and letters asking them to refer patients as soon as possible for specialist treatment (Johannessen, et al., 2001). Every high school in Norway was visited twice a semester and programs were developed for teachers, counsellors and students. These programs included discussions about signs and symptoms and presentation and discussion of illustrative cases of psychosis (Johannessen, et al., 2001). The program was evaluated by comparing people with first episode psychosis who were detected early and provided with early treatment in Rogalan (Norway) (the experimental sector where an early detection centre was established with the aim of reducing the duration of untreated psychosis) with those in two other jurisdictions where existing detection and referral processes were in operation, but no early detection centres were in operation (Johannessen, et al., 2001). Using a common set of rating instruments at baseline, three months, one, two and five years, researchers were able to measure differences between people who received early treatment and intervention for psychosis against those who relied on existing referral systems (Johannessen, et al., 2001). It was found that the duration of untreated first-episode psychosis was reduced significantly (from 114 weeks to 26 weeks) following the campaign which was reported to increase help-seeking behaviour by expanding pathways to care and reducing stigma through educational campaigns (Johannessen, et al., 2001).

A similar campaign has been implemented in Australia. *beyondblue: the national depression initiative* was launched in Australia in October 2000. According to *beyondblue* itself, *beyondblue* is

a bipartisan initiative of the Australian, state and territory governments with a key goal of raising community awareness about depression and reducing stigma associated with the illness” (*beyondblue: the national depression initiative*, 2006 p.1).

It has five priority areas: “increasing community awareness of depression, anxiety and related substance misuse disorders and addressing associated stigma; providing people living with depression and their carers with information on the illness and effective treatment options and promoting their needs and experiences with policy

makers and healthcare service providers; developing depression prevention and early intervention programs; improving training and support for GPs and other healthcare professionals on depression; and initiating and supporting depression-related research (Jorm, et al., 2005c).

There has been one study of the impact of *beyondblue* on the Australian publics' recognition of depression and beliefs about depression treatment. This study employed data from the Australian 1995 and 2003/2004 national mental health literacy surveys (Jorm, et al., 2005c). The survey conducted in 2003/2004 included a question about the respondent's knowledge/awareness of *beyondblue*. Australian states that provided funding to *beyondblue* and hence were likely to have been more exposed to its promotional campaign were classified as high-exposure states (although this term is now no longer used, it was an important distinction in the study reported, so is used to describe the findings). The remaining states were classified as low-exposure states. Respondents from high-exposure states were twice as likely as those from low-exposure states to recall and recognise *beyondblue* (Jorm, et al., 2005c). More significantly, there were greater changes over time in beliefs about treatments for depression among respondents from the high-exposure states, especially with respect to the benefits of counselling, medication and general help-seeking (Jorm, et al., 2005c). A greater decrease in the belief that it is helpful to deal with depression alone was also recorded in the high-exposure states (Jorm, et al., 2005c). In terms of antidepressant use, counselling, and the value of help-seeking in general, the authors concluded that *beyondblue* may have brought the publics' views closer to professionals' views about the benefits of these treatments (Jorm, et al., 2005c). Unexpectedly, they also found an increase in the belief about the helpfulness of tranquillisers and sleeping pills, which they suggested may have been a spill-over from the increase in the belief about the helpfulness of antidepressants (Jorm, et al., 2006a). States with high-exposure to *beyondblue* messages also demonstrated a two-fold increase in the percentage of people reporting that they had experienced a problem like the one presented in the vignette, which may be due to greater awareness or openness about depression (Jorm, et al., 2006a). Another important change in the high-exposure states was an increase in the belief that the person in the vignette would be discriminated against by others in the community if they knew about his/her problems (Jorm, et al., 2006a). The authors interpreted this as a positive finding, perhaps reflecting an increased awareness of discrimination as an issue for people with depression in the high-exposure states (Jorm, et al., 2006a). Respondents in the high-exposure states also indicated that they would be more willing to report depression in themselves and others (Jorm, et al., 2005c).

The campaigns described above were large scale public health initiatives. There have also been smaller trials of educational interventions. For example, Buist et al. (2007) evaluated an intervention designed to raise awareness about postnatal depression. In 2002, postnatal women (n=414) were recruited from 43 maternity hospitals/areas and district health services around Australia at the time of their 6-12 week postnatal checkups and received no intervention or screening for postnatal depression (group one). The second group of postnatal women (n=895) were recruited two years later, and had participated in the routine screening program for postnatal depression that had been introduced into Australia. As part of routine screening, participants in group two were screened for postnatal depression using the Edinburgh Postnatal Depression Scale (EPDS) and received an information booklet about the disorder. Both groups completed a series of questionnaires, including a mental health literacy survey, the Survey of Services Used questionnaire and the EPDS. Respondents in group two, who had been routinely screened for depression and provided with an information booklet, were significantly more likely to recognise depression from an unlabelled vignette (60.4%) than women in group one (47.1%) who had received no intervention or information on postnatal/antenatal mood disorders (Buist, et al., 2007). The screening program also led to more realistic expectations and increases in knowledge of where to obtain help (Buist, et al., 2007). Other factors may also have influenced the findings. For example, the two year difference between the two samples may have reflected improvements associated with other campaigns rather than the specific screening intervention.

The possible value of mental health first aid training as an intervention to raise the mental health literacy of the Australian public has also been considered (Kitchener & Jorm, 2002). First aid courses have been taught in Australia for more than 100 years and train around 315000 participants annually (Kitchener & Jorm, 2002). However, until recently, there has been no such training for mental disorders. As a consequence, a specialised mental health first aid course was developed by researchers in Australia (Kitchener & Jorm, 2002). This training is known as Mental Health First Aid (MHFA).

An evaluation of the effectiveness of MHFA training in the workplace environment in two large government agencies in Canberra, Australia, showed that the course improved participants' mental health literacy, but interestingly, also improved their own mental health (Kitchener & Jorm, 2004). In the trial, 301 participants were randomised either to MHFA training or a wait-list control (Kitchener & Jorm, 2004). Participants completed pre and post test questionnaires, similar to those described by Jorm et al. (2005c). Compared with the control group, the intervention group reported greater

confidence in providing help to others, greater likelihood of advising people to seek professional help, decreased social distance from people experiencing depression, views about treatment that were more closely aligned with those of health professionals and improvements in their own mental health (Kitchener & Jorm, 2004).

There is evidence that Internet interventions can also improve the mental health literacy of the general public in Australia (Christensen, Griffiths, & Jorm, 2004). A randomised controlled trial of 525 individuals with elevated depressive symptoms was conducted in Canberra, Australia. Respondents were recruited from the community via a questionnaire sent to individuals randomly selected from the electoral roll and invited to participate if they had access to the Internet, scored 22 or above on the Kessler-10 Psychological Distress Scale and were not receiving clinical care from a psychiatrist or psychologist (Christensen, et al., 2004). Participants were randomly allocated to a website offering information about depression (BluePages) (n=166), a cognitive behavioural therapy website (MoodGYM) (n=182) or a control intervention using an attention placebo (n=178). Relative to control, respondents who were allocated to BluePages demonstrated significantly improved understanding of effective evidence-based treatments for depression and reduced personal stigma (Christensen, et al., 2004; Griffiths, et al., 2004). MoodGYM respondents demonstrated an increased knowledge of cognitive behavioural therapy relative to control (Christensen, et al., 2004). In addition, both groups showed a significant reduction in depression symptoms relative to the attention control (Christensen, et al., 2004).

Similar findings to those described above have also been reported from a study which investigated the efficacy and feasibility of a web-based depression stigma education tool for healthcare professionals in the United States of America (Finkelstein & Lapshin, 2007). The researchers demonstrated a significant reduction in depression stigma and a significant increase in the participants' knowledge about depression at the conclusion of the web-based intervention (Finkelstein & Lapshin, 2007).

There have also been a number of programs in developing countries to improve mental health and general health literacy. Because general literacy (ability to read and write) rates in developing countries are typically lower than in developed countries (Rahman, Mubbashar, Gater, & Goldberg, 1998), different methods to increase community awareness of mental disorders have been trialled. Pakistan, with a general literacy rate of only 40%, attempted to promote awareness of mental health issues at all levels of health personnel, to involve school children and teachers in the community, and to collaborate with other sectors such as traditional faith healers (Rahman, et al., 1998).

One particular mental health literacy program, aimed at school children in a rural area of Pakistan involved using these children to disseminate health information to family, friends and neighbours (Rahman, et al., 1998). In this study, school children, who are often regarded as 'the eyes and ears of the community,' underwent a four-month program of mental health education. At the completion of the program, the attitudes and mental health knowledge of the school children, their friends and neighbours had increased significantly compared to a control group (Rahman, et al., 1998). The results indicate that mental health literacy can be increased using techniques that are culturally and contextually sensitive and appropriate and which take into account general literacy issues.

2.9 Limitations of reviewed studies

Some of the common limitations of the studies should be noted.

Methodological differences, such as using unlabelled vignettes or labels of mental disorders as stimuli for surveys and open-ended or multiple choice questions, may affect study results. For example, open-ended questions may require more thought and/or writing (and when respondents are pressed for time they may not provide comprehensive answers even if they know what an answer should be) whereas multiple choice questions may be easier to answer. Clearly, a consideration of such methodological differences is essential in interpreting these research findings (Angermeyer & Dietrich, 2006).

The relationship between attitudes or intentions expressed in mental health literacy surveys and actual behaviour of respondents has not been studied in detail due to the complexity of this type of research (Angermeyer & Dietrich, 2006). As a result, it is not known if the public's beliefs and attitudes about mental disorders, such as treatment they would use, help-seeking behaviour, desire for social distance or stigmatising behaviour, is congruent with actual behaviour in the context of a mental disorder (Angermeyer & Dietrich, 2006).

Although mental health literacy studies have investigated several different mental disorders, the majority have focused on depression and schizophrenia. It is not known to what extent the results might generalise to other mental disorders. The findings do however suggest that findings differ between disorders.

There are a paucity of cross cultural studies of mental health literacy studies, and few studies of mental health literacy in non-Western societies. Such studies may shed light

on the phenomenon of mental health literacy, and provide important data for pragmatic interventions, particularly in low income countries.

2.10 Conclusion

Australian and international studies of the mental health literacy of the general public have demonstrated that a sizeable proportion of respondents in many countries cannot correctly identify and label mental disorders, that they differ from mental health professionals in their beliefs about causes and the most effective treatments for the disorders, and that they hold stigmatising attitudes which may hinder recognition and appropriate help-seeking (Angermeyer & Matschinger, 1999; Jorm, et al., 1997a; Ozmen, et al., 2005; Priest, Vize, Roberts, Roberts, & Tylee, 1996). Findings demonstrated a preference for psychological treatments by the general public for depression, including psychotherapy (Priest, et al., 1996) and counselling (Angermeyer & Matschinger, 1996; Jorm, et al., 1997a; Ozmen, et al., 2005; Priest, et al., 1996). Antidepressant medication was not usually the preferred treatment for the disorders and was generally considered addictive and/or harmful by the general public. The studies have also demonstrated that the mental health literacy of males is inferior to that of females and that a higher level of education and exposure to a mental disorder is associated with better mental health literacy.

There is evidence that mental health education campaigns and interventions can increase mental health literacy and produce positive outcomes. The fact that mental health information can increase mental health literacy and reduce stigma is important and raises the possibility that media interventions could potentially play a critical role in improving public mental health literacy. Accordingly, the role that journalists play in contributing to the dissemination of health information will be explored in the next chapter.

CHAPTER THREE

MEDIA PORTRAYAL OF MENTAL ILLNESS – A REVIEW OF THE LITERATURE

3.1 Introduction

Australians have ready access to a large variety of media including newspapers, magazines, TV, radio, and the Internet. Through these media the general public is often exposed to material containing mental health content and there is evidence that this information influences people's attitudes towards mental health and illness (Francis, Pirkis, Dunt, & Blood, 2001). After briefly summarising the penetration and uptake of newspaper media in Australia, this chapter reviews the evidence concerning media portrayal of mental illness, describing existing literature reviews of the topic and presenting an updated summary of the methodology, findings and limitations of relevant studies for the period between 1997 and 2007. The latter includes a description of four key factors influencing media portrayal of mental illness (type of media, type of mental disorder, sources of information, and characteristics of the studies). Thereafter, the chapter addresses additional factors, such as whether the story is portrayed in fictional media, non-fictional media, magazines or newspapers, which may potentially influence how mental illness is reported. The next section reviews evidence concerning the beliefs of people who have previously experienced a mental disorder/consumers of mental health services, carers and journalists about the portrayal of mental health and illness by the media. The chapter concludes by highlighting the need to further explore the publics' recall of information from the media about mental illnesses.

3.2 Penetration of newspaper media in Australia

The penetration by newspaper media in Australia is large. For example, there are 49 daily English language newspapers in Australia including two national, ten metropolitan and 36 regional daily newspapers (Australian Press Council, 2006b). There are 11 metropolitan Sunday newspapers, 168 suburban/community newspapers, 238 country press newspapers and 162 regional community newspapers (Australian Press Council, 2006b). Additionally, there are nine non-English daily newspapers, four in Chinese languages and the others in Greek, Italian, Korean, Serbian and Vietnamese, and more than 100 other non-English language newspapers in 35 languages (Australian Press Council, 2006b). Worldwide online access to newspapers has increased 200 percent over the past five years (World Association of Newspapers, 2006) and Australians now have access to over 300 newspapers online.

In addition the uptake of newspapers by Australians is large. Specifically, a total of 2.3 million Australians purchase one or more national and/or metropolitan newspapers each day, which are read by an estimated nine million people (Australian Press Council, 2006b). On Saturdays, more than three million national and/or metropolitan newspapers are sold and read by an estimated 10.4 million people (Australian Press Council, 2006b). The number of purchases increases to 3.5 million on Sundays with an estimated readership of 10.8 million people (Australian Press Council, 2006b). Thus an estimated 54.6% of Australians aged 15 years or older read a weekday newspaper, a figure that rises to approximately 65% on the weekend (Australian Press Council, 2006b). These figures indicate that a large proportion of Australians access newspapers in either hard copy or online.

3.3 The portrayal of mental illness in the media: Previous literature reviews

There has been considerable research interest in the question of how mental health and illness are portrayed in both fiction and non-fiction media. This interest has largely been prompted by the potential for media stories with mental health and illness content to negatively influence people's beliefs about these topics (Domino, 1983; Wahl & Lefkowitz, 1989).

Major reviews investigating the portrayal of mental health in the media have been undertaken previously, and the results of these reviews are summarised below (Francis, et al., 2001; Pirkis, Blood, Francis, & McCallum, 2005; Pirkis, Blood, Francis, & McCallum, 2006b; Wahl, 2003).

A review of studies published prior to June 2001 was undertaken by Australian researchers (Francis, et al., 2001). The researchers examined three major content areas – the portrayal of mental health and illness in the media, the impact of media portrayal on community attitudes to mental illness, and the impact of mental health promotion in the media. The results from their analysis of 23 studies, which considered the portrayal of mental health and illness in both fiction and non-fiction media, were that:

- mental illness is portrayed negatively in the mass media;
- media representations of mental illness promote negative images and stereotypes;
- there is a strong link between mental illness and violence in media messages; and
- stories associating mental illness with violence were given greater prominence than positive items about mental illness (Francis, et al., 2001).

In addition, the authors found that the majority of literature focused on the nature and extent of media portrayals of mental health and illness and rarely considered the impact on community attitudes or impact of mental health promotion in the media. They also reported that the media is an important influence on community attitudes to mental illness and that members of the public who cited the media as the most important source of their information and beliefs on mental health and illness had more negative attitudes to mental illness (Francis, et al., 2001).

The majority of studies examining media depictions of mental disorders have focused on adult media, even though children also have extensive exposure to mass media and the messages they contain. However, a review of those studies which have been conducted on children's film depictions of mental illness suggests that the negative portrayals seen in adult media are also common in children's media (Wahl, 2003).

More specifically, the review of studies found that:

- depictions of mental illness in children's films were frequent and appear to contain the negative stereotypes seen in adult media;
- characters with mental illnesses were presented as violent, aggressive and fear-inducing;
- characters tended to be unattractive in personal appearance, typically fail in life, were ridiculed by others and seldom benefited from treatment; and
- the media's disparaging use of slang in relation to mental illnesses was common in children's films (Wahl, 2003).

Two other reviews of media portrayal of mental illness have also focused on entertainment media, with specific focus on adult media (Pirkis, et al., 2005; Pirkis, et al., 2006b). These reviews described the extent, nature and impacts of the portrayal of mental disorders in films and television reported in peer-reviewed journal articles published up to January 2005. The main findings from these reviews were that:

- on screen portrayals were frequent and generally negative;
- myths, stereotypes and stigma about mental illness were perpetuated;
- a biased picture of treatments for mental disorder was presented, in particular, one which focused on visually compelling, but relatively rare, treatments such as ECT;
- portrayals had a cumulative negative effect on the public's perception of people with mental illness; and

- negative portrayals increased stigma and reduced help-seeking as a result of the collective impression of what mental illness means (Pirkis, et al., 2005; Pirkis, et al., 2006b).

The authors concluded that the film and television media needed to collaborate with the mental health sector to counter negative portrayals of mental illness and promote more positive ones (Pirkis, et al., 2005; Pirkis, et al., 2006b).

More recently, a review of the content of media from all three sources described above – children’s media, fictional films and television and non-fictional media was conducted (Stout, Villegas, & Jennings, 2004). Specifically, 34 research studies published between 1990 and 2003 were examined and reviewed with regard to the portrayal of mental disorders in the media, how media images of mental illness impact on individuals’ knowledge, beliefs, attitudes and behaviours with regard to mental illness, and the role of the media in reducing the stigma associated with mental illness. The findings consistently demonstrated that mental illness is regularly misrepresented in media depictions through exaggerations and misinformation. In the majority of studies, the researchers concluded that depictions were often inaccurate and in particular, that they misrepresented people with mental illness as violent and provided inaccurate information about the nature of the disorders.

Although the reviews cited above provide information about the issue, there is now a clear need to undertake a review that incorporates more recent studies. In addition to the potential for greater coverage, such a review will identify whether the themes identified by the earlier studies continued to predominate or whether there have been any changes in the representation of mental health and illness by the media. In addition, this review describes the main themes for each mental disorder described in individual research papers.

3.4 Current literature review

The current review of literature considers key studies that were published between February 1997 and March 2007. This ten-year period was chosen to correspond to the literature review on mental health literacy in the previous chapter and encompasses the period since mental health literacy was first described in the literature. It was also designed to capture any new studies of fictional and non-fictional media.

3.4.1 Methodology

The MEDLINE, PsychINFO and Current Contents databases available through OVID were searched to identify studies relating to the portrayal of mental health and illness in the media. The search terms used to identify relevant English language articles published between February 1997 and March 2007 were:

((mass media) OR newspapers OR radio OR television OR magazines OR film OR literature OR books OR internet) AND ((mental disorder) OR (mental illness) OR psychiatr\$ OR depression OR schizophrenia OR anxiety OR (mood disorders) OR (obsessive compulsive disorder)) AND (portrayal).

From the 81 citations identified, 21 duplicate results were removed. The titles were then reviewed to exclude clearly irrelevant studies. Of the remaining studies, abstracts were screened to further exclude irrelevant studies. The remaining papers were read and were retained if they satisfied the inclusion criteria. Included key studies were those which were written in English, published between 1997 and 2007, and had a primary focus on media. To limit the review to key studies, papers were excluded if they were small scale descriptive studies, case studies, anecdotal reports, portrayals of a single incident, commentaries, studies where media was not the primary focus, intervention studies, studies which referred to the media but had a focus on mental health literacy or stigma (reviewed separately in Chapter 2), and studies which had been originally published prior to 1997. In addition, the reference lists of the relevant articles were examined and additional articles were obtained, reviewed and included if appropriate. A total of 27 studies were included in the review.

The results are presented in Table 3.1. The entries for Table 3.1 are grouped alphabetically by the country of the study (beginning with Australia), and within each country group are presented in reverse chronological order. Studies are categorised by type of media (entertainment (fictional) or news (non fictional)), and the medium by which information was delivered (e.g., newspapers, radio, television etc.). Twenty-seven studies met the inclusion criteria. Sixteen studies were of non-fictional portrayals (newspapers, television, radio, periodicals) of mental health and illness, 10 were of fictional portrayals (movies, television, films) and one study analysed both fictional and non-fictional portrayals of mental health and illness.

3.4.2 Main findings

It is clear from the summaries provided in Table 3.1 that mental health and illness were portrayed negatively in both fictional and non-fictional media. Two studies published in 2004 and 2005 (Francis, et al., 2005; Francis, et al., 2004) included fewer references to violence. However, the common themes of violence, unpredictability, fear, crisis, risk and deviance were still evident. In addition, the reviewed papers provided some evidence that fictional media was associated with more frequent media portrayals of negative attributes, and psychosis was portrayed more negatively than depression. The following sections examine the factors that appear to influence the media portrayal of mental illness. These factors are divided into four types: type of mental disorder, reporting source, characteristics of the studies and media factors.

3.4.3 Type of mental disorder

Portrayal of depression versus schizophrenia

Studies which considered the portrayal of depression, regardless of the medium, demonstrated more accurate and positive representations of mental health than did studies which considered schizophrenia (Francis, et al., 2005; Rowe, et al., 2003). Studies of portrayals of schizophrenia in the media frequently found that schizophrenia was linked to violence and community fear and that they often used the term inappropriately in non-medical, metaphorical contexts (Blood, et al., 2005; Blood, et al., 2002; Francis, et al., 2005; Pirkis, et al., 2005).

For example, one Australian study found that media portrayal of depression differed from that previously reported for schizophrenia (Rowe, et al., 2003). Specifically, a search of print media in Western Australia conducted in 2000 investigated representations of depression in newspapers. Researchers identified 49 articles containing the word 'depression' and conducted a systematic thematic analysis to identify the form and content of the articles, focusing on the ways in which depression was constructed (Rowe, et al., 2003). They found that unlike portrayals of other more severe mental illnesses, where the emphasis is often reported to be on the protection of 'others' from the person with the mental illness, the media stressed the need for protection of the 'sufferer' of depression (Rowe, et al., 2003). Depression in Western Australian newspapers was constructed via three broad discourses – the biomedical (attributing depression to a biological cause), the administrative/managerial (how to improve the recognition and management of depression) and the psychosocial (emphasising psychological and social bases for unhappiness), but all presented it as beyond the control of the individual who needed management (Rowe, et al., 2003).

Another study also highlighted the differences in the way depression is portrayed in the media compared with more severe mental illnesses such as schizophrenia (Sainsbury Centre for Mental Health, Mental health Media, & Rethink, 2005). Based on a survey conducted in the United Kingdom in March 2005 to determine media coverage of mental health issues, the authors reported that the majority of coverage about both common and severe mental health problems was seen in the print media. Depression was the most covered diagnosis, accounting for 10% of coverage, and content relating to depression focused on positive messages about treatment and recovery (Sainsbury Centre for Mental Health, et al., 2005). By contrast, messages associated with severe mental health problems such as psychosis were linked to a high risk of violence and negative reports of mental health services (Sainsbury Centre for Mental Health, et al., 2005).

The authors of this study also conducted a focus group comprising members with experience of one of a range of mental health problems. They believed the media generated misconceptions and stigma based on reporting extreme incidents. However, consistent with the content analysis of media items, they distinguished between the media stigma associated with severe mental illness such as schizophrenia and common mental illnesses such as depression, suggesting that the former was all about danger and violence while the latter more to do with laziness and a need to 'pull yourself together' (Sainsbury Centre for Mental Health, et al., 2005).

In summary, media representations of depression appear to be more positive than media representations of schizophrenia, which still commonly link schizophrenia with violence.

3.4.4 Sources of information

The source of information for a media report also appears to influence its accuracy. For example, information obtained from police and coroners' reports is often transformed into stories linking mental illness with violence, even though such stories relate to relatively rare and specific circumstances (Blood, et al., 2001). In an Australian study, the most problematic type of news coverage resulted from information obtained from courts or from the police and the news frames employed to describe these stories often focused on the perceived risk of violence associated with people with mental illnesses (Blood, et al., 2001).

Similarly, in the United Kingdom, a survey found that comments from mental health service users and carers were rarely included in stories about severe mental health

problems, whereas comments from lawyers, criminal justice professionals and victims' families were more often included and often linked crime to severe mental illness (Sainsbury Centre for Mental Health, et al., 2005).

3.4.5 Characteristics of the studies

Size of the study

Larger studies tend to be associated with more rigorous results regarding the portrayal of mental illness (see Pirkis, et al., 2001a). Reasons for this may be that larger studies sample a greater range of media, such as newspapers, radio and television, ensuring that reporting of these issues is considered across the spectrum of media. Smaller studies may also be reporting biased samples of media.

For example, the world's largest study of non-fiction media was undertaken in Australia (see Pirkis, et al., 2001a) and presented both a quantitative (Pirkis, et al., 2001b) and qualitative (Blood, et al., 2001) analysis of the reporting and portrayal of suicide and mental health and illness in the Australian media. Many of the subsequent papers produced by the authors used a subset of the data collected for this project (hereafter referred to as the Media Monitoring Project).

The Media Monitoring Project examined how the Australian media presented 17151 stories about mental health, mental illness and suicide from radio, television and newspapers between March 2000 and February 2001. The study found that media reporting on these topics was extensive across all media types, there was variability in terms of the nature and quality of stories about mental health and illness but that in general, good items outnumbered poorer items (Pirkis, et al., 2001a).

Other smaller studies have reported that mental health and illness stories are portrayed inappropriately. For example, an Australian study conducted by Hazelton (1997), analysed the discourse of 490 mental health and illness stories from two Australian newspapers in 1994 (The Australian and The Examiner) and demonstrated that coverage of mental health stories tended to be negative overall (Hazelton, 1997). Hazelton (1997) identified a range of themes and topics in Australian newspapers and identified a number of interpretive frames within which mental health stories were constructed. The underlying ideological nature of the discourse was then extrapolated. The majority of articles were framed according to at least one interpretative frame. In both newspapers, the 'disorder, crisis and risk' theme predominated. The author concluded that media coverage of mental health draws on "relatively standard and predictable narratives, discourses and preferred images" (Hazelton, 1997 p.87).

Smaller overseas studies have demonstrated that mental illness is predominantly portrayed negatively in the mass media and that these portrayals promote negative images and stereotypes and incorrectly link mental illness to violence (Huang & Priebe, 2003; Wahl, et al., 2002). Whilst the size and scope of the studies may explain these differences, other factors, such as the date of the study and the type of media analysed, may also have influenced findings. These are discussed below.

Date of publication: Later compared to earlier surveys and analyses

There may be a link between when a study was conducted and the findings from the study. For example, many of the older studies reported content containing very negative stereotypes about people with mental disorders (Bokey, et al., 2000; Hazelton, 1997; Rosen, et al., 1997). Conversely, some of the more recent studies have reported improvements in the portrayal of mental health and illness by the media (Francis, et al., 2005; Francis, et al., 2004), especially when journalists have been exposed to, or provided with, guidelines for appropriate reporting on these issues (Skehan, Greenhalgh, Hazell, & Pirkis, 2006). However, this pattern is not necessarily seen for smaller overseas studies, where even recent studies may still contain negative portrayals of mental illness.

Country where study conducted

The country where a study was conducted may be a relevant factor in influencing results, although the evidence for this is comparatively weak. For example, direct comparisons between portrayals in the USA, UK and Australia suggest that depictions may be somewhat more positive in the USA and Australian media (Huang & Priebe, 2003). This finding warrants further attention.

3.4.6 Media factors

There were two media factors that impacted on the portrayal of mental illness. These included whether mental illness is portrayed in fictional or non-fictional media and the type of publication in which a story appears.

Fictional versus non-fictional portrayals of mental health and illness

A consideration of the literature suggests that stereotypical depictions of people with mental illnesses in fictional media were common. The studies presented in Table 3.1 revealed that mental illness was portrayed more negatively in fictional media compared with non-fictional media. Fictional media also portrayed people with a mental illness as

significantly more violent than people with a mental illness in the real world (Diefenbach, 1997)⁴.

The negative depictions portrayed people with mental illnesses as violent and aggressive, eccentrics, seductresses (women), self-obsessives, objects for scientific observation and simpletons and/or failures (Pirkis, et al., 2005). Mental health professionals were depicted as incompetent, sinister, unrealistically selfless or seductive (women) (Pirkis, et al., 2005).

Portrayal of mental health treatments was also unrealistic and distorted, with an emphasis on treatments that were visually compelling and had melodramatic potential, such as ECT or psychotherapy (Pirkis, et al., 2005).

In particular, studies of Australian and New Zealand movies (entertainment media) with prominent psychiatric themes, such as the movie '*Shine*' (Rosen, et al., 1997) sometimes misrepresented individuals with mental illnesses, their families and the professionals who try to assist them, resulting in negative stereotypical portrayals (Rosen & Walter, 2000). It has been suggested that filmmakers should consider all points of view when constructing stories about people with mental illness including those which celebrate the individual and their victories over the adversity of their mental illness and provide inspiration for those who live with psychosis and other disorders (Rosen & Walter, 2000). In summary, fictional portrayals of people with mental illness are, frequently, inappropriate, inaccurate and stereotyped.

The major negative themes in studies of non-fictional portrayals of mental health and illness were similar to those for fictional portrayals; however these were less common than for fictional media. Perhaps the most noteworthy differences were that recent non-fictional portrayals of mental illness, demonstrated more accurate and less stigmatising portrayals of disorders (Francis, et al., 2005). A greater proportion of information was accurate, although a large portion of items still conveyed misleading messages (Francis, et al., 2005), with the common themes of violence, risk, fear, dangerousness, unpredictability, criminality, horror and crisis still observed, along with people with

⁴ It should be noted that people with mental illness who are receiving treatment are no more likely to perpetrate violence than the general public (Mental Illness Fellowship of Australia Inc., 2005). Violent behaviour is slightly higher among people with a psychotic illness who are not receiving treatment, have a history of violence or are abusing alcohol or drugs (SANE, 2005b). In contrast with this small level of elevated risk, 30% of characters with mental illness were depicted negatively as violent in one study of entertainment media in the USA (Diefenbach, 1997). SANE Australia has calculated the lifetime risk of someone with a mental illness such as schizophrenia seriously harming or killing another person as .005% (SANE, 2005b), considerably less than that portrayed in the media.

mental disorders being portrayed as 'others' (Blood, et al., 2005; Diefenbach & West, 2007; Francis, et al., 2005; Francis, et al., 2004; Hazelton, 1997; Huang & Priebe, 2003; Nairn, et al., 2001; Pirkis, et al., 2001a; Rosen, et al., 1997; Wahl, et al., 2002).

Type of publication (magazines versus newspaper articles)

A further distinction can be made between the types of media where stories appear. As this thesis focuses on print media, the main differences are observed when magazines are compared with newspapers. For example, presentation of information on obsessive compulsive disorder (OCD) (Wahl, 2000), schizophrenia (Wahl, Borostovik, & Rieppi, 1995) and mental health (Wahl & Kaye, 1992) was more accurate in magazines compared with newspaper reports.

In general, depictions of mental health and illness in newspapers were negative, associated mental illness with crime or violence and promoted negative stereotypes.

3.4.7 Limitations of the studies reviewed in Table 3.1

Methodological differences between the studies may impact on the findings. Sample selection is the most common issue (Francis, et al., 2001), with many studies including only a small sample of media items, drawing their sample from only one or two different types of media, such as newspapers or television while neglecting other media such as radio, or from only a small number of examples of a particular medium (eg, only two newspapers). The use of non-representative samples is problematic in that it limits the generalisability of findings to the broader media (Francis, et al., 2001) as does a failure by some researchers to describe their methods of sample selection and the number of items analysed.

3.5 Other factors influencing media reports of mental health and illness stories

So far, this chapter has reviewed the literature with regard to media portrayals of mental illness and described four media factors that may influence how these issues are reported. In addition to the factors that have been elucidated from the studies reviewed in Table 3.1, there are other factors that may influence how stories about mental health and illness are reported. This section considers two of these: the mental health literacy of journalists and the role of guidelines in informing journalists about appropriate ways of reporting stories about mental illness.

A multitude of factors may potentially influence how journalists report and write stories, beyond the 'newsworthiness' of an item. Some insight into these factors is provided by

an Australian survey of 100 news producers concerning issues relevant to news and current affairs (Pearson & Brand, 2001).

The factors identified as influencing reporting included: journalists' own views, pressure relating to audiences, ratings and circulation, commercial interests such as advertising, ownership, public relations operatives, politicians and government, other journalists and other media (Pearson & Brand, 2001). The role of guidelines, policies and codes of practice in influencing media reports about mental illness has also been cited as important (Hunter Institute for Mental Health, 2006). However, only journalists' views and the role of guidelines will be discussed here, since they relate directly to mental health literacy. The other factors, though important, are beyond the scope of this dissertation.

3.5.1 Mental health literacy of journalists

The report by Pearson & Brand (2001) identified journalists' own views about issues as one of the primary factors influencing reporting. Journalists' views about these issues may be influenced by their own knowledge and beliefs – their mental health literacy.

In the absence of systematic research on the topic, this issue may be illustrated by a case example. Shelly Jofre, a reporter on the BBC's Panorama program, investigated a reported link between an antidepressant and the withholding of information about its safety by the pharmaceutical company that manufactured it in 2001, in the process referring to the antidepressant as a 'happy pill' (Jofre & Paterson, 2005). Jofre subsequently reported that in exclusively focusing on exposing the scandal of the cover-up she neglected to consider the people who use the medication to treat their mental illness. She says that at the time she did not know the true nature of the illnesses for which the medication was prescribed and that it was only by reading the thousands of emails sent to the BBC about viewers' experiences with the medication that she began to feel a sense of responsibility to learn more about the illness that it treated. She also reported that in retrospect she may have entertained "the suspicion that you can't really trust the testimony of people who are depressed or suicidal" (Jofre & Paterson, 2005 p.39). The viewers' comments clearly affected both Jofre and her editor such that they ran a follow-up story based solely on the experiences of people who had experienced a mental disorder. Jofre concluded that although journalists get stories on mental health wrong, it is not done with deliberate or malicious intent, but rather is the result of their ignorance about these issues (Jofre & Paterson, 2005). Thus, determining journalists' views about mental health and illness, and correcting

misconceptions and inaccurate information, seems both important and necessary if accurate information about mental health is to be communicated to the public.

The way journalists present stories (news framing), both spatially and textually, may also be influenced by the factors identified by Pearson and Brand (2001). News frame theory describes the devices employed by journalists to organise news discourse. This is also referred to as the story's angle or pitch. The ability of the general public to make sense of information reported about a specific event is limited by the news frames employed by journalists in constructing the story (Blood, Pirkis, Hickie, & Martin, July 2003).

Journalists routinely organise news discourse through the above 'frames,' which generally reflect what journalists deem is newsworthy or significant, their work or newsroom routines, and cultural assumptions journalists make about their audiences (Blood, et al., July 2003).

The news story's frame, often signalled in the newspaper headline, directs the reader to what is in the frame and to ignore what is excluded. This framing process sets limits on the information available to audiences who are trying to make sense out of the reported event, which is often beyond their direct experience (Blood, et al., July 2003 p.4).

News reporting typically involves a complex process of selection and sorting which is subject to modifications by journalists and editors (Hazelton, 1997). There appear to be a multitude of factors at play, which may influence media reports of mental health and illness. Based on the literature, it seems that journalists' own views about a topic are one of the main factors influencing how it is reported. Thus, educating journalists about mental health and mental illness may be an important component to ensuring more accurate coverage of these topics. The development of guidelines, policies and codes of practices is one way that this issue has been addressed in Australia and this is now discussed.

3.5.2 Guidelines, policies and codes of practice developed to improve media reporting of mental health and illness

A range of interventions to improve media reports about mental health, mental illness and suicide have been developed in Australia. These include the development and implementation of guidelines for journalists on the appropriate reporting of mental health topics (Australian Press Council, 2006a; Commonwealth Department of Health and Ageing, 2006; Hunter Institute for Mental Health, 2006; Penrose-Wall, Baume, & Martin, 1999). Common concerns about media reports that have led to the development of these types of guidelines, centre around the use of

inappropriate/sensational language, stigmatising and stereotyping mental illness, inappropriate headlines and story placement, lack of provision of information about available help or services, inappropriate use of medical terminology and privacy issues.

In Australia, the reporting guidelines form part of the National *Mindframe* Initiative, which was developed as a comprehensive strategy aimed at influencing the quality of media coverage of issues related to mental illness and suicide and at encouraging responsible, accurate and sensitive reporting (Hunter Institute for Mental Health, 2006). The strategy included a number of projects which focus on the provision of resources and education for media professionals, inclusion of the issues in tertiary journalism education, development of print and web resources for media professionals, supporting StigmaWatch (a program that monitors media portrayals of mental illness and suicide to ensure they are accurate and respectful) and helping to build an evidence base for the *Mindframe* Initiative (Hunter Institute for Mental Health, 2006).

These guidelines, along with other *Mindframe* materials were designed to ensure that:

Reporting of mental illness is based on accurate information, challenges stereotypes and myths about mental illness and encourages people with mental health problems to seek help; Members of the media understand the potential impact of reporting suicide and mental illness, based on the evidence from up-to-date research; Research on suicide and mental illness, and the information on reliable sources of data and expert comment is available to media professionals (Hunter Institute for Mental Health, 2006 p.3).

Whilst it is not mandatory for media professionals to follow these reporting guidelines, around 2500 copies of the resource book were disseminated between 2000 and 2005 and the resources are also available without cost on the Internet. Based on more than 131 face-to-face interviews with media professionals the developers concluded that media professionals were motivated to access and use these resources (Hunter Institute for Mental Health, 2006) .

Additional information about reporting mental health and illness is available from the Australian Press Council (APC), which was established in 1976 and is the regulatory body for print media in Australia. It also exerts an important influence on the media and has itself developed a protocol for reporting these issues. In terms of reporting suicide and mental illness, the APC is not prescriptive, but it does urge care and responsibility in the reporting of these matters, in addition to consultation with reputable centres, counselling services and health authorities when seeking comment on the issues of mental illness and suicide (Australian Press Council, 2006a).

The APC also asserts that public interest and the pressure of news may be incompatible with better reporting practices at certain times (for example mass suicides, public figure suicides or bizarre cases). Thus, precise or prescriptive rules on reporting these issues are not deemed mandatory by the APC (Australian Press Council, 2006a).

In Australia, an active dissemination strategy of *Mindframe* resources was undertaken in mid 2002 (Skehan, et al., 2006) and a formal evaluation of the impact of the Australian guidelines on reporting suicide and mental illness was undertaken in 2006 (see Skehan, et al., 2006). Through the *Mindframe* Media and Mental Health Project and partner organisations, face-to-face briefings, distribution and promotion of resources and supporting materials, and collaboration with peak regulatory bodies to incorporate aspects of the guidelines into codes of practice and editorial policies was undertaken (Pirkis, Blood, Beautrais, Burgess, & Skehan, 2006a).

The results of this project indicated that awareness of the guidelines and associated resources (in printed form and on the *Mindframe* website) was substantial amongst Australian journalists and that target groups were more aware of the printed resource books than of the website (Skehan, et al., 2006). Awareness of the resource book was highest amongst journalists who had closer contact with the researchers, such as those who had received face-to-face briefings (67%) and lowest amongst a control group who had not (29%) (Skehan, et al., 2006). Eighty percent of participants who were aware of the resources used them. When 40 journalists were asked if they would use these resources in the future, 90% responded that they would, and all respondents thought the resources were either 'very useful' (58%) or 'moderately useful' (42%) (Skehan, et al., 2006). Thus, there is direct evidence for their effectiveness in the Australian media, particularly when the promotion of the resources was accompanied by a briefing or face-to-face visit from a member of the *Mindframe* project team.

An evaluation of a similar campaign in Canada showed positive, but weak effects. In Calgary, Alberta, an anti-stigma intervention was undertaken as part of the World Psychiatric Association's global anti-stigma program, Open the Doors (Stuart, 2003). The intervention aimed to assess the extent to which news about schizophrenia and mental illness could be influenced by providing reporters with more accurate background information and by helping them to develop more positive story lines (Stuart, 2003). All journalists were provided with background information at the start of the project and story content and length were evaluated over a 24 month period

including eight months prior to the anti-stigma campaign and 16 months after (Stuart, 2003). It was found that positive stories about mental health outnumbered negative stories by a factor of two to one in both the pre and post-intervention periods and that the number of positive mental health stories increased by 33%, and their length increased by 25% post intervention (Stuart, 2003). At the same time, negative stories also increased in number by 25% and in length by 100%, and the greatest increase in stigmatising stories occurred in relation to schizophrenia (Stuart, 2003). The results were therefore mixed – on one hand, the quality and quantity of reporting increased after the intervention, on the other hand, a detailed review of negative content demonstrated that newspaper coverage of homicide and public security stories were all linked to people with untreated schizophrenia (Stuart, 2003). The authors concluded that results were positive, but meagre, and that local influences may only exert limited effects on broader social stereotypes portrayed by the media, and that strong national and international anti-stigma alliances were needed to co-ordinate media intervention efforts globally (Stuart, 2003).

The research described above summarises the impact of guidelines on media portrayal of mental illness. The section that follows examines the views of journalists and people who have previously experienced a mental disorder/consumers about the quality, including the accuracy, of media coverage of mental health issues.

3.6 Beliefs about mental health coverage

Several studies have sought to canvass the views of journalists or consumers on mental health coverage in the media.

3.6.1 Journalists

Although no surveys of journalists have been conducted in Australia, surveys have been conducted in the United Kingdom and Wales with the aim of determining the views of journalists about the accuracy, appropriateness and quality of mental health coverage by the media, the areas where they believe reporting may be improved, and their views of the main themes that have emerged in media reports (Rethink, 2004). One survey of 50 journalists reported that the majority of respondents (80%) believed that most mental health coverage was negative and 86% believed the media in general linked violence and mental illness (Rethink, 2004). Journalists who worked for larger newspapers (broadsheet journalists) believed that one way of redressing this problem would be to talk with consumers and carers directly. However, when presented with a choice of different sources of mental health information, including access to a consumer, only 40% of these journalists opted to interview a person with a severe

mental illness or a carer (Rethink, 2004). One-third of tabloid journalists and 20% of broadsheet journalists believed that mental health coverage would be more positive if fewer people with mental illnesses committed crimes (Rethink, 2004). Journalists (64%) believed that using positive case studies, especially if they involved celebrities, would help humanise the issue of mental illness and lead to more positive coverage (Rethink, 2004).

Mental Health Media in the United Kingdom (Macmin, 2001) undertook a study to examine the factors influencing the coverage of mental health issues in national and regional newspapers. One component of their study investigated 17 journalists' views of mental health coverage by the media (see Macmin, 2001). The journalists judged 26% of the 146 stories presented to them as positive, 46% as neutral and 29% negative (see Macmin, 2001). Sixty-four percent of the journalists surveyed believed that the media could improve its coverage of mental health issues (see Macmin, 2001).

In another study in the UK, interviews with six journalists regarding the 'news value' of stories about mental illness were conducted (Sainsbury Centre for Mental Health, et al., 2005). Journalists suggested that there is no sexiness in the news value of mental health, unless someone has committed a terrible crime, and that the needs of people with mental illness are of little interest unless those people begin to threaten others in society (Sainsbury Centre for Mental Health, et al., 2005). None of the journalists interviewed were aware of any specific guidelines on reporting mental health issues. However, they were open to the idea of a 'style-sheet' which would describe sensitive ways of representing conditions, symptoms and individuals who experience the problems (Sainsbury Centre for Mental Health, et al., 2005).

In summary, it would appear that journalists themselves believe that reporting about mental health and illness issues could be improved and that possible strategies to achieve this might include interviewing consumers and carers and using case studies of celebrities.

3.6.2 Previous experience of a mental disorder

The beliefs held by people who have previously experienced a mental disorder/consumers and people who have cared for a person with a mental disorder have also been studied. There is only limited evidence concerning their beliefs about portrayals of mental health and illness stories in the media. In a study of 179 Australians comprising mental health consumers, carers and community members between March and May 2005, via 131 online surveys and six focus groups, more than half of the study participants (51.9%) reported having seen mental illness in dramas at

least once per month, and around two-thirds of respondents cited television dramas as a source of information about mental illness for themselves. No respondents thought that mental illness was depicted correctly all of the time and 87.9% thought that myths and stereotypes are perpetuated by the media more than accurate and informed representations (SANE, 2005a). Consumers reported that the language used to describe mental illness was inaccurate and offensive and that psychiatric labels were used incorrectly, in such a way as to misinform and confuse viewers (SANE, 2005a). Some portrayals of mental illness were praised, especially those that realistically portrayed the struggles of regular or successful characters or when social support and understanding were integrated into the storylines.

In the second phase of the study reported by Macmin (2001), 57 mental health service user groups were contacted by telephone and asked a series of questions about their views on regional and national media representations of mental illness. Mental health service user groups responded that negative coverage of these issues was more prevalent in the regional press compared with national press. Specifically, 68% of respondents felt that coverage in their local area was unbalanced or negative (Macmin, 2001).

3.7 Conclusion

Regardless of where people seek mental health information, the wide availability and accessibility of media reports about mental illness in Australia ensures that the general public are regularly exposed to mental health related information through newspapers, television, radio and the Internet. The review in this chapter suggests that mental illness is often portrayed negatively in the mass media and that people with mental disorders are regularly portrayed as dangerous, violent, unpredictable, criminals and people to be feared. However, there is some evidence that the quality of reporting about mental disorders may be improving, especially in recent times. Guidelines to assist journalists in reporting stories about mental health and illness appear to have been received positively but the evidence base is limited in quantity and scope.

There are a few studies investigating journalists' and consumers' views about media representations of mental disorders, but none that consider what the general public remembers from the media. It is important to gauge what the general public recall from the media as the media are an important source of information about mental illness for the general public. What is remembered, as well as what is reported by the media, may be significant in influencing people's attitudes to mental disorders. Audiences may draw incorrect conclusions about mental disorders and the people who have them. What the

general public recall about depression from the media is also important in determining the types of stories that have the greatest impact. Whether what is recalled accords with the frequency with which stories appear in the media warrants investigation. This information may provide clues about where to embed important messages about mental disorders that will have the greatest impact, and be more likely to be remembered by readers. Chapter 8 will investigate what readers remember from the media by analysing the results of an exploratory study of the general publics' recall of stories about depression from the Australian media.

CHAPTER FOUR

METHODOLOGY & SAMPLE CHARACTERISTICS

4.1 Introduction

This chapter describes the survey methodology employed in this study, including the construction and distribution of mental health literacy surveys and the characteristics of respondents.

Data for this study were derived from two mental health literacy surveys. The first study was conducted by researchers from the Centre for Mental Health Research at the Australian National University, Canberra in 2003/2004 and involved a face-to-face survey of 3998 members of the Australian general public (Jorm, et al., 2005a; Jorm, et al., 2005c; Jorm, et al., 1997a). Its aim was to measure the mental health literacy of the general public in Australia and Japan (Australia Japan survey). Although referred to as the Australia Japan survey, only the Australian component of the data was used for this thesis.

The second survey measured the mental health literacy of Australian newspaper journalists. This survey, the Health Attitudes of Media Professionals in Australia (HAMPA survey), was designed by this doctoral student, but modelled on the abovementioned Australia Japan survey. It was developed as a postal survey in 2003/2004.

Broadly, both surveys sought to determine the respondents' ability to recognise a mental disorder from an unlabelled vignette, their knowledge about various treatments and sources of help or information, knowledge about causes and risk factors, beliefs about recovery, stigmatising attitudes and social distance, and a series of questions about their own physical and mental health. The surveys used a number of different scales and were drawn from a variety of sources, but derived mainly from the original adult survey designed by Jorm and colleagues (1997a).

Results from the Australia Japan survey have been published previously (see Griffiths, et al., 2006; Jorm, et al., 2005a; Jorm & Butterworth, 2006; Jorm, et al., 2005b; Jorm, et al., 2005c; Jorm, et al., 2005d; Jorm, et al., 2006d; Nakane, et al., 2005). The analyses presented in this thesis involved comparing the Australian component of these data with data from journalists. A number of the findings presented in this thesis may differ in a small degree from the published research papers. This reflects the fact that the majority of outcome findings from the Australia Japan survey were weighted to

reflect population norms and not all data from older age groups were used. In this study, data were unweighted and all age groups were included in analyses.

Unweighted data were used on advice from the statistician involved in the analysis of the Australia Japan survey data. In published peer-reviewed articles, weights for the original Australia Japan survey data were provided for each respondent, based on complex ratio estimation procedures and to adjust for probabilities of selection and to reduce non-response bias. However, we were unable to use complex ratio estimation procedures on the journalist sample, as we did not have demographic data on the entire journalist group we approached. Consequently, it was decided that we would use unweighted data for both samples to ensure consistency.

Both surveys are now described in detail.

4.2 Australia Japan survey

The methodology of the 2003/2004 Australia Japan survey has been described by the researchers previously (see Jorm, et al., 2005a; Jorm, et al., 2005c; Jorm, et al., 1997a), and closely follows the methodology of a survey carried out in 1995 (Jorm, et al., 1997a). The complete 2003/2004 Australia Japan survey is included at Appendix 4.

The study design conformed to the National Health and Medical Research Council (NHMRC) *National Statement on Ethical Conduct of Research Involving Humans*. Approval for the study was granted by the Australian National University Human Research Ethics Committee in 2003 (see The Australian National University Human Research Ethics Committee approval letter at Appendix 5).

4.2.1 Sampling frame and response rate

A national clustered household survey of 3998 Australian adults aged over 18 years was carried out by the company AC Nielsen between November 2003 and February 2004. Households were sampled from 250 census districts covering all Australian states and territories, including metropolitan and rural areas. In order to achieve the target of surveying 3998 adults, 28947 households were visited and the outcome of these visits was: no contact after repeated visits 14630, vacant house or lot 306, refused 7815, person sampled within household temporarily unavailable 1132, no suitable respondent in household 287, did not speak English 383, incapable of responding 213 and unavailable for the duration of the survey 181. Up to five call-backs were made to metropolitan households and up to three to non-metropolitan households

(Jorm, et al., 2005a). The response rate to the Australian component of the Australia Japan survey was 34%.

A face-to-face interview was conducted with the respondent who had the most recent birthday and was over 18 years of age. On a random basis, respondents were presented with one of four vignettes: depression, depression with suicidal thoughts, early schizophrenia or chronic schizophrenia and were also randomly assigned to receive either male (John) or female (Mary) versions of the vignette (see below). Of the 3998 adults sampled, respondents were allocated each vignette as follows: the depression vignette (1001); the depression with suicidal thoughts vignette (999); the early schizophrenia vignette (997); and the chronic schizophrenia vignette (1001). All vignettes were written to satisfy the diagnostic criteria for either major depressive disorder or schizophrenia according to DSM-IV and ICD-10. The difference between the early and chronic schizophrenia vignettes was that the early schizophrenia vignette was written to satisfy the diagnostic criteria at a minimal level, in order to assess the reaction of the Australian public to a case of a developing disorder which had reached the point where intervention was needed (Jorm, et al., 2005a). The chronic schizophrenia vignette was written to determine their response to a severe, long standing disorder (Jorm, et al., 2005a). Similarly with the depression vignettes – the depression vignette was written to satisfy the diagnostic criteria at a minimal level whereas the suicidal depression vignette was designed to assess how the additional symptom of suicidal thoughts affected the public's responses (Jorm, et al., 2005a).

4.2.2 Measures

Respondents to the Australia Japan survey were presented with 122 questions, which comprised a mixture of forced-response and open-ended questions. Coding sheets were developed for some open-ended questions, which enabled the data to be sorted into discrete categories for further analysis. Not all open-ended questions were subsequently coded, as not all of the collected data were used in this thesis. Where open-ended questions were coded into discrete categories, they are described in this chapter, and coding sheets are included in the appendices.

4.2.3 Demographic variables

The initial survey questions sought to determine the demographics of respondents and included questions about age, gender, marital status, postcode, state where respondent resides, country of birth and level of education.

4.2.4 Recognition of a mental disorder

Respondents were randomly shown either a male (John) or female (Mary) version of one of four vignettes – depression, early schizophrenia, depression with suicidal thoughts or chronic schizophrenia.

The depression vignette (John version) read as follows:

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity.

The early schizophrenia vignette (John version) read as follows:

John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realize he is not taking drugs because he never sees anyone or goes anywhere.

The depression with suicidal thoughts vignette (John version) read as follows:

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making any decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss who is concerned about his lowered productivity. John feels he will never be happy again and believes his family would be better off without him. John has been so desperate, he has been thinking of ways to end his life.

The chronic schizophrenia vignette (John version) read as follows:

John is 44 years old. He is living in a boarding house in an industrial area. He has not worked for years. He wears the same clothes in all weathers and has left his hair to grow long and untidy. He is always on his own and is often seen sitting in the park talking to himself. At times he stands and moves his hands as if to communicate to someone in nearby trees. He rarely drinks alcohol. He speaks carefully using uncommon and sometimes made-up words. He is polite but avoids talking with other people. At times he accuses shopkeepers of giving information about him to other

people. He has asked his landlord to put extra locks on his door and to remove the television set from his room. He says spies are trying to keep him under observation because he has secret information about international computer systems which control people through television transmitters. His landlord complains that he will not let him clean the room which is increasingly dirty and filled with glass objects. John says he is using these 'to receive messages from space.'

After being presented with the vignette, respondents were asked two forced-response questions about what was wrong with the person in the vignette and how they could best be helped. Respondents were asked 'What would you say, if anything is wrong with John (Mary)?' Response categories were: depression; nervous breakdown; schizophrenia/paranoid schizophrenia; mental illness; psychological/mental/emotional problems; stress; has a problem; cancer; other; nothing; and don't know. This question was initially presented as an open-ended question in the 1995 Australian mental health literacy survey conducted by Jorm et al. (1997a). However, the question was changed to a forced-response question in the current survey, with the response categories matching the most common responses obtained in the 1995 survey.

The second forced-response question asked respondents how they 'think John (Mary) could best be helped.' Response categories were: talk over with friends/family; see a doctor/general practitioner (GP); see a psychiatrist; take medication; see a counsellor or have counselling; John/Mary must first recognise the problem; other; or don't know. The final question related to recognition was an open-ended question, which asked respondents to 'imagine John (Mary) is someone you have known for a long time and care about. You want to help him (her). What would you do?'

4.2.5 Recommendations for help-seeking and treatment

Respondents were then asked to rate the likely helpfulness of a range of interventions, on a five point Likert scale as either helpful, neither, harmful, depends, or don't know for the person in the vignette. The interventions were divided into medications that could potentially help (pain relievers, such as aspirin, codeine or panadol; vitamins and minerals, tonics or herbal medicines; antidepressants; antibiotics; sleeping pills; antipsychotics; and tranquilisers), lifestyle/psychosocial interventions that may potentially help (becoming more active physically; reading about people with similar problems and how they have dealt with them; getting out and about more; attending courses on relaxation, stress management, meditation or yoga; cutting out alcohol altogether; psychotherapy; hypnosis; being admitted to a psychiatric ward of a hospital; undergoing ECT; having an occasional alcoholic drink to relax; and going on a special diet or avoiding certain foods) and sources of information that could potentially help

(consulting a website that gives information about his/her problem; consulting an expert using email or The Web about his/her problem; consulting a book that gives information about his/her problem; and receiving information about her problem from a health educator).

Some of the treatments listed in this section of the survey have evidence for efficacy and some do not. Table 4.1 lists the treatments and indicates whether there is evidence to support their efficacy. Three sources, which represent the consensus opinion of experts based on systematic reviews of the scientific literature and research evidence, were consulted to determine efficacy of treatments for depression and postnatal depression. These included the *beyondblue* guidelines for treating depression in primary care (Ellis & Smith, 2002), the BluePages depression information website (Centre for Mental Health Research (CMHR), 2001) and the Royal Australian and New Zealand College of Psychiatrists guidelines (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression, 2004). Treatment recommendations were consistent between all sources and reflected evidence presented in peer-reviewed publications. The advantage of including the BluePages website was that it included efficacy of lifestyle/psychosocial interventions and sources of information in addition to the regular medical and psychological interventions.

One source, the Royal Australian and New Zealand College of Psychiatrists, was consulted to determine the efficacy of treatments for schizophrenia (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders, 2005b).

Using the same five-point Likert Scale, respondents were also asked to rate the likely helpfulness of 12 people who could potentially help the person in the vignette (GP; chemist (pharmacist); counsellor; social worker; telephone counselling service such as Lifeline; psychiatrist; psychologist; help from close family; help from close friends; naturopath or a herbalist; clergy, minister or priest; or John/Mary trying to deal with his/her problems on his/her own. People who could help are rated separately to medications, lifestyle/psychosocial interventions and sources of information as they represent a different class of intervention descriptor.

Dichotomous variables were created for some questions and response categories. For example, each treatment response was allocated into one of two categories – helpful (included respondents who agreed or strongly agreed that a treatment was helpful) or

not helpful (included respondents who disagreed or strongly disagreed that a treatment was helpful).

4.2.6 Beliefs about recovery

Next were questions asking about the likely result for the person in the vignette with and without ‘the sort of professional help you think is most appropriate.’ The response options were: full recovery with no further problems; full recovery, but problems would probably re-occur; partial recovery; partial recovery, but problems would probably re-occur; no improvement; and get worse (Jorm, et al., 2006b).

In addition, there were questions asking about certain likely long-term behaviours if the person in the vignette ‘had the sort of help you think is most appropriate for his (her) problems.’ The behaviours presented were: to be violent; to drink too much alcohol; to take illegal drugs; to have poor friendships; to attempt suicide; to be understanding of other people’s feelings; to have a good marriage; to be a caring parent; to be a productive worker; and to be creative or artistic. Response categories were: more likely; just as likely; less likely; depends; don’t know.

4.2.7 Personal and perceived stigma

Respondents were then presented with a series of questions that addressed various forms of stigma and discrimination. The initial question in this section asked whether the person in the vignette ‘would be discriminated against, by others in the community, if they knew about the problems he (she) has had.’ Response categories were: yes; no; and don’t know.

Additional items were based on the Depression Stigma Scale (Griffiths, et al., 2004) and modified for use with vignettes and disorders other than depression (Griffiths, et al., 2006). This scale comprised 18 items and measures two factors: personal stigma (reflecting the participants’ personal attitudes, and comprising nine items); and perceived stigma (reflecting the participants’ beliefs about the attitudes of others, and also comprising nine items). Respondents were asked to rate how strongly they personally agreed with the nine statements about the problems experienced by John (Mary) and what they thought most other people believed about the same issue. Respondents were asked to express agreement or disagreement with these attitude statements using a five-point Likert scale. Possible response categories were: strongly agree; agree; neither agree nor disagree; disagree; strongly disagree. Scores on each

Table 4.1*Evidence for efficacy of treatments for mental disorders*

Interventions	Major Depressive Disorder and Postnatal Depression	Schizophrenia
Medications		
Vitamins, minerals	Yes (folate only)*	No
Pain relievers	No	No
Antidepressants	Yes**	Yes (with co-morbid depression symptoms)
Antibiotics	No	No
Sleeping pills	No	No
Antipsychotics	Yes (with co-morbid psychosis)	Yes
Tranquillisers	No	Yes
Lifestyle/Psychosocial Interventions		
Physical activity	Yes	?
Read about problem	Yes	?
Get out more	?	?
Learn relaxation	Yes	?
Cut out alcohol	Yes	?
Psychotherapy	Yes	Yes (in combination with drug therapy)
Hypnosis	?	?
Psychiatric ward	Yes	Yes
ECT	Yes	Yes
Occasional drink	?	?
Special diet	?	?
Sources of Information		
Website	?	?
Email an expert	?	?
Consult a book	Yes	?
Health educator	?	?

? These treatments have not been properly researched. It is not possible to say whether they are useful or not

* Major Depressive Disorder only

** Use with caution during pregnancy and breastfeeding

scale have a potential range from 0 to 36. Higher scores indicate greater stigma (Griffiths, et al., 2004). The attitude statements used in the surveys are presented in Table 4.2

4.2.8 Attitudinal social distance

A modified version of the Link Social Distance Scale (Link, et al., 1999), comprised six questions, assessed respondents' willingness to interact with people with mental illness.

Respondents were asked how willing they would be to have contact with a person like John (Mary), specifically how willing they would be to: move next door to John (Mary); spend an evening socialising with John (Mary); make friends with John (Mary); have John (Mary) start working closely with you on a job; or have John (Mary) marry into your family. The possible answers were: definitely willing; probably willing; probably unwilling; definitely unwilling; or don't know.

Table 4.2

Attitude statements in Depression Stigma Scale

Item	Personal stigma	Item	Perceived stigma
1	People with a problem like John's (Mary's) could snap out of it if they wanted	10	Most other people believe that people with a problem like John's (Mary's) could snap out of it if they wanted
2	A problem like John's (Mary's) is a sign of personal weakness	11	Most people believe that a problem like John's (Mary's) is a sign of personal weakness
3	John's (Mary's) problem is not a real medical illness	12	Most people believe that depression is not a real medical illness
4	People with a problem like John's (Mary's) are dangerous	13	Most people believe that people with a problem like John's (Mary's) are dangerous
5	It is best to avoid people with a problem like John's (Mary's) so you don't develop this problem	14	Most people believe that it is best to avoid people with a problem like John's (Mary's) so that you don't develop this problem
6	People with a problem like John's (Mary's) are unpredictable	15	Most people believe that people with a problem like John's (Mary's) are unpredictable
7	If I had a problem like John's (Mary's) I would not tell anyone	16	If they had a problem like John's (Mary's) most people would not tell anyone
8	I would not employ someone if I knew they had a problem like John's (Mary's)	17	Most people would not employ someone they knew had suffered a problem like John's (Mary's)
9	I would not vote for a politician if I knew they had suffered a problem like John's (Mary's)	18	Most people would not vote for a politician they knew had suffered a problem like John's (Mary's)

4.2.9 Knowledge about causes and risk factors

Respondents were asked to rate the likelihood that specific factors could cause the problems John (Mary) was experiencing and were asked to endorse the likelihood that the symptoms could be caused by the listed factor. The response categories were: very likely; likely; not likely; depends; or don't know. The listed factors were: a virus or other infection; an allergy or a reaction; day-to-day problems such as stress, family arguments, problems at work, or financial difficulties; the recent death of a friend or relative; some recent traumatic event such as bushfires threatening your home; a severe traffic accident or being mugged; and problems from childhood such as being badly treated or abused, losing one or both parents when young or coming from a broken home. They were then asked to rate the likelihood that these sorts of problems: are inherited or genetic; that being a nervous person is likely to be a reason; or having weakness of character is likely to be a reason.

Respondents were then asked whether they believed some people in the community were more or less likely to have these problems such as: women, rather than men; young people, under 25 years of age; older people, aged over 65; people from poorer neighbourhoods; people who are unemployed; divorced or separated people; or single people. Response categories were: more likely; less likely; no difference; depends; or don't know.

4.2.10 Health of respondents

The next series of questions asked about their personal health and that of their close family. They were asked whether 'someone close to them had ever experienced an illness similar to John's (Mary's)' (yes; no; refused to answer; or don't know) and whether their relative had 'received treatment for the illness' (yes; no or don't know). The same two questions were then asked about their experience with such an illness and whether they had sought treatment. Respondents were also asked whether they had 'ever had a job that involved providing treatment or services to a person with a problem like John's (Mary's)' and whether they had ever 'had a job where they had to provide services for someone with a problem similar to John's (Mary's)'. Respondents were asked to report on their general health and whether it was: excellent; good; fair; poor; or don't know. They then completed a series of questions asking whether, in the last month, they had suffered from: colds; sore throats; headaches; dizziness; palpitations; breathlessness; backache; flu; anxiety; depression; tiredness; irritability; or nervousness. Response categories were: yes; no; or don't know.

4.2.11 Media and organisations related to depression

The final set of questions were about depression, the media and organisations associated with depression. Response categories to this set of forced-response questions were: yes; no; refused to answer; or don't know. Specifically, respondents were asked whether they had 'seen, read or heard anything about depression in the media in the last 12 months.' Respondents who answered 'yes' were then asked the open-ended question 'Can you tell me what you recall?' and were probed for up to five responses. They were then asked whether they had 'heard of any organisations related to depression,' whether they could 'name these organisations,' whether they had specifically heard of '*beyondblue: the national depression initiative*,' 'the initiative associated with Jeff Kennett' and if they had heard of *beyondblue*, 'what they could recall hearing about it.' The final question asked whether they had heard of the 'Mellow Yellow Institute' – a fictitious institute included as a control to assess what proportion of those recognising *beyondblue* may have been false positives (Jorm, et al., 2005c).

For the question relating to respondents recall of newspaper content, responses were coded according to categories identified from a study of items in the media conducted by Pirkis et al. (2001). In the study by Pirkis et al. (2001), descriptive information, including story content, was extracted from newspaper clippings and radio and television broadcasts about mental illness and suicide. The content of stories appearing on radio or television, or in newspapers, were coded and analysed separately.

The Australia Japan survey results presented in this chapter are compared with those obtained in newspapers in the (Pirkis, et al., 2001a) study, since respondents in our study cited printed media above other media as the primary source of their information. Open-ended responses were coded into 13 categories. These categories were: individual's experience; causes, symptoms and/or treatment of mental illness; statistical overview; mental health care and/or services; policy or program initiative; research initiative; opinion piece; language (identified either positive or negative use of language); mental health/illness issues associated with the workplace (or school); mental health/illness issues associated with physical health; mental health/illness mentioned in the context of suicide; mental health/illness mentioned in the context of crime; or other. Up to three responses were coded for each respondent. The coding sheet is attached at Appendix 6.

Initially, two raters independently coded the responses. However, inter-rater reliability was low for many of the categories. This was due to the small numbers of relevant

responses for some categories or simply misreading or misunderstanding some of the responses. For example, only three responses fell into the 'opinion piece' category. If one rater coded this article into a different category, inter-rater reliability on this item would be low. Consequently, after coding independently, both raters met and resolved coding disagreements. Wherever there was disagreement about which category an item should be coded into, both raters discussed the problem, outlined their reasons for coding into a particular category, and reached a consensus.

4.3 Health Attitudes of Media Professionals in Australia (HAMPA) survey

The HAMPA survey was designed to measure the mental health literacy of Australian newspaper journalists and was developed in three stages – an initial development phase, a pilot study, and the production of a final modified survey for media professionals.

The initial HAMPA survey included items from the Australia Japan survey, an additional module that described postnatal depression, and questions of relevance to media professionals.

Prior to distributing a final version of the surveys to journalists, a pilot of the three versions of the HAMPA survey (postnatal depression, depression with suicidal thoughts, and early schizophrenia vignettes) was conducted in June 2003. The pilot was required to test the flow of the questions, their acceptability with journalists, and any difficulties with items that differed from the Australia Japan questionnaire. Male and female versions of the vignettes were used in the pilot phase except for the postnatal depression vignette, which only included a female version.

Five health or medical writers for Australian newspapers, who were either known to the researcher or had been recommended to the researcher, participated in the pilot in August 2003. They were invited to provide feedback on the surveys. The health or medical writers agreed to participate in the piloting process included one journalist from each of the *Canberra Times*, the *Sydney Morning Herald*, the *Australian* and the *Herald Sun* (Victoria). A journalist from the *Medical Observer* also participated.

Forty-five third year journalism students from seven Australian universities also completed the surveys. Course co-ordinators from the seven participating universities distributed surveys to all interested students during a lecture near the end of the second semester in 2003. Students were invited to fill in the survey and return it in a reply paid envelope.

All staff and postgraduate students at the Centre for Mental Health Research at The Australian National University, researchers at beyondblue, and family and friends were also invited to participate in piloting the surveys. Seven people from the Centre for Mental Health Research, three from beyondblue and five family and friends completed the surveys and provided feedback. In total, 65 people piloted at least one version of the initial HAMPAs survey. All individuals who participated in the pilot survey were asked to pilot it with reference to their own identity, and not to complete it imagining they were journalists.”

As a consequence of the pilot, all vignettes were subsequently depicted as female. One of the main comments from the piloting was that because the postnatal depression vignette depicted a female, the other vignettes should only have a female version, to remove the confounding variable of gender in the identification process. Previous studies have demonstrated no difference in rates of identification based on whether a female or male was depicted in a vignette (Jorm, et al., 2006b). This choice of using female participants alone was thus unlikely to invalidate comparisons between the HAMPAs study and the Australia Japan survey. Suggestions on the wording of some of the questions relating to the media’s role in influencing attitudes by journalists involved in the piloting process were adopted. Journalists believed that short, punchy statements were more likely to engage journalists and elicit a response.

Comments on the layout of the survey were also provided by some respondents in the pilot survey. Suggestions such as making the survey physically smaller (for example reducing the page sizes by 50%), but still keeping the same number of questions, may entice journalists to fill it out. Therefore, the final version of the survey was only three pages (with questions on the front and back).

The final survey consisted of three versions describing depression with suicidal thoughts, early schizophrenia and postnatal depression. These can be found at Appendices 4, 5 and 6 respectively.

The study design conformed to the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct of Research Involving Humans. Approval for the study was granted by the Australian National University Human Research Ethics Committee in 2003 (see The Australian National University Human Research Ethics Committee approval letter in Appendix 10) including an information sheet (Appendix 11) and follow-up letter (Appendix 12).

4.3.1 Sampling frame and response rate

All Australian print media professionals (n=3763) listed in Volume 19 of the *2003 Media Monitors Guide* (Eddon, 2003) were randomly assigned (using the website <http://random.org/>) to receive one of the three versions of the survey (the depression with suicidal thoughts, early schizophrenia or postnatal depression vignette). Eight duplicate entries were removed and an additional 222 entries were excluded because journalists had changed workplace, retired or died. The original survey was posted to journalists in July and August 2003, and was accompanied by a generic letter outlining the project. However, personalised letters were subsequently sent to those who did not respond to the first mail out in an attempt to improve response rate. Response rate doubled after the personalised letters were sent to journalists.

Of the 636 journalists who returned the survey (response rate 18%), 197 received the depression with suicidal thoughts vignette, 221 received the early schizophrenia vignette and 218 received the postnatal depression vignette.

4.3.2 Measures

Journalists completed the majority of outcome measures described in the Australia Japan survey. This section describes any differences between the outcome measures.

Journalists were presented with 133 questions, which comprised a mixture of forced-response and open-ended questions.

Some response categories in the HAMP survey were slightly different to those in the Australia Japan survey. In summary, the HAMP survey omitted the 'depends' response category for all questions where one was presented in the Australia Japan survey. This was to simplify the already large survey for journalists to hopefully enable a greater response rate. Although these minor differences are observed, the data were comparable to the outcomes derived from the Australia Japan survey. Specifically, the 'depends' and 'don't know' categories were never included in any analyses. For example, when reporting the results of the individual treatments respondents thought would be most useful for a person experiencing a mental disorder, the 'strongly agree' and 'agree' responses were combined into a single category 'agree' and the 'strongly disagree' and 'disagree' responses were combined into a single category 'disagree.' Respondents who selected a 'depends,' 'don't know,' or 'neither agree nor disagree' response were excluded from the analysis.

4.3.3 Demographic variables

The demographic survey questions were similar to those contained in the Australia Japan survey and included questions about age, gender, and postcode, state where respondent usually works, country of birth and level of education. Additionally, the HAMPAsurvey asked respondents a forced-response question ‘Do you hold a Bachelor’s degree or higher degree (Masters, PhD) in journalism?’ and an open-ended question ‘What is your current area of expertise?’

4.3.4 Recognition of a mental disorder

As noted above, the HAMPAsurvey used female versions of the depression with suicidal thoughts, early schizophrenia and postnatal depression vignettes. The postnatal depression vignette was developed by Dr Anne Buist, an Australian researcher specialising in postnatal depression (Buist, et al., 2005), and used with her permission. The vignette satisfied the diagnostic criteria according to DSM-IV and ICD-10.

The postnatal depression vignette read as follows:

Six weeks after having her child, Mary is crying most days and is unable to sleep even when her child sleeps through. She is worrying constantly about her baby and thinks there is something wrong. She believes she is a bad mother and shouldn’t have had a baby. Most days when she wakes she wishes she were dead. James, her husband, finds there is nothing he can say to Mary that makes her feel better.

After being presented with the vignette, respondents were asked two open-ended questions including, ‘What would you say, if anything, is wrong with Mary?’ and ‘How do you think Mary could best be helped?’ Responses were open-ended, but were then coded into one of 11 categories, which matched the forced-response categories in the Australia Japan survey.

4.3.5 Recommendations for help-seeking and treatment

In addition to the items used to measure help-seeking from the Australia Japan survey, journalists were also asked to assess the helpfulness of a police officer. Response categories were: helpful; neither; harmful or don't know.

Dichotomous variables were created for some questions and response categories. For example, each treatment response was allocated into one of two categories – helpful (included respondents who agreed or strongly agreed that a treatment was helpful) or not helpful (included respondents who neither agreed nor disagreed, disagreed or strongly disagreed that a treatment was helpful).

4.3.6 Beliefs about recovery

Identical questions to the Australia Japan survey were used.

4.3.7 Personal and perceived stigma

The initial question which asked respondents whether they thought 'Mary would be discriminated against, by others in the community, if they knew about the problems she had' was identical to the one in the Australia Japan survey. However, journalists who believed that she would be discriminated against, were asked an additional open-ended question 'In what ways do you think she would be discriminated against?' Personal and Perceived Stigma scales did not differ for the HAMP A survey.

4.3.8 Attitudinal social distance

The social distance questions, which asked respondents about how willing they would be to have contact with a person like Mary, were identical to those in the Australia Japan survey for both the depression with suicidal thoughts and early schizophrenia vignettes, but were modified for the postnatal depression version of the survey. Instead of being asked how willing respondents would be to 'have Mary start working closely with you on a job,' recipients of the postnatal depression were asked how willing they would be to 'have Mary babysit your children.' The possible answers were; definitely willing; probably willing; probably unwilling; definitely unwilling; or don't know.

4.3.9 Knowledge about causes and risk factors

Questions related to knowledge about causes and risk factors were the same as those in the Australia Japan survey.

4.3.10 Health of respondents

Both male and female respondents were asked whether they or someone close to them had ever experienced an illness similar to Mary's, whether they received treatment for the illness, whether they had ever cared for someone with a problem like Mary's and whether they had ever written a story about someone with a problem like Mary's. Respondents were then asked two open-ended questions about what they considered 'the main mental illnesses were in Australia at present,' and 'which they believed was the most important mental illness.' They were also asked whether they 'knew of any organisations that provide information about mental illness.'

4.3.11 Media

The final set of questions related to respondents' knowledge of the existence of Australian media guidelines on the responsible reporting of suicide and mental illness, awareness of the existence of other reporting guidelines, and their beliefs regarding the role of the media in Australia. Respondents were asked to rate how strongly they agreed or disagreed with 12 statements about the media's role in Australia with regard to reporting suicide and mental illness. There were five response categories: strongly agree; agree; disagree; strongly disagree; or neither agree nor disagree. The statements were:

1. The Australian media plays an important role in influencing social attitudes about mental illness
2. The Australian media plays an important role in influencing social attitudes about suicide
3. Most media report suicide and mental illness appropriately
4. Negative reporting of mental illness impacts significantly on people experiencing mental illness
5. I follow suggested media guidelines when reporting about suicide or mental illness
6. My colleagues follow suggested media guidelines when reporting about suicide or mental illness
7. The presentation of negative images of mental illness in both fiction and non-fiction media results in the development of more negative beliefs about mental illness
8. Responsible reporting about mental illness and suicide is a priority for the media
9. The current media guidelines for the reporting on suicide and mental illness are adequate
10. The current media guidelines for the reporting on suicide and mental illness should be mandatory
11. I do not believe in censorship in relation to mental illness or suicide
12. Suicide risk may increase as a result of reading media reports about suicide.

4.4 Data analysis

All data were analysed using version 14.0 of SPSS (SPSS, 2005).

The proportions of respondents responding to each question were calculated using the Frequencies command of SPSS 14.0 for each sample. Ninety-five percent Confidence Intervals were estimated using the Explore procedure in SPSS 14.0.

Multiple binary logistic regression analyses were conducted to examine the levels of association between participants' responses regarding 34 potential treatments for mental disorders. The predictor variables included which vignette respondents received (suicidal depression or early schizophrenia), their age (18-39 years, 40-59 years or 60 years or older), gender (male or female), level of education (no university education, bachelor's degree or higher level of education), previous personal experience of a mental disorder (consumer or not a consumer), level of stigma (continuous variable) and the population from which respondents were drawn (HAMPA or Australia Japan).

Chi-square analysis was used to test the significance of some of the data. For example, chi-squares were used to test for any associations between gender and vignette received, or gender and levels of educational attainment.

Open-ended questions were coded into discrete categories for further analysis. A variety of methods were used to code open-ended questions.

All analyses used unweighted data, excluded missing cases and included respondents from all age categories.

4.5 Characteristics of the samples

Age, gender, highest level of education, country of birth, vignette received and experience with a mental disorder for the two samples are summarised in Table 4.3. The sample differences and similarities are discussed below.

4.5.1 Australia Japan sample characteristics

Males comprised 41.2% of this sample. Ages of participants ranged from 18 years to 70+ years and respondents were fairly evenly spread across all age groups. The

Table 4.3

Sample characteristics – Australian public and journalists

Variable		Australia Japan N=3998			HAMPA N=636		
		Male Number (%)	Female Number (%)	Total Number (%)	Male Number (%)	Female Number (%)	Total Number (%)
Age	18-29 yrs	282 (17.1)	387 (16.5)	669 (16.7)	33 (10.7)	109 (36.6)	142 (22.5)
	30-39 yrs	307 (18.7)	471 (20.0)	778 (19.5)	65 (21.1)	90 (27.8)	155 (24.5)
	40-49 yrs	344 (20.9)	442 (18.8)	786 (19.7)	89 (28.9)	77 (23.8)	166 (26.3)
	50-59 yrs	275 (16.7)	379 (16.1)	654 (16.4)	82 (26.6)	35 (10.8)	117 (18.5)
	60-69 yrs	191 (11.6)	316 (13.4)	507 (12.7)	34 (11.0)	9 (2.8)	43 (6.8)
	70+ yrs	247 (15.0)	357 (15.2)	604 (15.1)	5 (1.6)	4 (1.2)	9 (1.4)
	Total	1646 (41.2)	2352 (58.8)	3998 (100)	324 (51.3)	308 (48.7)	632 (100)
Gender		1646 (41.2)	2352 (58.8)	3998 (100)	324 (51.3)	308 (48.7)	632 (100)
Education	Bachelor's Degree or Higher	390 (23.7)	500 (21.3)	890 (22.3)	150 (39.6)	229 (73.9)	379 (62.4)
	Trade, diploma, other certificate	462 (28.1)	471 (20.0)	933 (23.3)	46 (15.5)	39 (12.6)	85 (14.0)
	Secondary School Certificate or still completing school	609 (37.0)	1122 (47.7)	1731 (43.3)	92 (31.0)	38 (12.3)	130 (21.4)
	Other	185 (11.2)	259 (11.0)	444 (11.1)	9 (3.0)	4 (1.3)	13 (2.1)
	Total	1646 (41.2)	2352 (58.8)	3998 (100)	310 (51.1)	297 (48.9)	607 (100)
Country of Birth	Australia	1155 (28.9)	1797 (44.9)	2952 (73.8)	246 (39.1)	263 (41.7)	509 (80.8)
	Other	491 (12.3)	555 (13.9)	1046 (26.2)	59 (9.4)	62 (9.8)	121 (19.2)
	Total	1646 (41.2)	2352 (58.8)	3998 (100.0)	305 (48.4)	325 (51.6)	630 (100.0)
Vignette Received	Depression	401 (10.0)	600 (15.0)	1001 (25.0)	-	-	-
	Depression (suicidal thoughts)	440 (11.0)	559 (14.0)	999 (25.0)	104 (16.4)	93 (14.6)	197 (31.0)
	Early Schizophrenia	405 (10.1)	592 (14.8)	997 (25.0)	108 (17.0)	113 (17.8)	221 (34.7)
	Chronic schizophrenia	400 (10.0)	601 (15.0)	1001 (25.0)	-	-	-
	Postnatal depression	-	-	-	98 (15.4)	120 (18.9)	218 (34.3)
	Total	1646 (41.2)	2352 (51.8)	3998 (100.0)	310 (48.7)	326 (51.3)	636 (100)
Previous experience of a mental disorder		340 (8.5)	508 (12.7)	848 (21.2)	45 (7.2)	90 (14.4)	135 (21.6)

majority of respondents were born in Australia (73.8%). Of those who were born outside Australia, 988 specified the country in which they were born. People born in the United Kingdom (Ireland, Scotland, England and Wales) made up the largest proportion of overseas born Australians (n=312, 31.6%). People born in New Zealand were also well represented in the sample (n=92, 9.3%).

The Australian public were randomly shown one of four vignettes as stated previously. Using chi square analysis, results indicated that there were no significant differences in the proportion of male and female respondents who received each vignette (χ^2 [3, N=3998] =4.645, p=.200).

Approximately 22% of respondents held a bachelors degree or higher qualification, while the highest level of education for 42.7% of respondents was a Secondary School Certificate. Chi-square analysis demonstrated that there were significant differences in the proportion of male and female respondents' levels of education (χ^2 [3, N=3998] =55.095, p=.000). Men were more likely than women to hold a trade, diploma or other certificate (men 28.1%, women 20.0%) and women were more likely hold a secondary school certificate (men 37.0%, women 47.7%).

Approximately one in five (21.2%) respondents had previously experienced a mental disorder.

4.5.2 HAMPA sample characteristics

Although 636 journalists returned the survey, not all journalists replied to every question. Therefore, the sample characteristics of the respondents presented below are based on the actual number of responses (as stated for each table) and exclude the missing responses.

This sample comprised approximately equal percentages of male and female respondents. Ages of participants ranged from 18 years to 75+ years and just over half (51%) of the respondents were aged between 30 and 49 years of age. Eighty percent of respondents were born in Australia. Of the 121 respondents who were born overseas, two-thirds were born in either the United Kingdom or New Zealand. The remainder were born in one of 17 other countries.

Respondents generally had a very high level of education with 62.4% holding a bachelors degree or higher qualification, a qualification that is often a prerequisite for the work they do. As might be expected, the educational levels of journalists in this

survey were, overall, higher than those for mental health literacy surveys of the general population. Only 13% of respondents held a bachelors degree or higher in the 1995 cross sectional mental health literacy survey of the Australian public (Jorm, et al., 1997a) and 22.3% of respondents in 2003/2004 survey. Higher levels of education have been consistently demonstrated in mental health literacy surveys of health professionals in Australia (Caldwell & Jorm, 2000; Jorm, et al., 1997d).

In terms of gender differences, the results show clear differences in the educational qualifications of males versus females. Chi square analysis demonstrated that there were significant gender differences in levels of education (χ^2 [3, N=607] =41.138, $p=.000$). Female journalists are more likely to hold a bachelor's degree or higher qualification than males – 73.9% versus 39.6%. This is likely to reflect the fact that many of the male respondents entered journalism through work experience undertaken in a cadetship, which is an older form of journalism training, a category that was not explicit in the HAMPAs survey. Male journalists frequently mentioned cadetships as their training for journalism and this was probably recorded in the other category.

Of the 636 journalists, 194 received the depression with suicidal thoughts version of the survey, 218 received the postnatal depression version of the survey and 221 received the early schizophrenia version of the survey. There were no significant differences in the proportion of male and female respondents who received each vignette (χ^2 [2, N=636] =2.547, $p=.280$).

Approximately one in five (21.6%) respondents had previously experienced a mental disorder.

4.5.3 Differences between the Australia Japan and HAMPAs samples

When the Australia Japan sample was compared with the HAMPAs sample, a number of differences were observed.

The most notable differences were that:

- There were fewer male respondents in the Australia Japan sample than the HAMPAs sample (41.2% versus 51.3%)
- A greater proportion of HAMPAs respondents held a Bachelor's degree or higher qualification than Australia Japan respondents (62.4% versus 22.3%);
- A greater proportion of HAMPAs respondents were aged between 18-59 years than Australia Japan respondents (91.8% versus 72.3%)

- A greater proportion of Australia Japan respondents were aged 60 years or older than HAMPAs respondents (27.7% versus 8.2%).

4.6 Conclusion

The two surveys described above were based on the initial mental health literacy survey developed by Jorm and colleagues (1997a) and sought to gain an understanding of the mental health literacy of respondents by examining their knowledge and beliefs about mental disorders.

Analysis of the sample characteristics of the two surveys demonstrated a number of similarities and differences between the samples. Similarities included the fact that the ages of participants ranged from 18 years to 70+ years, the majority of respondents were born in Australia, there were no significant differences in the proportion of male and female respondents who received each vignette and the proportions of respondents who had experienced a mental disorder were similar in both samples. The main differences between the samples were that journalists were approximately three times more likely to hold tertiary qualifications than the Australian public. Female journalists were almost twice as likely as male journalists to hold tertiary qualifications while this was not the case for the Australian public, where tertiary qualifications were equally likely for males and females. A greater proportion of HAMPAs respondents were aged between 18-59 years whilst a greater proportion of Australia Japan respondents were aged 60 years or older.

CHAPTER FIVE

MENTAL HEALTH LITERACY OF NEWSPAPER JOURNALISTS COMPARED TO THE AUSTRALIAN PUBLIC – SUICIDAL DEPRESSION AND EARLY SCHIZOPHRENIA

5.1 Introduction

This chapter examines the mental health literacy of the two samples of respondents – journalists and the Australian public. In particular, this chapter investigates differences in the respondents' ability to recognise suicidal depression and early schizophrenia, their recommendations for help-seeking and treatment, their knowledge about causes and risk factors, beliefs about recovery, levels of personal and perceived stigma and levels of attitudinal social distance.

5.2 Hypotheses

This chapter provides a descriptive account of the mental health literacy of journalists and the Australian public regarding suicidal depression and early schizophrenia and describes the factors which may explain these differences.

It tests the hypothesis that the mental health literacy of journalists will be at a higher level than that of the general public. Previous surveys of the Australian public have linked higher education to better depression literacy, especially with regard to knowledge about the debilitating effects of depression and its prevalence (Highet, Luscombe, Davenport, Burns, & Hickie, 2006). Since the previous chapter indicated that journalists had a much higher level of educational attainment than the Australia sample – 62.4% of journalists hold a Bachelor's degree or higher qualification compared to only 22.3% of the Australian public – this chapter tests the assumption that better education will be linked to better mental health literacy. This chapter will also consider what other factors, if any, may explain any differences in mental health literacy between the samples.

In particular, when compared with the general public, it is hypothesised that journalists will demonstrate:

- a. Greater capacity to recognise depression and schizophrenia from an unlabelled vignette;
- b. Better knowledge of evidence-based treatments for these conditions;
- c. Better knowledge of known causes and risk factors;
- d. More optimistic views about the prognosis and recovery of these conditions in circumstances where appropriate treatment is provided;
- e. Lower stigma; and

- f. Less social distance.

5.3 Data analysis

The proportions of respondents responding to each category were calculated using the Frequencies command of SPSS 14.0 for each sample (SPSS, 2005). Ninety-five percent Confidence Intervals were estimated using the Explore procedure in SPSS 14.0. All analyses used unweighted data, excluded missing cases and included respondents from all age categories.

The 95% Confidence Intervals were used as a proxy for reporting possible differences, patterns and trends between the samples. A comparison of the confidence intervals provides information about potential differences. If the Confidence Intervals overlap, the difference between the samples is probably not significant. Where Confidence Intervals do not overlap, the difference between the estimates being compared is most likely statistically significant.

One way analysis of variance (ANOVA) was used to test for differences in the mean personal and perceived stigma scores attained by respondents.

5.4 Results

5.4.1 Recognition of mental disorder

Respondents were asked to nominate what was wrong with the person described in the unlabelled suicidal depression and early schizophrenia vignettes. Journalists (88.8%, 95% CI 84.4%-93.3%) were significantly more likely to correctly label the suicidal depression vignette than the Australian public (77.3%, 95% CI 74.4%-79.9%). There were no significant differences between journalists (49.4%, 95% CI 42.9%-56.2%) and the sample of Australians (42.6%, 39.5%-45.7%) ability to correctly identify early schizophrenia from an unlabelled vignette. Journalists and the Australian public most often used the term depression to describe the depression with suicidal thoughts vignette and schizophrenia or psychosis to describe the schizophrenia vignette. Rates of identification of schizophrenia were low overall – less than half of all respondents to both surveys identified the early schizophrenia vignette correctly.

Early schizophrenia was most often misdiagnosed as depression by the sample of Australians (34.0%) and as a mental illness/mental health problem by journalists (22.8%). Depression with suicidal thoughts was most often misdiagnosed as stress in the Australia Japan (10.5%) and HAMP (1.5%) surveys. Other responses to both vignettes were: nervous breakdown; mental illness; psychological/mental/emotional problems; stress; has a problem; cancer; nothing; other; or don't know.

5.4.2 Recommendations for help-seeking and treatment

Tables 5.1 to 5.4 illustrate how respondents rated the likely helpfulness and harmfulness of a range of interventions for suicidal depression and early schizophrenia for the two samples. Helpfulness and harmfulness ratings were reported for people who could help, medications that could help, lifestyle/psychosocial interventions that could help and sources of information that could help.

Table 5.6 ranks medical interventions, lifestyle/psychosocial interventions and information sources from most to least helpful for the disorders. People who could help are ranked separately (Table 5.7), as they represent a different class of intervention descriptor. In particular, people who could help may be trained or qualified to deliver multiple interventions, thus they are ranked separately. For example, both GPs and psychiatrists have the ability to prescribe medication for the disorders represented in the vignettes, and a range of people, including GPs, psychiatrists and psychologists may be trained to deliver different types of psychotherapy.

Table 5.1

Percentage (and 95% Confidence Intervals) of respondents rating each type of person as 'helpful' and 'harmful' for the person described in the vignette^{1,2}

People who could help		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA (%)	Australia Japan survey (%)	HAMPA (%)	Australia Japan survey (%)
GP	Helpful	89.7 (85.4-94.0)	83.6 (81.3-85.9)	87.4 (82.9-91.8)*	77.5 (74.9-80.1)
	Harmful	0.5 (-0.5-1.5)	1.0 (0.4-1.6)	0.9 (-0.3-2.2)	2.3 (1.4-3.2)
Chemist/Pharmacist	Helpful	16.0 (10.7-21.4)	34.2 (31.3-37.2)#	10.6 (6.5-14.8)	24.4 (21.7-27.0)#
	Harmful	5.9 (2.5-9.3)	7.7 (6.1-9.4)	8.8 (5.0-12.6)	8.0 (6.3-9.7)
Counsellor	Helpful	92.3 (88.5-96.1)*	85.4 (83.2-87.6)	87.4 (83.0-91.9)	84.9 (82.6-87.1)
	Harmful	0.5 (-0.5-1.5)	2.5 (1.5-3.5)	1.9 (0-3.7)	3.2 (2.1-4.3)
Social worker	Helpful	56.8 (49.6-64.0)	67.0 (64.1-69.9)#	65.3 (58.8-71.7)	68.8 (65.9-71.7)
	Harmful	6.5 (2.9-10.1)	5.3 (3.9-6.7)	3.8 (1.2-6.3)	4.4 (3.1-5.7)
Phone counselling	Helpful	78.8 (73.0-84.7)*	66.6 (63.6-69.5)	62.9 (56.4-69.5)	57.1 (54.0-60.2)
	Harmful	2.1 (0.1-4.2)	6.3 (4.8-7.8)#	2.4 (0.3-4.4)	7.1 (5.5-8.7)#
Psychiatrist	Helpful	77.2 (71.2-83.2)	69.9 (67.0-72.7)	85.8 (81.1-90.5)	80.7 (78.3-83.2)
	Harmful	3.6 (1.0-6.3)	8.3 (6.6-10.0)#	2.8 (0.5-4.5)	4.9 (3.6-6.3)
Psychologist	Helpful	77.5 (71.5-83.5)	69.9 (67.0-72.7)	78.6 (73.1-84.1)	73.4 (70.7-76.2)
	Harmful	2.1 (.1-4.1)	5.0 (3.7-6.4)	2.3 (0.3-4.4)	3.4 (2.3-4.5)

¹ 'Depends' and 'Don't know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%.

* HAMPA result higher, #Australia Japan result higher

Table 5.1 continued

Percentage (and 95% Confidence Intervals) of respondents rating each type of person as 'helpful' and 'harmful' for the person described in the vignette^{1,2}

People who could help		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA (%)	Australia Japan survey (%)	HAMPA (%)	Australia Japan survey (%)
Close family	Helpful	87.1 (82.4-91.9)*	64.3 (61.3-67.2)	81.3 (76.1-86.5)*	61.7 (58.7-64.7)
	Harmful	0 (n/a)	4.6 (3.3-5.9)	2.3 (0.3-4.3)	5.6 (4.2-7.1)
Close friends	Helpful	91.7 (87.7-95.6)*	77.1 (74.5-79.7)	83.3 (78.2-88.3)*	71.9 (69.2-74.7)
	Harmful	0 (n/a)	2.6 (1.6-3.6)	2.3 (0.3-4.4)	3.1 (2.0-4.2)
Naturopath/herbalist	Helpful	24.9 (18.6-33.1)	31.5 (28.7-34.4)	12.2 (7.8-16.7)	24.1 (21.4-26.7)#
	Harmful	15.3 (10.2-20.5)	13.2 (11.1-15.3)	21.1 (15.6-26.7)	14.5 (12.4-16.7)
Police Officer	Helpful	5.8 (2.4-9.2)	not measured	11.2 (6.9-15.4)	not measured
	Harmful	14.8 (9.7-19.9)	not measured	31.6 (25.4-37.9)	not measured
Clergy	Helpful	32.2 (25.4-39.1)	51.3 (48.2-54.4)#	26.9 (20.9-33.0)	38.2 (35.2-41.2)#
	Harmful	10.4 (5.9-14.8)	9.8 (8.0-11.7)	16.4 (11.3-21.4)	10.6 (8.7-12.6)
Deal with it alone	Helpful	9.8 (5.5-14.1)	9.9 (8.1-11.8)	5.8 (2.6-9.0)	10.9 (9.0-12.9)
	Harmful	69.6 (62.9-76.3)	74.9 (72.2-77.6)	80.8 (75.4-86.2)*	71.2 (68.4-74.0)

¹ 'Depends' and 'Don't know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%

* HAMPA result higher, #Australia Japan result higher

Table 5.2

Percentage (and 95% Confidence Intervals) of respondents rating each type of medication as 'helpful' and 'harmful' for the person described in the vignette^{1,2}

		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Medications					
Vitamins, minerals or tonics	Helpful	42.7 (35.7-49.8)	43.5 (40.5-46.6)	21.6 (16.1-27.1)	31.1 (28.2-34.0)#
	Harmful	6.3 (2.8-9.7)	5.5 (4.1-6.9)	2.8 (0.6-5.0)	5.4 (4.0-6.8)
Pain relievers	Helpful	5.4 (2.1-8.7)	12.8 (10.7-14.9)#	4.2 (1.5-6.9)	7.8 (6.2-9.5)
	Harmful	38.2 (31.1-45.2)	37.8 (34.8-40.9)	30.1 (24.0-36.3)	37.8 (34.8-40.9)
Antidepressants	Helpful	68.3 (61.6-75.0)*	52.7 (49.6-55.8)	67.6 (61.3-74.0)*	50.2 (47.0-53.3)
	Harmful	9.0 (4.9-13.1)	23.3 (20.7-25.9)#	8.9 (5.1-12.8)	22.4 (19.8-25.0)#
Antibiotics	Helpful	0.5 (0-1.6)	7.8 (6.1-9.5)#	1.9 (0-3.7)	3.8 (2.6-5.0)
	Harmful	37.1 (30.1-44.1)	37.1 (34.1-40.1)	27.0 (21.0-33.0)	36.1 (33.1-39.1)#
Sleeping pills	Helpful	16.1 (10.8-21.5)	23.1 (20.5-25.7)	12.7 (8.2-17.2)	17.9 (15.5-20.2)
	Harmful	46.2 (39.0-53.5)	49.9 (46.7-53.0)	47.4 (40.7-54.2)	53.9 (50.8-57.0)
Antipsychotics	Helpful	14.4 (9.4-19.5)	16.5 (14.2-18.8)	59.1(52.4-65.7)*	33.5 (30.6-36.4)
	Harmful	31.6 (24.8-38.3)	40.1 (37.1-43.2)	7.4 (3.9-11.0)	23.9 (21.2-26.5)#
Tranquillizers	Helpful	11.7 (6.9-16.4)	14.9 (12.7-17.1)	19.0 (13.7-24.4)	17.4 (15.0-19.7)
	Harmful	47.8 (40.4-55.2)	59.2 (56.1-62.2)#	38.6 (31.9-45.2)	48.1 (45.0-51.3)

¹ 'Depends' and 'Don't know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%

* HAMPA result higher, #Australia Japan result higher

Table 5.3

Percentage (and 95% Confidence Intervals) of respondents rating each type of lifestyle/psychosocial intervention as 'helpful' and 'harmful' for the person described in the vignette²

		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Lifestyle Interventions					
Physical activity	Helpful	89.6 (85.3-94.0)	92.2 (90.5-93.9)	71.5 (65.4-77.6)	86.5 (84.3-88.6)#
	Harmful	0 (n/a)	0.3 (0-0.6)	0.5 (-0.5-1.4)	0.5 (0.1-0.9)
Read about problem	Helpful	82.9 (77.5-88.3)	79.3 (76.8-81.8)	82.1 (76.9-87.3)	79.4 (76.9-82.0)
	Harmful	1.0 (-0.4-2.5)	5.8 (4.4-7.3)#	1.4 (-0.2-3.0)	4.6 (3.3-5.9)#
Get out more	Helpful	73.5 (67.2-79.9)	89.9 (88.0-91.8)#	67.5 (61.1-73.8)	86.4 (84.2-88.5)#
	Harmful	0.5 (-0.5-1.6)	0.3 (0-0.6)	1.9 (0-3.7)	1.8 (1.0-2.6)
Learn relaxation	Helpful	82.4 (77.0-87.8)	85.2 (83.0-87.4)	73.6 (67.6-79.6)	76.9 (74.3-79.6)
	Harmful	0.5 (-0.5-1.5)	0.9 (0.3-1.5)	1.4 (-0.2-3.0)	1.1 (0.5-1.8)
Cut out alcohol	Helpful	38.5 (31.6-45.5)	59.4 (56.3-62.4)#	57.5 (50.8-64.2)	67.0 (64.1-69.9)
	Harmful	4.2 (1.3-7.0)	5.1 (3.7-6.5)	2.3 (0.3-4.4)	3.0 (2.0-4.1)
Psychotherapy	Helpful	47.9 (40.7-55.1)	50.3 (47.1-53.4)	61.3 (54.7-68.0)	58.7 (55.6-61.7)
	Harmful	1.6 (-0.2-3.4)	10.4 (8.5-12.3)#	4.3 (1.5-7.0)	5.9 (4.5-7.4)
Hypnosis	Helpful	15.9 (10.6-21.1)	23.7 (21.1-26.4)	17.3 (12.1-22.5)	30.1 (27.2-32.9)#
	Harmful	11.6 (7.0-16.3)	19.6 (17.2-22.1)#	9.1 (5.2-13.1)	13.0 (11.0-15.1)

¹ 'Depends' and 'Don't know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%

* HAMPA result higher, #Australia Japan result higher

Table 5.3 continued

Percentage (and 95% Confidence Intervals) of respondents rating each type of lifestyle/psychosocial intervention as 'helpful' and 'harmful' for the person described in the vignette²

		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Lifestyle Interventions					
Psychiatric ward	Helpful	5.9 (2.5-9.2)	19.8 (17.3-22.3)#	30.0 (23.8-36.3)	32.1 (29.2-35.0)
	Harmful	48.4 (41.2-55.6)	49.7 (46.6-52.9)	29.1 (23.0-35.3)	39.1 (36.1-42.2)#
ECT	Helpful	11.0 (0-2.5)*	6.6 (5.1-8.2)	5.6 (2.5-8.7)	7.0 (5.4-8.6)
	Harmful	62.1 (55.1-69.1)	65.8 (62.8-68.7)	57.5 (50.8-64.2)	64.4 (61.4-67.4)
Occasional drink	Helpful	39.8 (32.8-46.8)	42.9 (39.9-48.0)	13.9 (9.2-18.7)	30.7 (27.8-33.6)#
	Harmful	14.7 (9.6-19.7)	18.6 (16.2-21.0)	26.9 (20.9-33.0)	30.0 (27.1-32.6)
Special diet	Helpful	26.9 (20.6-33.3)	45.9 (42.8-48.9)#	21.5 (15.6-27.0)	42.3 (39.3-45.4)#
	Harmful	12.4 (7.7-17.1)	9.0 (7.2-10.8)	9.8 (5.8-13.8)	7.0 (5.4-8.6)

¹ 'Depends' and 'Don't know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%

* HAMPA result higher, #Australia Japan result higher

Table 5.4

Percentage (and 95% Confidence Intervals) of respondents rating each source of information as 'helpful' and 'harmful' for the person described in the vignette^{1,2}

		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Sources of information					
Website	Helpful	65.8 (59.1-72.6)*	53.3 (50.2-56.4)	63.7 (57.2-70.2)	57.3 (54.2-60.4)
	Harmful	8.3 (4.4-12.2)	15.7 (13.5-18.0)#	10.7 (6.5-14.9)	13.9 (11.8-16.1)
Email an expert	Helpful	47.9 (40.7-55.1)	48.4 (45.2-51.5)	51.4 (44.7-58.2)	53.4 (50.3-56.5)
	Harmful	11.7 (7.1-16.3)	17.5 (15.2-19.9)	13.6 (8.9-18.2)	15.4 (13.2-17.7)
Consult a book	Helpful	74.3 (68.1-80.6)*	63.4 (60.4-66.4)	68.2 (61.9-74.5)	69.7 (66.9-72.6)
	Harmful	3.7 (1.0-6.4)	10.2 (8.3-12.1)#	5.6 (2.5-8.7)	7.5 (5.9-9.2)
Health educator	Helpful	88.0 (83.4-92.7)	85.6 (83.4-87.8)	91.1 (87.3-95.0)	85.5 (83.3-87.7)
	Harmful	0.5 (-0.5-1.6)	2.2 (1.3-3.1)	0 (n/a)	1.5 (0.8-2.3)

¹ 'Depends' and 'Don't know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%

* HAMPA result higher, #Australia Japan result higher

People who could help

The three people most commonly endorsed as helpful for suicidal depression by journalists were seeing a counselor (92.3%), close friends (91.7%) and a GP (89.7%). The three most commonly endorsed by the Australian public were seeing a counselor (85.4%), GP (83.6%) and close friends (77.1%).

For early schizophrenia, the three people most commonly endorsed as likely to be helpful by journalists were seeing a GP (87.4%), counselor (87.4%) or psychiatrist (85.8%). The three most endorsed by the sample of Australians were seeing a counselor (84.9%), psychiatrist (80.7%) and GP (77.5%).

Harmful ratings were most common for dealing with the problem alone for both suicidal depression and early schizophrenia by journalists and the sample of Australians (69.6%-80.8%).

There were some considerable differences in the perceived level of helpfulness and harmfulness of a range of professionals and lay people for suicidal depression. Confidence Intervals did not overlap for seven of the professionals/lay people who were thought to potentially help and two who were thought to potentially harm the person in the vignette. Specifically, the Australian public who received the suicidal depression vignette were more likely than journalists to rate a chemist (Australia Japan 34.2%; HAMP A 16.0%), social worker (Australia Japan 67.0%; HAMP A 56.8%) and the clergy (Australia Japan 51.3%; HAMP A 32.2%) as helpful. Journalists were more likely to rate a counselor (Australia Japan 85.4%; HAMP A 92.3%), telephone counseling (Australia Japan 66.6%; HAMP A 78.8%), close family (Australia Japan 64.3%; HAMP A 87.1%) and close friends (Australia Japan 77.1%; HAMP A 91.7%) as helpful. The sample of Australians were more likely than journalists to assign harmfulness ratings to telephone counseling (Australia Japan 6.3%; HAMP A 2.1%) and a psychiatrist (Australia Japan 8.3%; HAMP A 3.6%) for the suicidal depression vignette.

Similarly, there were also some significant differences in the perceived level of helpfulness or harmfulness of professionals and lay people for early schizophrenia. Confidence Intervals did not overlap for six of the professionals/lay people who could potentially help and one who was perceived as being able to potentially harm the person in the early schizophrenia vignette, suggesting that these results may also be significant. The Australian public who received the early schizophrenia vignette were more likely than journalists to rate a chemist (Australia Japan 24.4%; HAMP A 10.6%), naturopath (Australia Japan 24.1%; HAMP A 12.2%) or the clergy (Australia Japan

38.2%; HAMPAs 26.9%) as helpful. Journalists were more likely to rate a GP (Australia Japan 77.5%; HAMPAs 87.4%), close family (Australia Japan 61.7%; HAMPAs 81.3%) and close friends (Australia Japan 71.9%; HAMPAs 83.3%) as helpful. The Australian public were more likely than journalists to assign harmfulness ratings to telephone counseling (Australia Japan 7.1%; HAMPAs 2.4%) and less likely to assign harmfulness ratings to dealing with it alone (Australia Japan 71.2%; HAMPAs 80.8%) for the early schizophrenia vignette.

Medications that could help

There was a moderate level of endorsement for some standard psychiatric treatments by the journalists, such as antidepressants for the suicidal depression vignette (68.3%) and antipsychotics for the early schizophrenia vignette (59.1%). Endorsement of these standard psychiatric treatments by the Australian public was significantly lower – antidepressants for the suicidal depression vignette (52.7%) and antipsychotics for the early schizophrenia vignette (33.5%). The most helpful medications for suicidal depression nominated by both journalists and the Australian public were antidepressants (as previously stated) and vitamins, minerals or tonics (HAMPAs 42.7%; Australia Japan survey 43.5%). Antibiotics and pain relievers received low helpfulness ratings by all respondents for both disorders.

Although antidepressants received moderate helpfulness ratings for both disorders, significantly more of the Australian public believed they would be harmful for the person with suicidal depression (Australia Japan 23.3%; HAMPAs 9.0%) and schizophrenia (Australia Japan 22.9%; HAMPAs 8.4%).

For suicidal depression, medications that received the highest harmfulness ratings by respondents in both surveys were tranquilisers (HAMPAs 47.8%; Australia Japan survey 59.2%) and sleeping pills (HAMPAs 46.2%; Australia Japan survey 49.9%). For early schizophrenia, sleeping pills (HAMPAs 47.4%; Australia Japan survey 53.9%) and tranquilisers (HAMPAs 38.6%; Australia Japan survey 48.1%) also received the highest harmfulness ratings.

There were some considerable differences in the perceived level of helpfulness or harmfulness of medications for depression. Three of the medications were seen as significantly more helpful and two as significantly more harmful by respondents who received the depression with suicidal thoughts vignette. The Australian public who received the suicidal depression vignette were significantly more likely than journalists to rate pain relievers (Australia Japan 12.8%; HAMPAs 5.4%) and antibiotics (Australia

Japan 7.8%; HAMPAs 0.5%) as helpful. Journalists were more likely to rate antidepressants (Australia Japan 57.2%; HAMPAs 68.3%) as helpful. The sample of Australians were more likely than journalists to assign harmfulness ratings to antidepressants (Australia Japan 23.3%; HAMPAs 9.0%) and tranquilisers (Australia Japan 59.2%; HAMPAs 47.8%) for the suicidal depression vignette.

There were also some significant differences in the perceived level of helpfulness or harmfulness of medications for early schizophrenia. Confidence Intervals did not overlap for three of the medications that were perceived as potentially helpful for schizophrenia and three that were perceived as potentially harmful suggesting that these results may also be significant. The Australian public who received the early schizophrenia vignette were more likely than journalists to rate vitamins, minerals and tonics (Australia Japan 31.1%; HAMPAs 21.6%) as helpful, whilst journalists were more likely to rate antidepressants (Australia Japan 50.2%; HAMPAs 67.6) and antipsychotics (Australia Japan 33.5%; HAMPAs 59.1) as helpful. The Australian public were more likely than journalists to assign harmfulness ratings to antidepressants (Australia Japan 22.4%; HAMPAs 8.9%), antibiotics (Australia Japan 36.1%; HAMPAs 27.0%) and antipsychotics (Australia Japan 23.9%; HAMPAs 7.4%) for early schizophrenia vignette.

Lifestyle/psychosocial interventions that could help

Less than one-third of respondents in both surveys thought that admission to a psychiatric ward, a standard psychiatric intervention for schizophrenia, would be helpful for the disorder. In fact, the Australian public thought admission to a psychiatric ward for schizophrenia would be more harmful (39.1%) than helpful (32.1%) while journalists were divided on its value (helpful 29.1%; harmful 30.0%). Similarly, admission to a psychiatric ward for suicidal depression was seen as more harmful (Australia Japan 49.7%; HAMPAs 48.4%) than helpful (Australia Japan 19.8%; HAMPAs 5.5%) by respondents in both surveys. These figures also reveal that the Australian public gave significantly higher helpfulness ratings to this evidence-based treatment than journalists for suicidal depression.

Physical activity (89.6%), reading about the problem (82.9%) and learning relaxation (82.4%) were most likely to help with suicidal depression according to journalists. The Australian public nominated physical activity (92.2%), getting out more (89.9%) and learning relaxation (85.2%) as the lifestyle interventions most likely to be helpful for suicidal depression.

Journalists nominated reading about the problem (82.1%), learning relaxation (73.6%) and physical activity (71.5%) as helpful lifestyle interventions for early schizophrenia. Lifestyle/psychosocial interventions deemed most likely to be helpful for early schizophrenia by the Australian public were similar to those nominated by journalists and included physical activity (86.5%), getting out more (86.4%) and reading about the problem (79.4%).

Other lifestyle/psychosocial interventions were frequently nominated as more helpful than harmful for a person with suicidal depression by respondents in both surveys, including getting out more, psychotherapy, cutting out alcohol, having an occasional alcoholic drink, hypnosis and going on a special diet. Lifestyle/psychosocial interventions that were nominated as more helpful than harmful for early schizophrenia in both samples were cutting out alcohol, psychotherapy, hypnosis and going on a special diet.

Harmful ratings were highest for ECT as a treatment for depression with suicidal ideation (Australia Japan 65.8%; HAMPAs 62.1%) and early schizophrenia (Australia Japan 64.4%; HAMPAs 57.5%) and admission to a psychiatric ward for both disorders (as described above). Journalists believed that having an occasional alcoholic drink was more likely to be harmful (26.9%) than helpful (13.9%) for people with early schizophrenia. The Australian public gave equal helpful (30.7%) and harmful (30.0%) ratings to having an occasional drink as a lifestyle/psychosocial intervention for early schizophrenia.

There were some considerable differences in the perceived level of helpfulness or harmfulness of lifestyle/psychosocial interventions for depression. Five of the lifestyle/psychosocial interventions were seen as significantly more helpful and three as significantly more harmful by respondents who received the depression with suicidal thoughts vignette. Specifically, the Australian public who received the suicidal depression vignette were significantly more likely than journalists to rate getting out more (Australia Japan 89.9%; HAMPAs 73.5%), cutting out alcohol (Australia Japan 59.4%; HAMPAs 38.5%), admission to a psychiatric ward (Australia Japan 19.8%; HAMPAs 5.9%) and a special diet (Australia Japan 45.9%; HAMPAs 26.9%) as helpful. Journalists were significantly more likely to rate ECT (Australia Japan 6.6%; HAMPAs 11.0%) as helpful. The Australian public were more likely than journalists to assign harmfulness ratings to reading about the problem (Australia Japan 5.8%; HAMPAs 1.0%), psychotherapy (Australia Japan 10.4%; HAMPAs 1.6%) and hypnosis (Australia Japan 19.6%; HAMPAs 11.6%) for the suicidal depression vignette.

Similarly, there were also some significant differences in the perceived level of helpfulness or harmfulness of lifestyle/psychosocial interventions for early schizophrenia. Confidence Intervals did not overlap for five of the lifestyle/psychosocial interventions that were rated as potentially helpful for schizophrenia and two that were rated as potentially harmful suggesting that these results may also be significant. The Australian public who received the early schizophrenia vignette were more likely than journalists to rate physical activity (Australia Japan 86.5%; HAMPAs 71.5%), getting out more (Australia Japan 86.4%; HAMPAs 67.5%), hypnosis (Australia Japan 30.1%; HAMPAs 17.3%), having an occasional alcoholic drink (Australia Japan 30.7%; HAMPAs 13.9%) and going on a special diet (Australia Japan 42.3%; HAMPAs 21.5%) as helpful. The sample of Australians were more likely than journalists to assign harmfulness ratings to reading about the problem (Australia Japan 4.6%; HAMPAs 1.4%) and psychiatric ward admission (Australia Japan 39.1%; HAMPAs 29.1%) for the early schizophrenia vignette.

Sources of information that could help

All four sources of information, including websites, emailing an expert, consulting a book and contacting a health educator were seen as being more helpful than harmful for suicidal depression and early schizophrenia by journalists and the Australian public. A health educator was nominated as the most helpful source of information for suicidal depression by journalists (88.0%) and the Australian public (85.6%). A health educator was also nominated as the most helpful for early schizophrenia by journalists (91.1%) and the Australian public (85.5%).

There were some differences in the perceived level of helpfulness or harmfulness of sources of information for depression. Two of the sources of information were seen as significantly more helpful and two as significantly more harmful by respondents who received the depression with suicidal thoughts vignette. Specifically, journalists who received the suicidal depression vignette were significantly more likely than the Australian public to rate websites (Australia Japan 53.3%; HAMPAs 65.8%) and consulting a book (Australia Japan 63.4%; HAMPAs 74.3%) as helpful. The Australian public were more likely to rate both of these sources of information as significantly more harmful for suicidal depression (websites – Australia Japan 15.7%, HAMPAs 8.3%; consulting a book – Australia Japan 3.7%, HAMPAs 3.7%).

There were no significant differences in the perceived levels of helpfulness or harmfulness of information sources for schizophrenia among the samples.

Rank order of helpful interventions

Table 5.5 ranks people who could help from most to least helpful for the disorders.

Table 5.6 ranks medical interventions, lifestyle/psychosocial interventions and information sources from most to least helpful, as nominated by respondents.

Interventions that could help are colour coded: black for people who could help, blue for medications that could help, red for lifestyle/psychosocial interventions that could help and green for information sources that could help.

Table 5.5 reveals that the three people most commonly believed to be helpful for suicidal depression and early schizophrenia are the same in both samples, albeit in a different order. In both samples, a counsellor, close friends and a GP are believed to be the most helpful people for suicidal depression. For early schizophrenia, a GP, counsellor and psychiatrist are believed to be the most helpful.

Table 5.6 reveals that a combination of lifestyle/psychosocial interventions and information sources are the preferred interventions for both suicidal depression and early schizophrenia by respondents from both samples. According to respondents, receiving information from a health educator is the most helpful source of information for the disorders, and physical activity, getting out and about more, and learning relaxation are helpful lifestyle/psychosocial interventions for the disorders.

Antidepressants were ranked 7th and 9th for depression by journalists and the Australian public respectively, in terms of their perceived helpfulness for the disorder. Antipsychotics were ranked 10th and 13th by journalists and the Australian public respectively. Admission to a psychiatric ward was not seen as very helpful for depression or schizophrenia.

Table 5.5

Rank order (percentage) of 'helpful' people (from most to least helpful) for the person described in the vignette

Rank	Depression with suicidal thoughts vignette		Early schizophrenia vignette	
	HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
1	Counsellor (92.3)	Counsellor (85.4)	GP (87.4)	Counsellor (84.9)
2	Close friends (91.7)	GP (83.6)	Counsellor (87.4)	Psychiatrist (80.7)
3	GP (89.7)	Close friends (77.1)	Psychiatrist (85.8)	GP (77.5)
4	Close family (87.1) [P]	Psychiatrist (69.9)	Close friends (83.3)	Psychologist (73.4)
5	Phone counselling (78.8)	Psychologist (69.9)	Close family (81.3)	Close friends (71.9)
6	Psychologist (77.5)	Social worker (67.0)	Psychologist (78.6)	Social worker (68.8)
7	Psychiatrist (77.2)	Phone counselling (66.6)	Social worker (65.3)	Close family (61.7)
8	Social worker (56.8)	Close family (64.3)	Phone counselling (62.9)	Phone counselling (57.1)
9	Clergy (32.2)	Clergy (51.3)	Clergy (25.9)	Clergy (38.2)
10	Naturopath/herbalist (24.9)	Chemist/Pharmacist (34.2)	Naturopath/herbalist (12.2)	Chemist/Pharmacist (24.4)
11	Chemist/Pharmacist (16.0)	Naturopath/herbalist (31.5)	Chemist/Pharmacist (10.5)	Naturopath/herbalist (24.1)
12	Deal with it alone (9.8)	Deal with it alone (9.9)	Deal with it alone (5.8)	Deal with it alone (10.9)

Table 5.6

Rank order (percentage) and type of 'helpful' interventions* (from most to least helpful) for the person described in the vignette

Rank	Depression with suicidal thoughts vignette		Early schizophrenia vignette	
	HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
1	Physical activity (89.6)	Physical activity (92.2)	Health educator (91.1)	Physical activity (86.5)
2	Health educator (88.0)	Get out more (89.9)	Read about problem (82.1)	Get out more (86.4)
3	Read about problem (82.9)	Health educator (85.6)	Learn relaxation (73.6)	Health educator (85.5)
4	Learn relaxation (82.4)	Learn relaxation (85.2)	Physical activity (71.5)	Read about problem (79.4)
5	Consult a book (74.3)	Read about problem (79.3)	Consult a book (68.2)	Learn relaxation (76.9)
6	Get out more (73.5)	Consult a book (63.4)	Antidepressants (67.6)	Consult a book (69.7)
7	Antidepressants (68.3)	Cut out alcohol (59.4)	Get out more (67.5)	Cut out alcohol (67.0)
8	Website (65.8)	Website (53.3)	Website (63.7)	Psychotherapy (58.7)
9	Psychotherapy (47.9)	Antidepressants (52.7)	Psychotherapy (61.3)	Website (57.3)
10	Email an expert (47.9)	Psychotherapy (50.3)	Antipsychotics (59.1)	Email an expert (53.4)
11	Vitamins, minerals (42.7)	Email an expert (48.4)	Cut out alcohol (57.5)	Antidepressants (50.2)
12	Occasional drink (39.8)	Special diet (45.0)	Email an expert (51.4)	Special diet (42.3)
13	Cut out alcohol (38.5)	Vitamins, minerals (43.5)	Psychiatric ward (30.0)	Antipsychotics (33.5)
14	Special diet (26.9)	Occasional drink (42.9)	Vitamins, minerals (21.5)	Psychiatric ward (32.1)
15	Sleeping pills (16.1)	Hypnosis (23.7)	Special diet (21.5)	Vitamins, minerals (31.1)
16	Hypnosis (15.9)	Sleeping pills (23.1)	Tranquilisers (19.0)	Occasional drink (30.7)
17	Antipsychotics (14.4)	Psychiatric ward (19.8)	Hypnosis (17.3)	Hypnosis (30.1)
18	Tranquilisers (11.7)	Antipsychotics (16.5)	Occasional drink (13.9)	Sleeping pills (17.9)
19	ECT (11.0)	Tranquilisers (14.9)	Sleeping pills (12.7)	Tranquilisers (17.4)
20	Psychiatric ward (5.9)	Pain relievers (12.6)	ECT (5.6)	Pain relievers (7.8)
21	Pain relievers (5.4)	Antibiotics (7.8)	Pain relievers (4.2)	ECT (7.0)
22	Antibiotics (0.5)	ECT (6.6)	Antibiotics (1.9)	Antibiotics (3.8)

* Medications that could help, Lifestyle/psychosocial interventions that could help, Information sources that could help

5.3.3 Knowledge about causes and risk factors

Table 5.7 shows the percentage of respondents rating different causes as 'likely' or 'very likely' for suicidal depression and early schizophrenia.

More than 90% of the Australian public thought that day-to-day problems (95.6%), problems from childhood (94.9%), the death of someone close (94.7%) and a traumatic event (93.0%) were likely causes of suicidal depression. Journalists nominated the same factors as causes of suicidal depression, but in a different order, including the death of someone close (93.8%), problems from childhood (93.7%), day-to-day problems (93.2%) and a traumatic event (92.2%).

The Australian public rated several risk factors as more likely to cause suicidal depression than journalists. Respondents to the Australia Japan survey were significantly more likely than journalists to nominate a virus or infection (Australia Japan 41.7%; HAMP A 17.6%), allergy (Australia Japan 38.5%; HAMP A 20.3%), being a nervous person (Australia Japan 65.4%; HAMP A 40.0%) or having weakness of character (Australia Japan 45.4%; HAMP A 12.6%) as likely causes of depression. Conversely, journalists were significantly more likely to endorse genetic or inherited factors as a cause of depression (Australia Japan 68.7%; HAMP A 80.1%).

A similar pattern of responses was observed for the early schizophrenia vignette. When compared to the journalists, the Australian public were significantly more likely to nominate a virus or infection (Australia Japan 32.3%; HAMP A 6.9%), allergy (Australia Japan 32.2%; HAMP A 14.9%), day-to-day problems (Australia Japan 88.8%; HAMP A 78.3%), the death of someone close (Australia Japan 87.0%; HAMP A 74.6%), a traumatic event (Australia Japan 86.3%; HAMP A 73.2%), being a nervous person (Australia Japan 57.7%; HAMP A 29.3%) and weakness of character (Australia Japan 17.8%; HAMP A 3.7%) as causes of schizophrenia. Journalists were significantly more likely to nominate genetic or inherited factors (Australia Japan 71.2%; HAMP A 84.3%) as a likely cause of schizophrenia.

Table 5.7

Percentage (and 95% Confidence Intervals) of respondents giving each cause as 'very likely' or 'likely' for the person described in the vignette

Cause	Depression with suicidal thoughts vignette		Early schizophrenia vignette	
	HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Virus or infection	17.6 (12.2-23.0)	41.7 (38.7-44.8)#	6.9 (3.5-10.4)	32.3 (29.4-35.2) #
Allergy	20.3 (14.6-26.1)	38.5 (35.5-41.6)#	14.9 (10.1-19.7)	32.2 (29.3-35.1) #
Day-to-day problems	93.2 (89.6-96.8)	95.6 (94.3-96.9)	78.3 (72.8-83.9)	88.8 (86.8-90.7) #
Death of someone close	93.8 (90.3-97.2)	94.7 (93.3-96.1)	74.6 (68.8-80.5)	87.0 (84.9-89.1) #
Traumatic event	92.2 (88.4-96.0)	93.0 (91.4-94.6)	73.2 (67.2-79.1)	86.3 (84.2-88.5) #
Problems from childhood	93.7 (90.2-97.2)	94.9 (93.5-96.3)	85.6 (80.9-90.3)	90.2 (88.3-92.0)
Inherited or genetic	80.1 (74.4-85.8)*	68.7 (65.8-71.6)	84.3 (79.5-89.2)*	71.2 (68.4-74.0) #
Nervous person	40.0 (33.0-47.0)	65.4 (62.4-68.3) #	29.3 (23.2-35.4)	57.7(54.7-60.8) #
Weakness of character	12.6 (7.9-17.4)	45.4 (42.3-48.4) #	8.4 (4.7-12.2)	38.7 (35.7-41.7) #

Note: 'Just as likely', 'Depends' and 'Don't know' responses are not shown

* HAMPA result higher, #Australia Japan result higher

Table 5.8 presents respondents' beliefs about the groups of people most at risk of developing the problem described in the vignette. The table shows that both journalists and the Australian public believed that unemployed people (HAMPA 74.5%; Australia Japan survey 76.9%) and divorced or separated people (HAMPA 65.1%; Australia Japan survey 64.1%) had the greatest risk of developing suicidal depression in comparison with other population groups.

When compared to the journalists, the Australian public were significantly more likely to nominate young people (Australia Japan 47.2%; HAMPA 30.7%) and poor people (Australia Japan 51.5%; HAMPA 30.7%) as more likely to experience suicidal depression. Results also demonstrate that the Australian public who received the suicidal depression vignette more often thought that women (Australia Japan 13.9%; HAMPA 4.7%), old people (Australia Japan 36.9%; HAMPA 22.9%), unemployed people (Australia Japan 4.5%; HAMPA 0%), divorced or separated people (Australia Japan 5.6%; HAMPA 0.5%) and single people (Australia Japan 19.7%; HAMPA 4.7%) were less likely to experience depression than the journalists.

A similar pattern was observed for the early schizophrenia vignette. Both journalists and the Australian public believed that unemployed people and young people are more likely to develop schizophrenia than other groups in the population. The main differences were related to the degree to which respondents believed that a person was more likely to develop schizophrenia. The Australian public rated women (Australia Japan 21.3%; HAMPA 11.2%), young people (Australia Japan 55.1%; HAMPA 42.6%), poor people (Australia Japan 37.3%; HAMPA 15.0%), the unemployed (Australia Japan 62.9%; HAMPA 48.2%) and divorced or separated people (Australia Japan 52.9%; HAMPA 36.3%) as more likely to experience early schizophrenia than journalists. When compared with the journalists, more of the Australian public who received the schizophrenia vignette believed that old people (Australia Japan 43.7%; HAMPA 28.2%), poor people (Australia Japan 9.1%; HAMPA 3.3%), unemployed people (Australia Japan 5.1%; HAMPA 0%), divorced or separated people (Australia Japan 5.0%; HAMPA 0.5%) and single people (Australia Japan 17.8%; HAMPA 3.7%) would be less likely to experience the disorder.

Table 5.8

Percentage (and 95% Confidence Intervals) of respondents rating each group in the population as 'more likely' or 'less likely' to experience the problem described in the vignette

Population group		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Women	More likely	23.4 (17.4-29.5)	27.9 (25.1-30.7)	11.2 (6.9-15.4)	21.3 (18.7-23.8)#
	Less likely	4.7 (1.7-7.7)	13.9 (11.8-16.1)#	8.4 (4.7-12.1)	13.0 (11.0-15.1)
Young	More likely	30.7 (24.1-37.3)	47.2 (44.1-50.3)#	42.6 (36.0-49.2)	55.1 (52.0-58.2)#
	Less likely	14.1 (9.1-19.0)	18.5 (16.1-20.9)	6.0 (2.8-9.2)	10.8 (8.0-12.8)
Old	More likely	24.0 (17.9-30.1)	28.9 (26.1-31.8)	16.7 (11.7-21.7)	21.9 (19.3-24.4)
	Less likely	22.9 (16.9-28.9)	36.9 (33.9-39.9)#	28.2 (22.2-34.3)	43.7 (40.7-46.8)#
Poor	More likely	30.7 (24.1-37.3)	51.5 (48.4-54.6)#	15.0 (10.1-19.8)	37.3 (34.3-40.3)#
	Less likely	4.2 (1.3-7.0)	7.7 (6.1-9.4)	3.3 (0.9-5.7)	9.1 (7.3-10.9)#
Unemployed	More likely	74.5 (68.3-80.7)	76.9 (74.3-79.5)	48.2 (41.4-54.9)	62.9 (59.9-65.9)#
	Less likely	0	4.5 (3.2-5.8)#	0	5.1 (3.8-6.5)#
Divorced/ separated	More likely	65.1 (58.3-71.9)	64.1 (61.1-67.0)	36.3 (29.8-42.8)	52.9 (49.8-56.0)#
	Less likely	0.5 (-0.5-1.6)	5.6 (4.2-7.0)#	0.5 (-0.5-1.4)	5.0 (3.7-6.4)#
Single	More likely	20.4 (14.7-26.2)	25.7 (23.0-26.4)	20.0 (14.6-25.4)	21.7 (19.1-24.2)
	Less likely	4.7 (1.7-7.7)	19.7 (17.3-22.2)#	3.7 (1.2-6.3)	17.8 (15.4-20.1)#

Note: 'Just as likely,' 'Depends' and 'Don't know' responses are not shown

* HAMPA result higher, #Australia Japan result higher

5.3.4 Beliefs about recovery

Respondents' beliefs about outcomes after receiving professional help and outcomes without professional help are presented in table 5.9.

For suicidal depression, both journalists and the Australian public thought that a person receiving appropriate help would make either a full recovery with later relapse (HAMPA 44.7%; Australia Japan survey 49.0%) or a full recovery (HAMPA 24.5%; Australia Japan survey 31.4%). Without professional help, respondents in both surveys thought the person with suicidal depression would get worse, although the Australian public were significantly more likely to hold this view (HAMPA 54.5%; Australia Japan survey 74.0%).

A different pattern of responses was demonstrated for the early schizophrenia vignette. After receiving professional help, journalists believed that full recovery with later relapse (40.7%) or partial recovery with later relapse (20.6%) were the most likely outcomes. The Australian public respondents believed that full recovery with later relapse (48.2%) or full recovery (25.4%) were most likely after receiving professional help. Journalists were not at all optimistic about a full recovery from schizophrenia. The Australian public were significantly more optimistic than journalists that a person who received professional help for schizophrenia would make a full recovery (Australia Japan 25.4%; HAMPA 11.2%).

Without professional help, all respondents believed that the person in the schizophrenia vignette would get worse with the Australian public significantly more likely to believe in a poor outcome for the disorder (Australia Japan 80.2%, HAMPA 67.1%)

Table 5.10 presents respondents' beliefs about the likelihood that people will engage in a number of negative and positive behaviours after they have received professional assistance for their problem.

Table 5.9

Percentage (and 95% Confidence Intervals) of respondents giving each outcome as likely for the person described in the vignette

Likely outcome	Depression with suicidal thoughts vignette		Early schizophrenia vignette	
	HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
With professional help				
Full recovery	24.5 (18.3-30.7)	31.4 (28.5-34.3)	11.2 (7.0-15.5)	25.4 (22.6-28.1)#
Full recovery with relapse	44.7 (37.5-51.9)	49.0 (45.9-52.2)	40.7 (34.0-47.3)	48.2 (45.0-51.4)
Partial recovery	6.4 (2.9-9.9)	9.2 (7.4-11.1)	11.2 (7.0-15.5)	12.5 (10.4-14.6)
Partial recovery with relapse	9.0 (4.9-13.2)	9.8 (8.0-11.7)	20.6 (15.1-26.0)	13.5 (11.4-15.7)
No improvement	0.5 (-0.5-1.6)	0.3 (0-0.7)	0 (n/a)	0.2 (-0.1-0.5)
Get worse	0 (n/a)	0.2 (-0.1-0.5)	0 (n/a)	0.2 (-0.1-0.5)
Don't know	14.9 (9.8-20.0)	0 (n/a)	16.4 (11.4-21.4)	0 (n/a)
Without professional help				
Full recovery	1.1 (-0.4-2.5)	0.4 (0-0.8)	0 (n/a)	0.7 (0.2-1.2)
Full recovery with relapse	2.6 (0.3-4.9)	1.6 (0.8-2.4)	0.5 (-0.5-1.4)	0.6 (0.1-1.1)
Partial recovery	4.2 (1.3-7.1)	2.7 (1.7-3.7)	0.5 (-0.5-1.4)	1.1 (0.5-1.8)
Partial recovery with relapse	10.5 (6.1-14.9)	6.9 (5.3-8.5)	8.5 (4.7-12.2)	3.9 (2.7-5.1)
No improvement	11.5 (7.0-16.1)	14.5 (12.3-16.7)	10.8 (6.6-15.0)	13.5 (11.4-15.7)
Get worse	54.5 (47.3-61.6)	74.0 (71.2-76.7)#	67.1 (60.8-73.5)	80.2 (77.7-82.7)#
Don't know	15.7 (10.5-20.9)	0 (n/a)	12.7 (8.2-17.2)	0 (n/a)

* HAMPA result higher, #Australia Japan result higher

For the suicidal depression vignette there was little difference in the percentage of journalists and the Australian public rating each of the negative outcomes as more or less likely for the person in the vignette. Attempt suicide was the most frequently endorsed negative outcome measure. Respondents who received the suicidal depression vignette (HAMPA 30.3%; Australia Japan survey 21.5%) and early schizophrenia vignette (HAMPA 40.7%; Australia Japan survey 34.4%) believed that a person was more likely to attempt suicide even after receiving treatment. Conversely, attempting suicide also received the highest less likely rating for suicidal depression (HAMPA 38.3%; Australia Japan survey 39.8%). These results, although appearing contradictory, demonstrate that people hold strong opinions either way about suicide and were unlikely to choose a depends, don't know or no difference/same response category. Only a minority of respondents thought that the person described in the suicidal depression vignette would be more likely to be violent after receiving treatment (HAMPA 2.1%; Australia Japan survey 5.4%). In fact, journalists (37.6%) and the Australian public (32.6%) thought that after receiving treatment for depression, a person would be less likely to be violent.

In terms of positive outcomes, being understanding of others' feelings was the most frequently endorsed statement. The Australian public who received the depression vignette were significantly more likely to endorse being understanding of others' feelings compared with the journalists (Australia Japan 61.8%, HAMPA 47.6%). Being a caring parent (Australia Japan 29.4%, HAMPA 31.9%) and productive worker (Australia Japan 24.7%, HAMPA 34.2%) were also endorsed as more likely long term outcomes after receiving treatment for suicidal depression. A significantly greater percentage of journalists believed that a person with suicidal depression would be less likely to be a productive worker than the Australian public, although these percentages were still relatively small (Australia Japan 7.1%, HAMPA 13.7%).

Table 5.10

Percentage (and 95% Confidence Intervals) of respondents rating each long-term outcome as 'more likely' or 'less likely' after the person described in the vignette has received professional help

Outcomes		Depression with suicidal thoughts vignette		Early schizophrenia vignette	
		HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Negative outcomes					
Be violent	More likely	2.1 (0.1-4.2)	5.4 (4.0-6.8)	10.3 (6.2-14.5)	12.1 (10.1-14.2)
	Less likely	37.6 (30.6-44.5)	32.6 (29.7-35.6)	30.5 (24.3-36.8)	23.8 (21.1-26.4)
Drink too much	More likely	18.9 (13.3-24.4)	14.4 (12.2-16.6)	16.8 (11.8-21.9)	15.2 (12.9-17.4)
	Less likely	33.0 (26.3-39.7)	26.0 (23.3-28.8)	27.6 (21.5-33.6)	20.0 (17.5-22.5)
Take illegal drugs	More likely	13.2 (8.3-18.0)	14.4 (12.2-16.6)	18.8 (13.5-24.1)	16.6 (14.2-18.9)
	Less likely	34.7 (27.9-41.6)	31.1 (28.3-34.0)	28.6 (22.5-34.8)	25.3 (22.6-29.0)
Have poor friendships	More likely	22.5 (16.5-28.5)	15.0 (12.8-17.2)	33.0 (26.7-39.4)	25.0 (22.3-27.7)
	Less likely	30.4 (23.8-37.0)	29.6 (26.8-32.5)	26.1 (20.1-32.0)	18.3 (15.9-20.7)
Attempt suicide	More likely	30.3 (23.7-37.0)	21.5 (19.0-24.1)	40.7 (34.0-47.3)	34.4 (31.5-37.4)
	Less likely	38.3 (31.3-45.3)	39.8 (36.8-42.9)	25.7 (19.8-31.6)	24.4 (21.7-27.0)
Positive outcomes					
Understand others' feelings	More likely	47.6 (40.4-54.8)	61.8 (58.7-64.8)#	38.4 (31.9-45.0)	46.5 (43.4-49.6)
	Less likely	14.3 (9.3-19.3)	9.2 (7.4-11.0)	14.8 (10.0-19.6)	16.5 (14.1-18.8)
Have good marriage	More likely	26.5 (20.1-32.8)	22.2 (19.6-24.8)	17.2 (12.1-22.3)	14.4 (12.3-16.6)
	Less likely	14.3 (9.3-19.3)	9.9 (8.1-11.8)	26.5 (20.6-32.5)	19.3 (16.8-21.7)
Be caring parent	More likely	31.9 (25.3-38.6)	29.4 (26.6-32.3)	20.8 (15.4-26.3)	20.3 (17.7-22.8)
	Less likely	9.4 (5.2-13.6)	5.6 (4.2-7.0)	12.0 (7.7-16.4)	11.7 (9.7-13.7)
Be productive worker	More likely	34.2 (27.4-41.0)	24.7 (22.0-27.4)	25.5 (19.6-31.3)*	15.7 (13.4-17.9)
	Less likely	13.7 (8.8-18.6)*	7.1 (5.5-8.7)	15.7 (10.9-20.6)	13.5 (11.4-15.7)
Be creative	More likely	25.7 (19.4-31.9)	22.1 (19.5-24.7)	35.4 (28.9-41.8)	26.1 (23.4-28.8)#
	Less likely	8.9 (4.8-13.0)	6.4 (4.9-7.9)	4.2 (1.5-7.9)	7.5 (5.9-9.2)

Note: 'Just as likely', 'Depends' and 'Don't know' responses are not shown

* HAMPA result higher, #Australia Japan result higher

For the schizophrenia vignette, significantly more respondents believed that people who had received treatment for their disorder would be more understanding of people's feelings (HAMPA 38.4%; Australia Japan survey 46.5%) in the long term but would also be more likely to attempt suicide (HAMPA 40.7%; Australia Japan survey 34.4%) and have poor friendships (HAMPA 33.0%; Australia Japan survey 25.0%). When compared with the Australian public, journalists also believed that a person who received treatment for schizophrenia would be significantly more likely to be a productive worker (Australia Japan 15.7%, HAMPA 25.5%) and to be creative in the long term (Australia Japan 26.1%, HAMPA 35.4%).

5.3.5 Personal and perceived stigma

Tables 5.11 to 5.13 present the results obtained from the stigma measures in the surveys. Table 5.11 shows the mean personal and perceived stigma scores of respondents. As described in the methodology section, scores on each of the stigma scales can potentially range from 0 to 36, with higher scores representing greater stigma. Personal stigma scores of journalists ranged from 0 to 27 for suicidal depression ($M=10.8$) and 0 to 23 for early schizophrenia. ($M=10.2$) Perceived stigma scores ranged from 6 to 36 for suicidal depression ($M=22.6$) and 0 to 34 for early schizophrenia ($M=22.6$). Personal stigma scores for the Australian public ranged from 0 to 34 for suicidal depression ($M=13.0$) and 0 to 36 for early schizophrenia ($M=13.7$). Perceived stigma scores ranged from 1 to 36 for both suicidal depression ($M=21.6$) and early schizophrenia ($M=22.2$) in the Australian public. ANOVAs were used to test for significant differences in the mean stigma scores between the samples. The mean personal stigma score of the Australian public was significantly higher than that of journalists for suicidal depression ($F_{(1,1184)} = 27.708, p < 0.001$) and early schizophrenia ($F_{(1,1213)} = 90.027, p < 0.001$), indicating that the Australian public have greater

Table 5.11

Mean (M) stigma scores and standard deviations (SD) of respondents for the Personal and Perceived Stigma Scales

Vignette	Sample	Personal Stigma Score	Perceived Stigma Score
Depression (suicidal)	HAMPA	M=10.8, SD=4.8	M=22.6, SD=5.0
	Australia Japan	M=13.0, SD=5.5	M=21.6, SD=5.1
Schizophrenia (early)	HAMPA	M=10.2, SD=4.6	M=22.6, SD=4.8
	Australia Japan	M=13.7, SD=5.2	M=22.2, SD=5.2

Table 5.12

Percentage (and 95% Confidence Intervals) of respondents who 'agree' or 'strongly agree' with each statement from the Personal Stigma Scale

Personal Stigma statements I believe that ...	Depression with suicidal thoughts vignette		Early schizophrenia vignette	
	HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Person could snap out of the problem	4.2 (1.3-7.0)	23.0 (20.4-25.6)#	2.3 (0.3-4.3)	17.7 (15.3-20.0)#
Problem is a sign of personal weakness	4.7 (1.7-7.7)	16.7 (14.4-19.0)#	4.1 (1.5-6.8)	18.4 (16.0-20.8)#
Problem is not a real medical illness	3.7 (1.0-6.3)	16.7 (14.4-19.0)#	2.7 (0.6-4.9)	14.6 (12.5-16.8)#
People with this problem are dangerous	2.6 (0.3-4.9)	17.7 (15.4-20.1)#	13.7 (9.1-18.3)	24.9 (22.2-27.6)#
Avoid people with this problem	0.5 (-0.5-1.6)	4.4 (3.1-5.7)#	0.5 (-0.4-1.4)	4.6 (3.3-5.9)#
People with this problem are unpredictable	41.5 (34.4-48.5)	51.6 (48.5-54.7)	63.9 (57.5-70.3)	67.6 (64.7-70.5)
If I had this problem I wouldn't tell anyone	17.0 (11.7-22.3)	21.3 (18.8-23.9)	16.0 (11.1-20.9)	27.0 (24.2-29.7)#
I would not employ someone with this problem	22.4 (16.5-28.4)	22.8 (20.2-25.4)	19.7 (14.4-25.1)	25.1 (22.4-27.8)
I would not vote for a politician with this problem	17.5 (12.1-22.9)	32.6 (29.7-35.6)#	18.7 (13.5-23.9)	36.4 (33.4-39.4)#

Note: 'Neither Agree nor Disagree,' 'Depends' and 'Don't know' responses are not shown

* HAMPA result higher, #Australia Japan result higher

Table 5.13

Percentage (and 95% Confidence Intervals) of respondents who 'agree' or 'strongly agree' with each statement from the Perceived Stigma Scale

Perceived Stigma Statements	Depression with suicidal thoughts vignette		Early schizophrenia vignette	
	HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Most other people believe that...				
Person could snap out of the problem	62.4 (55.5-69.4)	60.8 (57.7-63.8)	51.4 (44.7-58.1)	53.0 (49.9-56.1)
Problem is a sign of personal weakness	64.0 (57.1-70.9)	55.1 (52.0-58.1)	54.4 (47.7-61.1)	52.7 (49.6-55.8)
Problem is not a real medical illness	63.0 (56.0-69.9)	55.2 (52.1-58.2)	48.4 (41.6-55.1)	47.1 (44.0-50.3)
People with this problem are dangerous	38.7 (31.6-45.6)	40.3 (37.3-43.4)	67.0 (60.6-73.3)	59.0 (55.9-62.0)
Avoid people with this problem	35.5 (28.6-42.3)	36.4 (33.5-39.4)	38.1 (31.6-44.7)	40.2 (37.2-43.3)
People with this problem are unpredictable	73.9 (67.6-80.3)	68.7 (65.8-71.6)	87.0 (82.4-91.5)	79.1 (76.6-81.7)
If I had this problem I wouldn't tell anyone	63.4 (56.5-70.4)	66.6 (63.6-69.5)	63.6 (57.1-70.1)	68.6 (65.7-71.5)
I would not employ someone with this problem	76.9 (70.8-83.0)	72.7 (69.9-75.4)	80.4 (75.0-85.7)	77.0 (74.4-79.7)
I would not vote for a politician with this problem	68.7 (61.9-75.4)	70.6 (67.7-73.4)	77.1 (71.4-82.8)	76.8 (74.2-79.5)

Note: 'Neither Agree nor Disagree,' 'Depends' and 'Don't know' responses are not shown

* HAMPA result higher, #Australia Japan result higher

stigma than journalists. The mean perceived stigma score of journalists was significantly higher than that of the Australian public for suicidal depression ($F_{(1,1181)} = 6.129, p < 0.05$). There were no significant differences in the mean perceived stigma scores between respondents who received the early schizophrenia vignette ($F_{(1,1209)} = 1.059, p > 0.05$).

Mean perceived stigma scores were higher than mean personal stigma scores in both samples for both disorders.

For suicidal depression, the item most commonly endorsed by respondents in both surveys was that people with this problem are unpredictable (HAMPA 41.5%; Australia Japan survey 51.6%). For suicidal depression, the next most endorsed item by journalists was that they would not employ someone with this problem (22.4%). In contrast, the next most endorsed item for the Australia Japan survey was that respondents would not vote for a politician with this problem (32.6%). For early schizophrenia, the item most commonly endorsed by respondents in both surveys was that people with this problem are unpredictable (HAMPA 63.9%; Australia Japan survey 67.6%). The next most endorsed item for early schizophrenia by journalists was that they would not employ someone with this problem (19.7%) and for the Australia Japan survey was that they would not vote for a politician with this problem (36.4%). Stigmatising attitudes from all respondents were generally higher for early schizophrenia compared with suicidal depression.

Table 5.12 demonstrates the percentage of respondents who agreed with each statement from the personal stigma scale. Across the board, stigmatising attitudes were greater among the sample of the Australian public than the journalists. The Australian public who received the suicidal depression vignette were significantly more likely than journalists to agree or strongly agree with six of the personal stigma statements contained in the Depression Stigma Scale. For suicidal depression, the Australian public were more likely to believe that a person could snap out of the problem (Australia Japan 23.0%, HAMPA 4.2%), problem is a sign of personal weakness (Australia Japan 16.7%, HAMPA 4.7%), problem is not a real medical illness (Australia Japan 16.7%, HAMPA 3.7%), people with this problem are dangerous (Australia Japan 17.7%, HAMPA 2.6%), avoid people with this problem (Australia Japan 4.4%, HAMPA 0.5%) and they would not vote for a politician with this problem (Australia Japan 32.6%, HAMPA 17.5%).

Stigmatising attitudes were also greater among the Australian public who received the early schizophrenia vignette. When compared with journalists, the Australian public was significantly more likely to agree or strongly agree with seven of the personal stigma statements. For early schizophrenia, the Australian public were more likely to believe that a person could snap out of the problem (Australia Japan 17.7%, HAMPAs 2.3%), problem is a sign of personal weakness (Australia Japan 18.4%, HAMPAs 4.1%), problem is not a real medical illness (Australia Japan 14.6%, HAMPAs 2.7%), people with this problem are dangerous (Australia Japan 24.9%, HAMPAs 13.7%), it is best to avoid people with this problem (Australia Japan 4.6%, HAMPAs 0.5%), if they had this problem they wouldn't tell anyone (Australia Japan 27.0%, HAMPAs 16.0%) and that they would not vote for a politician with this problem (Australia Japan 36.4%, HAMPAs 18.7%).

Table 5.13 demonstrates the percentage of respondents who agreed with each statement from the Perceived Stigma Scale. Respondents generally agreed that others in the community would hold stigmatising attitudes toward people with mental disorders. The percentage of journalists endorsing a statement from the Perceived Stigma Scale for suicidal depression ranged from 35.5% to 76.9% and for early schizophrenia ranged from 38.1% to 87.0%. The percentage of the Australian public endorsing a statement from the Perceived Stigma Scale for suicidal depression ranged from 36.4% to 72.7% and for early schizophrenia ranged from 40.2% to 79.1%. For suicidal depression, the item most commonly endorsed by respondents was that others would not employ someone with this problem (HAMPAs 76.9%; Australia Japan survey 72.7%). For early schizophrenia, the most commonly endorsed item was that people with this problem are unpredictable (HAMPAs 87.9%; Australia Japan survey 79.1%). The least endorsed item for both disorders and by respondents in both surveys was that others would avoid a person with this problem (35.5% to 40.2%). There were no significant differences between the samples for Perceived Stigma Statements.

Discrimination

To gauge respondents' beliefs about potential discrimination facing the person described in the vignette, respondents were asked the following question: 'Do you think that John/Mary would be discriminated against by others in the community, if they knew about her condition?' Respondents believed that the person in the vignettes had a high chance of being discriminated against by others in the community. Respondents more commonly believed that discrimination would occur in the case of the person with early schizophrenia (Australia Japan 75.8%; HAMPAs 84.4%) compared to the person with suicidal depression (Australia Japan 62.2%; HAMPAs 63.1%).

5.3.6 Attitudinal social distance

Table 5.14 presents the results from the Social Distance Scale showing the percentage of respondents who were unwilling (combines definitely unwilling and probably unwilling responses) to make social contact for each item and each vignette.

For both disorders, respondents from both samples were least willing to have the person in the vignette marry into the family (suicidal depression HAMPA 33.0%, Australia Japan 34.3%; schizophrenia HAMPA 29.2%, Australia Japan survey 40.7%). The Australian public were significantly more unwilling than journalists to have a person with schizophrenia marry into the family.

Around one-quarter of respondents in both surveys would be unwilling to work closely with a person with suicidal depression or schizophrenia (suicidal depression HAMPA 26.0%, Australia Japan 19.6%; schizophrenia HAMPA 24.0%, Australia Japan 23.4%). Social distance was lowest for moving next door to a person with suicidal depression (HAMPA 9.4%, Australia Japan 11.0%) and making friends with a person with schizophrenia (HAMPA 16.1%, Australia Japan 12.3%).

5.3.7 Summary of similarities and differences between the samples

Table 5.15 summarises the differences in mental health literacy between the samples that have been described in this chapter.

5.4 Discussion

Suicidal depression was correctly identified by the majority of respondents in both surveys, however early schizophrenia was poorly recognised by both journalists and the Australian public. Journalists endorsed lifestyle/psychosocial interventions and sources of information in preference to medications for the treatment of the disorders. Similarly, social environmental causes and risk factors were endorsed over biological factors in the development of the suicidal depression, but biological factors were considered important for early schizophrenia. Respondents were optimistic in their prognosis for suicidal depression when treatment was sought for the condition but were less optimistic about the prognosis for early schizophrenia.

Table 5.14

Percentage (and 95% Confidence Intervals) of respondents who would be 'definitely unwilling' or 'probably unwilling' to have various types of social contact from the person in the vignette

Social contact	Depression with suicidal thoughts vignette		Early schizophrenia vignette	
	HAMPA	Australia Japan survey	HAMPA	Australia Japan survey
Move next door	9.4 (5.2-13.6)	11.0 (9.9-13.0)	14.8 (10.0-19.6)	15.9 (13.6-18.1)
Spend evening socialising	15.6 (10.4-20.8)	12.3 (10.3-14.4)	15.2 (10.4-20.0)	15.7 (13.4-17.9)
Make friends	12.5 (7.8-17.2)	9.3 (7.5-11.1)	16.1 (11.2-21.1)	12.3 (10.3-14.4)
Work closely	26.0 (19.8-32.3)	19.6 (17.2-22.1)	24.0 (18.2-29.7)	23.4 (20.7-26.0)
Marry into family	33.0 (26.3-39.7)	34.3 (31.4-37.3)	29.2 (23.1-35.3)	40.7 (37.7-43.8)#

Note: 'Probably willing', 'Definitely willing' and 'Don't know' responses are not shown

* HAMPA result higher, #Australia Japan result higher

Table 5.15

Summary of **differences** in results between the Australian sample and journalists by vignette received

	Suicidal Depression	Early Schizophrenia
Recognition	Journalists better at recognising suicidal depression from unlabelled vignette	
Treatments	<p>The Australian public gave higher helpfulness ratings to:</p> <ul style="list-style-type: none"> ·Pain relievers ·Antibiotics ·Get out more ·Cut out alcohol ·Psychiatric ward admission ·Special diet ·Chemist/pharmacist ·Social worker ·Clergy <p>Journalists gave higher helpfulness ratings to:</p> <ul style="list-style-type: none"> ·Antidepressants ·ECT ·Website ·Consult a book ·Counsellor ·Phone counselling ·Close family ·Close friends 	<p>The Australian public gave higher helpfulness ratings to:</p> <ul style="list-style-type: none"> ·Vitamins, minerals or tonics ·Physical activity ·Get out more ·Hypnosis ·Occasional alcoholic drink ·Special diet ·Chemist/pharmacist ·Naturopath/herbalist ·Clergy <p>Journalists gave higher helpfulness ratings to:</p> <ul style="list-style-type: none"> ·Antidepressants ·Antipsychotics ·GP ·Close family ·Close friends
<p>Medications that could help, Lifestyle/psychosocial interventions that could help, Information sources that could help, People who could help</p>		

Table 5.15 continued

Summary of **differences** in results between the Australian sample and journalists by vignette received

	Suicidal Depression	Early Schizophrenia
Treatments	<p>The Australian public gave higher harmfulness ratings to:</p> <ul style="list-style-type: none"> ·Antidepressants ·Tranquilisers ·Read about problem ·Psychotherapy ·Hypnosis ·Website ·Consult a book ·Phone counselling ·Psychiatrist 	<p>The Australian public gave higher harmfulness ratings to:</p> <ul style="list-style-type: none"> ·Antidepressants ·Antibiotics ·Antipsychotics ·Read about problem ·Psychiatric ward admission ·Phone counselling <p>Journalists gave higher harmfulness ratings to:</p> <ul style="list-style-type: none"> ·Deal with it alone
Causes & Risk Factors	<p>The Australian public think the following are more likely causes:</p> <ul style="list-style-type: none"> ·Virus or infection ·Allergy ·Being a nervous person ·Weakness of character <p>Journalists think the following are more likely causes:</p> <ul style="list-style-type: none"> ·Inherited or genetic factors 	<p>The Australian public think the following are more likely causes:</p> <ul style="list-style-type: none"> ·Virus or infection ·Allergy ·Day-to-day problems ·Death of someone close ·A traumatic event ·Being a nervous person ·Weakness of character <p>Journalists think the following are more likely causes:</p> <ul style="list-style-type: none"> ·Inherited or genetic factors
<p>Medications that could help, Lifestyle/psychosocial interventions that could help, Information sources that could help, People who could help</p>		

Table 5.15 continued

Summary of differences in results between the Australian sample and journalists by vignette received

	Suicidal Depression	Early Schizophrenia
Recovery	Without professional help the Australian public think person will get worse	Without professional help the Australian public think person will get worse With professional help The Australian public think person will make a full recovery
Long term behaviours	With professional help, the Australian public think person in vignette is more likely to be understanding of others feelings With professional help, the Australian public think person in vignette is less likely to be a productive worker	With professional help, Journalists think person in vignette is more likely to be: ·A productive worker ·Creative
Stigma – personal	The Australian public have significantly higher mean personal stigma scores The Australian public were more likely to agree with the following statements. I believe that: ·Person could snap out of the problem ·Problem is a sign of personal weakness ·Problem is not a real medical illness ·People with this problem are dangerous ·Avoid people with this problem ·I would not vote for a politician with this problem	The Australian public have significantly higher mean personal stigma scores The Australian public more likely to agree with the following statements. I believe that: ·Person could snap out of the problem ·Problem is a sign of personal weakness ·Problem is not a real medical illness ·People with this problem are dangerous ·Avoid people with this problem ·If I had this problem I wouldn't tell anyone ·I would not vote for a politician with this problem
Stigma – perceived	Journalists have significantly higher mean perceived stigma scores	
Social Distance		The Australian public more unwilling to have the person in the vignette marry into the family

5.4.1 Recognition of mental disorder

Journalists (88.8%) were better at identifying suicidal depression than the Australian public (77.3%), although both groups demonstrated a relatively high level of recognition of the disorder.

Better depression literacy has previously been linked to educational attainment. The review of the literature in Chapter 2 reported that surveys of the Australian public have linked higher education to better depression literacy, especially with regard to knowledge about the debilitating effects of depression and its prevalence (Hight, et al., 2006). A high proportion of journalists (62.4%) had tertiary qualifications relative to the Australian public (22.0%), which may have contributed to their better recognition of the disorder from an unlabelled vignette.

The increased profile of depression as a mental illness in both the Australian community and journalist's own workplaces may also explain the finding. This explanation requires that the journalists were either more likely to absorb the information than the Australian public, or were more often exposed to this kind of information in their job. The latter explanation is more likely to account for these differences since both journalists and the public were exposed to campaigns run by *beyondblue: the national depression initiative*, but that only journalists were exposed to an industry run campaign specifically aimed at increasing their knowledge of depression and other mental disorders through the development of hard copy and online guidelines on reporting suicide and mental health, in combination with face-to-face interventions by the Hunter Institute of Mental Health.

The fact that the Australian public were better at recognising depression in 2003/2004 than in previous surveys may also be explained by the rising profile of depression associated with the establishment and continuation of *beyondblue: the national depression initiative* (Jorm, et al., 2005c).

Less than half of the journalists and the Australian public used the correct psychiatric label for the early schizophrenia vignette, although its symptomatic descriptions were often identified as a mental health problem. It is of no real surprise that rates of identification of schizophrenia were relatively low amongst the general public, as this pattern has been established in other national and international studies of the disorder (for example Jorm, et al., 1997a; Magliano, et al., 2004c; Magliano, Guarneri, Fiorillo, Marasco, Malangone, & Maj, 2001). Journalists were no more adept at identifying the disorder than the Australian public. One explanation for poor identification of the

disorder by all respondents may be linked to the fact that schizophrenia is a low prevalence disorder, which means that neither journalists nor the general public are exposed to the illness with the same frequency as depression. Lower prevalence may also be associated with less information of a medical/scientific nature about schizophrenia (Peluso & Blay, 2004).

The low level of recognition of schizophrenia in the journalists is somewhat surprising since the *Mindframe* initiative to raise awareness of mental health issues for journalists focused on both depression and schizophrenia. It is possible that the ongoing focus on depression in Australia by *beyondblue: the national depression initiative* has not been matched with a similar campaign for schizophrenia and therefore, education campaigns, specifically focusing on schizophrenia, may be warranted.

5.4.2 Recommendations for help-seeking and treatment

The results demonstrated that journalists' help-seeking recommendations for mental disorders show some similarities to those held by the Australian public. However, there are also some marked differences indicating that journalists' overall knowledge of interventions for both suicidal depression and schizophrenia is better than the knowledge of the Australian public. These claims are now discussed in light of the review of evidence-based interventions for mental disorders presented in Chapter 4 (methodology chapter).

People who could help

There was general agreement between journalists and the Australian public that GPs, counsellors and close friends would be helpful for a person with suicidal depression. Several previous surveys of the general public have also demonstrated a preference for help from GPs (for example Goldney, et al., 2005; Hight, et al., 2002; Jorm, et al., 1997e; Priest, et al., 1996) and counsellors (for example Buist, et al., 2005; Jorm, et al., 1997a; Jorm, et al., 1997d) for depression, although these findings are not necessarily universal (McKeon & Carrick, 1991), especially in some developing countries where people such as spiritual healers are preferred over medical practitioners (Mubbashar & Farooq, 2001).

Endorsement of close friends for depression has also been demonstrated in previous surveys (Goldney, et al., 2001). In fact, close friends were rated as being more helpful than psychiatrists and psychologists in this survey, a finding that has been reported in a previous survey of the Australian public (Goldney, et al., 2002). A preference for close friends is an interesting finding and suggests that informal sources of help from

the lay system, such as friends, are seen as being of immense benefit to a person experiencing depression. However, respondents in these two samples appear to have also recognised the potential helpfulness of health professionals for suicidal depression, suggesting that they are well informed about different people in both the lay and professional systems that they can access for help.

For schizophrenia, GPs, counsellors and psychiatrists were seen as the top three people that could help with the disorder. Similar findings were obtained in the 1995 survey of the Australian public (Jorm, et al., 1997a), an Australian survey of health professionals (Jorm, et al., 1997c), initial and repeat surveys of the German public (Angermeyer & Matschinger, 2005b; Angermeyer, et al., 1999), a survey of the Italian public (Magliano, et al., 2004b), a survey of the Swiss public (Lauber, et al., 2001), cross cultural surveys of the German, Russian and Slovakian public (Angermeyer, et al., 2005a) and a survey of Singaporean GPs (Parker, et al., 2001). This finding potentially suggests that respondents recognised the seriousness of schizophrenia from the vignette and were clear that medical help was warranted.

Dealing with either of the disorders alone received the highest harmful ratings from respondents in both samples. This finding is interesting, given that only a small proportion of people who met the diagnostic criteria for a mental disorder sought help for their problem in 1997 (38%) (Australian Bureau of Statistics, 1998) and 2007 (35%) (Australian Bureau of Statistics, 2008). A preference for not dealing with mental disorders alone, and seeking help from professionals, may be indicative of subtle changes occurring in society as a result of initiatives to increase awareness of depression, such as *beyondblue: the national depression initiative*, which started disseminating information in 2000, and greater acceptance that seeking help for mental disorders is beneficial, even though the action of actually seeking help is not yet being practiced at optimal levels. Over time, perhaps, we may see an increase in the proportion of people seeking help for their mental disorder as campaigns to increase awareness of mental disorders continue and stigma towards such people is reduced.

In addition to the similarities described above, the results also demonstrated that there were some significant differences in perceived levels of helpfulness of people across the different samples. For depression, the results revealed that journalists were more likely to nominate a counsellor, telephone counselling, close family and close friends as helpful and that the Australian public were more likely to nominate a chemist, social worker and the clergy as helpful for suicidal depression. In addition, the Australian public gave higher harmfulness ratings to telephone counselling and a psychiatrist for

suicidal depression, although the absolute percentage of respondents agreeing that these treatments were harmful was low.

For schizophrenia, journalists were more likely to nominate a GP, close family and close friends as helpful and more likely to nominate dealing with the disorder alone as harmful. The Australian public were more likely to nominate a chemist, naturopath and the clergy as helpful and telephone counselling as harmful.

These are interesting findings, especially the strong preferences that journalists demonstrated for seeking help from friends or family for both suicidal depression and early schizophrenia. A preference for friends may be related to the fact that people are becoming more open about their illnesses and more willing to talk them over with people. Another possibility is that journalists were all engaged in full-time employment and may not have had time to seek treatment from health professionals, thus turning to friends and family. This theory appears to hold some weight. When the help-seeking behaviour of a sub-sample of the Australian public who worked full-time and who had diagnoses of one-month DSM-IV affective, anxiety and substance-related disorders was considered, researchers found that only 15% of these people sought help for their disorder (Lim, Sanderson, & Andrews, 2000). Such a low rate of help-seeking amongst these full-time employees is potentially a major health issue for the workforce, especially in terms of potential lost productivity (Lim, et al., 2000) and is a factor that should be considered in workplaces of Australian journalists.

Other reasons for this disparity may be that friends and family might be more likely to have mental health expertise (given the high prevalence rates of mental disorders) or that journalist may just be more talkative than the general public

Journalists' preferences for counselling and telephone counselling for depression and GPs for schizophrenia are most likely explained by the fact that they have received materials on the appropriate reporting of depression which strongly suggest including telephone counselling numbers, such as the Lifeline telephone number, or GP contact details, at the bottom of all stories they produce. Specifically, the guidelines suggest that:

appropriate contact details are provided for services to help people distressed or prompted to act by a story (Commonwealth Department of Health and Ageing, 2007 p.1). Including helpline numbers, and information about the options for seeking help—such as visiting a GP or health professional—provides immediate support for those who may be distressed, or prompted to act, by your story (Commonwealth Department of Health and Ageing, 2007 p.11)

The guidelines may have sensitised journalists to the fact that treatments such as telephone counselling and counsellors for depression or GPs for schizophrenia would be important first-line treatments. In addition, more journalists indicated that dealing with schizophrenia alone was likely to be harmful. Again, this result may be explained by the fact that guidelines distributed through their workplaces emphasise the importance of seeking treatment for schizophrenia, and that dealing with it alone can be harmful.

The Australian public's preferences for seeking help from a chemist or the clergy for suicidal depression and schizophrenia are interesting. Although it is difficult to conclusively explain these findings, the fact that visits to these people are free, they are easily accessible (no appointments required) and are constants in the community may hold some appeal. According to the 2006 Australian census, Christianity is the most widely adopted religion in Australia (Australian Bureau of Statistics, 2009). Consequently, the clergy most likely plays a role in advising and counselling people with mental disorders. In a recent American study of 98 members of the clergy, 90% of respondents reported that they spend time counselling people with mental disorders each week, even though the majority of the clergy are not specifically trained to complete this task (Farrell & Goebert, 2008). In fact, the clergy play a large role in the treatment of mental illness in America, serving around 40% of people with mental health problems (Farrell & Goebert, 2008). Only 29% of the clergy thought that their training in the area of mental health was adequate (Farrell & Goebert, 2008). The study also found that parishioners with mental disorders were not being referred to appropriate mental health professionals such as psychiatrists, partly because clergy members' ability to identify serious mental illness was lacking or absent (Farrell & Goebert, 2008). These figures are large and if considered in the Australian context, mean that members of the Australian public seeking help exclusively from the clergy may well be receiving advice that is not evidence-based and they may not be being directed to appropriate sources of help.

A social worker was also nominated as being significantly more helpful for depression by respondents to the Australia Japan survey than journalists. Reasons for this differential are unclear, but may be related to the fact that social workers are perceived as less threatening than other health professions such as a psychiatrist. Further research is required to explain this finding.

Similarly, the Australian public suggested that a naturopath would be significantly more helpful for schizophrenia than journalists. This may be linked to the finding that vitamins, minerals and tonics (discussed below) were also rated as being significantly more helpful for schizophrenia by the Australian public. There is no evidence to support the efficacy of vitamins, minerals or tonics for schizophrenia, and such a finding suggests that journalists' mental health literacy about this treatment is better than the mental health literacy of Australians.

Although telephone counselling was considered less harmful by journalists for both depression and schizophrenia, the actual absolute values were small overall and may simply reflect the fact that guidelines issued to journalists encourage the use of these sources of information in reports about mental disorders.

The Australian public's belief that a psychiatrist is significantly more likely to be harmful for suicidal depression is most likely related to the fact that psychiatrists have the ability to prescribe medication for mental disorders. Indeed, when we look at the results for helpfulness of medications, we see that antidepressants were also nominated as significantly less likely to be helpful and significantly more likely to be harmful for suicidal depression by the Australian public compared with journalists. The fact that journalists are significantly more likely to find antidepressants helpful for suicidal depression suggests that they have a better knowledge of evidence-based treatments for depression than the general public. Again, this information is available in the resources which were developed for journalists for writing stories about mental disorders.

Medications that could help

Journalists were much more adept at discerning evidence-based medications for suicidal depression and schizophrenia. They were significantly more likely than the Australian public to rate antidepressants as helpful for both disorders and significantly less likely to rate these medications as harmful. They were also significantly more likely to rate antipsychotics as helpful for schizophrenia.

The Australian public were more likely to rate tranquilisers and antibiotics as harmful for schizophrenia. They were also significantly more likely to incorrectly rate some medications as helpful for depression (pain relievers and antibiotics) and schizophrenia (vitamins, minerals or tonics). They were also more likely to incorrectly rate some evidence-based interventions as harmful for the disorders, such as antidepressants for depression and antipsychotics for schizophrenia. Concerns about potential side effects

of antidepressants and the belief that antidepressants are habit forming may explain these results. A recent survey of 3538 members of the Swedish general public also demonstrated public scepticism toward the use of antidepressants and similarly suggested that these results were influenced by concerns about potential side effects and the belief that antidepressants may cause dependency (Dahlberg, Waern, & Runeson, 2008).

Overall, journalists displayed superior knowledge about the efficacy of medications for the treatment of mental disorders.

Lifestyle/psychosocial intervention that could help

Both the Australian public and journalists identified a number of lifestyle/psychosocial interventions as likely to be helpful for depression and schizophrenia, such as physical activity, getting out more, learning relaxation and reading about the problem. Some of these interventions have supporting evidence for the treatment of depression, such as physical activity, learning relaxation and reading about the problems (Centre for Mental Health Research (CMHR), 2001), however they lack evidence of efficacy for schizophrenia.

One of the most striking findings was that admission to a psychiatric ward, a standard intervention for both suicidal depression and early schizophrenia, was considered more harmful than helpful by both journalists and the Australian sample. Less than one-third of all respondents who received the schizophrenia vignette nominated that it would be helpful. The Australian public gave significantly higher helpfulness ratings to admission to a psychiatric ward than journalists for suicidal depression.

Previous comparisons of the 1995 and 2003/2004 Australia Japan survey data demonstrated that there was an increase in beliefs about the helpfulness of being admitted to the psychiatric ward of a hospital for depression between 1995 and 2005 (Jorm, et al., 2005e), however the absolute number of respondents endorsing this intervention is still low. One possible reason that journalists view this intervention less favourably than the general public could be that they have become sensitised to this intervention. Specifically, stories regarding people in psychiatric wards are usually limited to reporting negative outcomes, such as the recent 'escape' and 'murder' of psychiatric patients at the Thomas Embling Hospital in Victoria. The media's internal focus on the criminally insane, rather than the average person with a mental disorder who may benefit from admission to psychiatric ward, may explain this finding.

Respondents from both samples gave high harmfulness ratings to ECT as a treatment for suicidal depression and early schizophrenia, even though it is an evidence-based treatment for both disorders (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression, 2004; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders, 2005b) and its use in Australia is high with Australian research revealing that 7469 people received ECT between October 2002 and February 2004 (Chanpattana, 2007). Jorm and colleagues (1997a) reported similar perceptions of harm from ECT in their study of a Australian public in 1995. Jorm et al. (1997a) suggested that this finding may reflect the fact that the person described in the suicidal depression and early schizophrenia vignettes may not have been regarded by respondents as unwell enough to warrant ECT. Additionally, both distorted and accurate media portrayals of ECT have done little to increase its acceptance as a viable treatment modality. For example, portrayal of ECT in American films is often unrealistic and mostly negative (McDonald & Walter, 2001). In the Australian context, media reports from the *Sydney Morning Herald* in the early 1980s accurately described individual's experiences of Chelmsford Hospital in Sydney, where ECT was given as a treatment to psychiatric patients in combination with Deep Sleep Therapy, resulting in 26 deaths (Wikipedia, 2009). Presenting ECT as a safe and viable treatment for some mental disorders will continue to be a significant challenge, given its history in Australia.

In addition to the results regarding lifestyle/psychosocial interventions described so far, the Australian public who received the suicidal depression vignette were more likely than the journalists to rate cutting out alcohol and a special diet as helpful and reading about the problem, psychotherapy and hypnosis as harmful. For schizophrenia, the Australian public thought that hypnosis, having an occasional alcoholic drink and going on a special diet would be helpful and reading about the problem would be harmful. It is difficult to explain why the Australian public was more likely to choose these interventions for depression and schizophrenia, since the only intervention that has some evidence of efficacy is cutting out alcohol for suicidal depression. These findings warrant further investigation in the future.

Sources of information that could help.

All sources of information were deemed to be more helpful than harmful for the person in the suicidal depression and early schizophrenia vignettes. This probably reflects that fact that Australians have greater access to information through several different mediums such as the Internet, books and email. Websites and books were nominated

as being significantly more likely to be helpful and significantly less likely to be harmful for suicidal depression by journalists compared with the Australian public. These are unsurprising findings since the Internet is a primary means of communication amongst journalists in Australia due to its ease of access and the speed at which information can be retrieved (Metcalfe & Gascoigne, 2001). In addition, journalists still use traditional methods to retrieve information, such as books, in their day-to-day workplace. In a profession that relies on constantly retrieving information for stories and articles, such findings make sense.

Rank order of helpful interventions

Colour coding interventions by type, and ranking them from most to least helpful visually demonstrated that both lifestyle/psychosocial interventions and information sources are the preferred interventions for both suicidal depression and early schizophrenia by respondents from both samples. However, journalists ranked a number of evidence-based interventions higher than the Australian public, especially medical interventions such as antidepressants for suicidal depression and antipsychotics for schizophrenia suggesting that they have better mental health literacy on this measure.

Based on these results, it may be concluded that journalists hold more sophisticated views about lifestyle/psychosocial interventions that have the best efficacy for mental disorders when compared with the Australian public. The Australian public appears to favour non-evidence based lifestyle/psychosocial treatments significantly more often than journalists and could benefit from interventions to increase their mental health literacy.

5.4.3 Knowledge about causes and risk factors

Social environmental factors, particularly day-to-day problems, problems from childhood, the death of someone close or a traumatic event were nominated by more than 90 percent of journalists and the Australian public as causes of suicidal depression. These findings are consistent with the results from earlier studies of the general public in Australia (Jorm, et al., 1997b) and Germany (Angermeyer & Matschinger, 1999; Angermeyer & Matschinger, 2003) in which respondents demonstrated a strong belief in psychosocial factors as causes of depression. Such views are supported by evidence from studies which suggest that adverse life events are a potent factor in predicting depression (Mazure, Bruce, Maciejewski, & Jacobs, 2000).

At the same time, more than 80 percent of journalists and two-thirds of the Australian public attributed suicidal depression to biological causes, such as inherited or genetic factors. Data from earlier surveys of the Australian public demonstrated that genetic factors were the most under-rated cause of depression, nominated by only half of respondents (Jorm, et al., 1997b), even though research has demonstrated that they play a significant role in vulnerability to the disorder (Kendler, Neale, Kessler, Heath, & Eaves, 1993). Although reasons for the high level of endorsement of genetic factors as causes of suicidal depression by journalists and the general public remain unclear, it has been suggested that publicity about the Human Genome Project, linking a variety of diseases to various genes, may have contributed to an awareness of the potential role of genetics in the disorder (Jorm, et al., 2005d).

Almost half of the Australian public also thought that weakness of character was a cause of suicidal depression, compared with only 12.6% of journalists. Whilst this figure is somewhat less than in earlier surveys of the Australian public (Jorm, et al., 1997b), it implies a negative evaluation of the sufferer as a person (Jorm, et al., 1997b) and may carry a stigmatising intent. Weakness of character was less likely to be seen as a cause of early schizophrenia compared with suicidal depression although around one-third of the general public and 8.4% of journalists still believed it could cause the disorder.

Being a nervous person, a personal vulnerability trait which has previously been linked to the development of depression (Kendler, et al., 1993) was more often nominated as a cause of suicidal depression by the Australian public compared with the journalists.

As with suicidal depression, social environmental factors were most often nominated as causes of early schizophrenia. More than 70% of journalists and 80% of the Australian public nominated day-to-day problems, problems from childhood, the death of someone close or a traumatic event as causes of schizophrenia. However, the epidemiological evidence for the direct role of social factors in the development of schizophrenia is not strong (Jorm, et al., 1997b) and social environmental factors are more likely to be a trigger rather than a cause (Jorm, 2000). Paralleling these results was a strong belief in the role of genetic or inherited factors as a cause of early schizophrenia by respondents from both surveys. Similar results have been obtained in other countries such as Austria (Grausgruber, et al., 2007), Canada (Stip, et al., 2001; Stuart & Arboleda-Florez, 2001), Germany (Angermeyer & Matschinger, 2003; Beck, et al., 2003; Dietrich, et al., 2006; Gaebel, et al., 2002; Schomerus, et al., 2006b), Holland (van t Veer, et al., 2006), Italy (Magliano, et al., 2004a; Magliano, et al., 2004b;

Magliano, et al., 2004c), Japan (Nakane, et al., 2005; Tanaka, et al., 2005), Switzerland (Lauber, et al., 2003a), Turkey (Ozmen, et al., 2005) and the United States of America (Link, et al., 1999), and there appears to be strong evidence that inherited or genetic factors are indeed influential in the development of schizophrenia.

Respondents were able to nominate multiple causal factors in the development of early schizophrenia, and results indicated that both journalists and the Australian public had a strong belief in the role of both psychosocial and genetic factors.

Risk factors for the disorders were similarly in accordance with causal factors and reflect the strong belief in social environmental causes of the disorders. For suicidal depression, unemployment and divorce or separation, were nominated as the most likely risk factors by journalists and the Australian public. There is strong evidence to support the role of unemployment (Fortney, Rushton, Wood, Zhang, Xu, Dong, & Rost, 2007; Montgomery, Cook, Bartley, & Wadsworth, 1999) and divorce or separation as risk factors for depression, suggesting that respondents were accurate in their identification of these risk factors. Poverty and being young were also nominated as potential risk factors for depression and again, there is strong evidence to indicate that people in these groups are at greater risk of developing depression (Eibner, Sturn, & Gresenz, 2004; Fortney, et al., 2007; Kelly, 2005).

For schizophrenia, the unemployed, young people and divorced or separated people were identified as being at greatest risk of developing the disorder by respondents from both surveys. Whilst numerous purported risk factors have been identified for schizophrenia, the risk of developing the disorder has been linked to unemployment (Byrne, Agerbo, Eaton, & Mortensen, 2004). However, social disadvantage, such as unemployment and divorce or separation, is probably more likely to be an effect of, rather than a risk factor for, the disorder (Jorm, et al., 1997b). Respondents suggesting that young people are greater risk of developing the disorder are indeed correct in nominating this as a risk factor. Schizophrenia frequently presents in the teenage years between the ages of 15 and 25, and males often have an earlier onset (Royal Australian and New Zealand College of Psychiatrists, 2005).

The fact that the Australian public and journalists seem to be adept at discriminating many important causes and risk factors of suicidal depression and early schizophrenia is encouraging. Whilst the frequency with which journalists accurately endorsed common social environmental factors as causes of depression was similar to the Australian public, they were less adept at recognising the role of personal vulnerability

traits. On the flip side, they were better at identifying the potential role of genetic factors, were less likely to believe in weakness of character and less likely to falsely attribute suicidal depression to factors such as a virus or infection or an allergy, neither of which are known causes of depression.

5.4.4 Beliefs about recovery

The responses to the HAMP survey and the Australia Japan survey suggest that respondents were clear that the person in the vignettes did need help and that if appropriate help was accessed, better outcomes would be achieved. Professional help was seen as beneficial for both depression and schizophrenia, however better outcomes could be expected for depression than for schizophrenia. These results compare well with an Australian study of rural dwelling Queenslanders which showed that 96% of respondents clearly believed that a person with major depression needed help, and that accessing appropriate treatment was linked to a good chance of recovery (Bartlett, et al., 2006). The literature also supports the notion that appropriate treatment of depression is linked to better outcomes. There is strong evidence “that treating major depression markedly improves depressive symptoms, health-related functioning, and the patients quality of life” (Jackson, DeZee, & Berbano, 2004 p.1054). For example, a study of 202 depressed people in New Zealand, who were prescribed antidepressant medication for six months, found that more than half of the respondents became well and remained well on the medication, a further one-third had a fluctuating course but remained well most of the time, and that one in nine people remained unwell despite active treatment (Mulder, Joyce, Frampton, Luty, & Sullivan, 2006).

Recovery from schizophrenia was regarded more pessimistically than recovery from suicidal depression by both journalists and the Australian public. Poor outcomes for schizophrenia accord with the literature. With no more than one in five people estimated to completely recover from schizophrenia (Spearing, 1999), responses indicating partial recovery are accurate. Journalists were even more cautious about the likelihood of full recovery than the Australian public and were more likely to suggest partial recovery, with possible later relapse. These responses are quite accurate and appear to reflect respondents’ knowledge of the potentially chronic or episodic nature of schizophrenia.

5.4.5 Personal and perceived stigma

Personal stigma scores were significantly lower for journalists. Although reasons for this are unclear, they may reflect the higher level of education amongst journalists

compared with the sample of the Australian public, as higher levels of education have been linked to lower levels of stigma (Griffiths, Christensen, & Jorm, 2008).

Across the stigma items, and for both samples, perceived stigma was considerably higher than personal stigma. This was also confirmed by the open-ended question asking respondents whether they believed the person in the vignette would be discriminated against – a consequence of stigmatising attitudes – by others in the community. Journalists and the Australian public were more likely to state that others held stigmatising beliefs. A similar pattern was observed in a study comparing Australian and Japanese respondents (Griffiths, et al., 2006). Griffiths et al. (2006) suggested that such a disparity between personal and perceived stigma may simply represent a propensity of people to overestimate stigma in the community, or may reflect a social desirability bias in that respondents are reluctant to reveal their true attitudes toward the person with the mental disorder. Alternatively, it may be the result of media exposure or public awareness campaigns, such as those run by *beyondblue: the national depression initiative* that have created an exaggerated public perception of the level of stigma in the community (Griffiths, et al., 2006; Jorm, et al., 2006a). A final explanation may be that respondents have actually answered the stigma questions honestly, and truly believe that stigma in the community is high.

Beliefs about the unpredictability of people with suicidal depression and early schizophrenia were high amongst journalists and the sample of the Australian public. People with early schizophrenia were seen as being even more unpredictable than those with suicidal depression, a pattern which has been described in studies of the general public in other countries such Germany (Angermeyer & Matschinger, 2003). Although unpredictability is a theme that regularly emerges in the literature, and may indeed occur during the acute phase of schizophrenia (Magliano, et al., 2004b), both relatives and professionals who have direct experience with people with schizophrenia do not believe it is a core component of the illness (Corrigan, Edwards, Green, Diwan, & Penn, 2001).

Belief in the dangerousness of people was also higher for the schizophrenia vignette, with almost twice as many of the Australian public indicating that they thought the person would be dangerous compared with the journalists. Perceived dangerousness is a significant dimension of stigma and it is commonly assumed that people with schizophrenia are more dangerous than people without a mental disorder (Grausgruber, et al., 2007). This may indeed be true during an acute phase of psychosis, when people with the disorder remain untreated, if they are not taking

medication for their illness, or if they have a co-morbid substance use disorder. However, the risk of dangerousness appears to be largely overstated by the general public who may benefit from stigma reduction programs aimed at dispelling the myths of dangerousness and unpredictability.

Around one-fifth of journalists would not employ a person with suicidal depression or schizophrenia, suggesting that in some areas, they still hold views that are stigmatising to people with mental disorders.

5.4.6 Attitudinal social distance

The level of social distance displayed by respondents in the HAMP A and Australia Japan surveys appeared to be related to the degree of intimacy suggested by the relationship. Respondents in both surveys displayed increasing reluctance to interact with people with suicidal depression or early schizophrenia the closer the social contacts were suggested, which is consistent with results from previous studies (Gaebel, et al., 2002; Grausgruber, et al., 2007; Griffiths, et al., 2006). Specifically, having a person with suicidal depression or schizophrenia marry into the family attracted the highest social distance by respondents in both surveys. Interestingly, journalists were less willing to have a person with suicidal depression marry into the family than a person with schizophrenia, which appears to contradict other surveys that have shown greater social distance for schizophrenia (Angermeyer & Matschinger, 2003; Angermeyer, et al., 2004b). One explanation for this may be that respondents who received the depression vignette had the additional symptom of suicidal thoughts – a symptom that did not accompany depression vignettes from other studies – and that people may be either uncomfortable dealing with a person who is suicidal or unsure of how to help them. Conversely, the schizophrenia vignette represented a person in the early, rather than chronic stage of schizophrenia, which may have been less confronting to respondents. Another explanation may simply lie in the fact that less than half of the journalists correctly labelled the early schizophrenia vignette, most often misidentifying it as depression, thereby their responses may reflect the fact that they thought they were actually dealing with a person with depression, rather than schizophrenia.

Working closely with a person with either suicidal depression or schizophrenia also attracted a high level of social distance. This was especially evident in the HAMP A responses where more than one-quarter of respondents would be unwilling to work closely with a person with suicidal depression. Again, journalists showed greater social distance on this measure for suicidal depression compared with schizophrenia.

Explanations for this apparent disparity may be the same as those for marrying into the family. Although it quite concerning that around one-quarter of journalists would be unwilling to work with a person with a mental disorder, it is pleasing that the Australian public displayed lower levels of social distance on this measure, which was an unexpected outcome. These results suggest that workplaces may be important places to target for any future stigma reduction programs, especially for journalists.

5.5 Summary of reasons for differences in mental health literacy between journalists and the Australian public

The results demonstrated that journalists' mental health literacy regarding suicidal depression and early schizophrenia showed some similarities to those held by the Australian public. However, there were also some differences. The reasons for these differences have been explored throughout this chapter. Apart from having a high level of education, which is known to be associated with better mental health literacy, journalists appear to be more exposed to mental health information than the average Australian. Specifically, journalists appear to:

- be better educated, and hence have acquired more information in general;
- have greater exposure to evidence based information – through guidelines developed specifically for journalists and their regular use of the Internet and books to source story information;
- learn more from public awareness campaigns – such as the *beyondblue* campaign; and
- mix with more medical and mental health professionals than the average person – especially in sourcing information for stories.

The literature appears to support these conclusions. For example, improvements in the portrayal of mental health and illness by the Australian media (Francis, et al., 2005; Francis, et al., 2004) were demonstrated when journalists were exposed to, or provided with, guidelines for appropriate reporting on these issues, especially when combined with face-to-face briefings about mental disorders (Skehan, et al., 2006). Presumably, raising their mental health literacy through the provision of these resources resulted in better portrayal of mental health information.

The provision of appropriate mental health information was also shown to lead to better knowledge about postnatal depression by Australian women who had been screened regularly for, and provided with, an information booklet about postnatal depression. These women were significantly more likely to recognise depression from an unlabelled

vignette (60.4%) than a control group (47.1%) who had received no intervention or information on postnatal/antenatal depression (Buist, et al., 2007).

The provision of mental health information appears to be a primarily positive intervention for journalists and may go part way to explaining their superior mental health literacy on many measures, when compared with the Australian public. However, the down side to this argument is that they are more aware of negative events associated with mental disorders, such as the recent murder of a person in the Thomas Embling psychiatric hospital by a person with schizophrenia. This may sensitise them to some of the negative, but rare consequences of mental disorders, and may explain why they do not endorse some evidence-based interventions, such as admission to a psychiatric hospital.

5.6 Conclusion

This chapter has described the similarities and differences in the mental health literacy of journalists and the Australian public with respect to their ability to recognise suicidal depression and early schizophrenia from an unlabelled vignette, their recommendations for help-seeking and treatment, knowledge about causes and risk factors, beliefs about recovery, levels of personal and perceived stigma and levels of attitudinal social distance.

Across the board, journalists held more sophisticated views about most aspects of mental health literacy than the Australian public.

Compared with the Australian public, journalists demonstrated better recognition of suicidal depression from an unlabelled vignette. Although journalists' ability to recognise early schizophrenia from an unlabelled vignette was similar to the Australian public, they were much better at recognising evidence-based treatments for both disorders than the Australian public, and more similar to health professionals in their treatment beliefs. Respondents from both samples recognised that the person in the vignette needed treatment and agreed that the prognosis for recovery was better if appropriate treatment was accessed.

Both the Australian public and journalists had a good knowledge of many important causes and risk factors of suicidal depression and early schizophrenia. Respondents from both samples accurately endorsed common social environmental factors as causes of depression. Journalists were less likely to nominate personal vulnerability traits as playing a role in the development the disorders but were better at identifying

the potential role of genetic factors. Journalists rejected the notion that weakness of character was a cause of depression or schizophrenia.

Journalists demonstrated significantly lower personal stigma scores than the Australian public and were significantly less likely to endorse several negative statements from the personal stigma scale, indicating that they were less likely to stigmatise people with mental disorders.

The level of social distance displayed by respondents in the HAMP and Australia Japan surveys appeared to be related to the degree of intimacy suggested by the relationship. Respondents in both surveys displayed increasing reluctance to interact with people with suicidal depression or early schizophrenia the closer the social contacts were suggested. In addition, both stigma and social distance were greater for the person with schizophrenia.

Finally, it may be concluded that the overall mental health literacy of journalists is higher than the mental health literacy of the Australian public. Aside from being better educated than the Australian sample, journalists appear to be more exposed to mental health information than the average Australian, resulting in better mental health literacy amongst this group. However, the mental health knowledge of journalists could be further enhanced by developing and implementing interventions to raise their mental health literacy in some areas. For example, improving their ability to recognise schizophrenia, improving their knowledge of some evidence-based treatments and implementing stigma reduction programs in their workplaces would enhance their skills and further increase their mental health literacy.

CHAPTER SIX

MENTAL HEALTH LITERACY OF NEWSPAPER JOURNALISTS – POSTNATAL DEPRESSION

6.1 Introduction

The previous chapter compared journalists' knowledge and beliefs about suicidal depression and early schizophrenia with those held by a sample of the Australian public. However, no previous large scale surveys of the Australian public have measured knowledge and beliefs about postnatal depression, thus a robust comparison between the Australian public and journalists regarding this disorder was not possible. A couple of Australian studies of postnatal women, Maternal and Child Health Nurses and GPs (Buist, et al., 2005) have provided some baseline data about postnatal depression, and are considered in the discussion section of this chapter.

This chapter briefly summarises the descriptive data regarding journalists' ability to recognise postnatal depression, their recommendations for help-seeking and treatment, their knowledge about causes and risk factors, beliefs about recovery, levels of personal and perceived stigma and levels of attitudinal social distance.

6.2 Data Analysis

The proportions of journalists responding to each category were calculated using the Frequencies command of SPSS 14.0 for each sample (SPSS, 2005). Ninety-five percent Confidence Intervals were estimated using the Explore procedure in SPSS 14.0. All analyses used unweighted data, excluded missing cases and included journalists from all age categories.

6.3 Results

6.3.1 Recognition of mental disorder

Ninety-six percent of journalists correctly identified postnatal depression from an unlabelled vignette of the disorder. Journalists most often used the correct term – postnatal depression – to describe the postnatal depression vignette.

6.3.2 Recommendations for help-seeking and treatment

Tables 6.1 and 6.2 illustrate how journalists rated the likely helpfulness and harmfulness of a range of interventions for postnatal depression. Helpfulness and harmfulness ratings were reported for people who could help, medications that could help, lifestyle/psychosocial interventions that could help and sources of information that could help.

Table 6.1

Percentage (and 95% Confidence Intervals) of journalists rating different types of people (professionals and lay people) as 'helpful' and 'harmful' for the person described in the postnatal depression vignette^{1,2}

People	Helpful	Harmful
GP	93.4 (90.1-96.8)	0
Chemist/Pharmacist	24.5 (18.6-30.5)	6.9 (3.4-10.4)
Counsellor	92.9 (89.4-96.4)	3.3 (0.8-5.7)
Social worker	66.5 (60.1-73.0)	6.7 (3.3-10.1)
Phone counselling	80.6 (75.2-86.0)	2.4 (0.3-4.4)
Psychiatrist	65.9 (59.4-72.3)	8.5 (4.7-12.3)
Psychologist	75.8 (70.0-81.7)	5.7 (2.5-8.8)
Close family	88.3 (83.9-92.6)	0.5 (-0.5-1.4)
Close friends	92.9 (89.4-96.4)	0.5 (-0.5-1.4)
Naturopath/herbalist	27.8 (21.8-33.9)	10.4 (6.2-14.5)
Clergy	37.8 (31.2-44.4)	12.4 (7.9-17.0)
Deal with it alone	6.3 (3.0-9.7)	72.7 (66.5-78.8)

¹ 'Neither Helpful nor Harmful' and 'Don't Know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%

Table 6.2

Percentage (and 95% Confidence Intervals) of journalists rating medications, lifestyle/psychosocial interventions and sources of information as 'helpful' and 'harmful' for the person described in the postnatal depression vignette^{1,2}

Interventions	Helpful	Harmful
Medications		
Vitamins, minerals or tonics	36.2 (29.6-42.7)	6.3 (2.8-9.7)
Pain relievers	6.7 (3.3-10.1)	38.2 (31.1-45.2)
Antidepressants	56.5 (49.9-63.2)	9.0 (4.9-13.1)
Antibiotics	1.9 (0.04-3.8)	37.1 (30.1-44.1)
Sleeping pills	10.0 (5.9-14.1)	46.2 (39.0-53.5)
Antipsychotics	7.6 (4.0-11.2)	31.6 (24.8-38.3)
Tranquillisers	8.4 (4.6-12.3)	47.8 (40.4-55.2)
Lifestyle/psychosocial		
Physical activity	75.5 (69.6-81.3)	0
Read about problem	94.3 (91.2-97.5)	1.0 (-0.4-2.5)
Get out more	75.4 (69.5-81.2)	0.5 (-0.5-1.6)
Learn relaxation	87.6 (83.1-92.1)	0.5 (-0.5-1.5)
Cut out alcohol	35.9 (29.3-42.4)	4.2 (1.3-7.0)
Psychotherapy	40.0 (33.3-46.7)	1.6 (-0.2-3.4)
Hypnosis	13.3 (8.7-18.0)	11.6 (7.0-16.3)
Psychiatric ward	7.1 (3.6-10.6)	48.4 (41.2-55.6)
ECT	2.8 (.6-5.1)	62.1 (55.1-69.1)
Occasional drink	33.2 (26.8-39.6)	14.7 (9.6-19.7)
Special diet	23.2 (17.5-29.0)	12.4 (7.7-17.1)
Sources of information		
Website	80.1 (74.7-85.5)	13.9 (11.8-16.1)
Email an expert	61.9 (55.3-68.5)	15.4 (13.2-17.7)
Consult a book	86.7 (82.1-91.3)	7.5 (5.9-9.2)
Health educator	95.7 (93.0-98.5)	1.5 (0.8-2.3)

¹ 'Neither Helpful nor Harmful' and 'Don't Know' responses are not shown

² Multiple responses were permitted so percentages do not add up to 100%

People who could help

The three people most commonly endorsed as helpful for postnatal depression by journalists were seeing a GP (93.4%), seeing a counselor (92.9%) or close friends (92.9%). All of the people who could potentially help a person with postnatal depression were seen as being more helpful than harmful except for dealing with the problem alone which was seen as being more harmful (72.7%) than helpful (6.3%). Harmful ratings were also highest for dealing with the problem alone (72.7%).

Medications that could help

Just over half of the journalists (56.5%) thought that antidepressants, an evidence-based intervention for postnatal depression, would be helpful for the person in the vignette. Vitamins, minerals or tonics (36.2%) were ranked as the second most helpful medication for the disorder. Medications that received the highest harmfulness ratings for postnatal depression were tranquilisers (47.8%) and sleeping pills (46.2%). Both of these medications, along with pain relievers and antipsychotics were believed to be more harmful than helpful for postnatal depression.

Lifestyle/psychosocial interventions that could help

Only 7.1% of journalists thought that admission to a psychiatric ward, an evidence-based intervention for severe postnatal depression, would be helpful for the disorder. Almost half of the journalists thought admission to a psychiatric ward for postnatal depression would be more harmful (48.4%) than helpful (7.1%). Similarly, journalists thought ECT for postnatal depression would be more harmful (62.1%) than helpful (2.8%).

Lifestyle interventions, such as reading about the problem (94.3%), learning relaxation (87.6%) and physical activity (75.5%), were most likely to help with postnatal depression according to journalists. The remaining lifestyle/psychosocial interventions were all thought to be more helpful than harmful.

Sources of information that could help

All four sources of information, including websites, emailing an expert, consulting a book and contacting a health educator were seen as being more helpful than harmful for postnatal depression. A health educator was nominated as the most helpful source of information for postnatal depression (95.7%).

6.3.3 Knowledge about causes and risk factors

Table 6.3 shows the percentage of journalists rating different causes as likely or unlikely for postnatal depression.

More than 80% of journalists thought that day-to-day problems (88.2%), the death of someone close (83.4%), problems from childhood (82.9%), and a traumatic event (81.5%), were likely causes of postnatal depression. Inherited or genetic (71.0%) factors were also thought to be likely causes of the disorder.

Journalists thought that a virus or infection (75.5%), allergy (72.4%) and weakness of character (71.6%) were the most unlikely causes of postnatal depression. Journalists were divided about whether being a nervous person caused postnatal depression – 37.4% of journalists thought that it would be a likely cause of the disorder while 35.1% thought it was unlikely.

Table 6.4 presents journalists' beliefs about the groups of people most at risk of developing postnatal depression. The table shows that journalists believed that unemployed people (56.7%), women (55.5%) and divorced or separated people (51.0%) had the greatest risk of developing postnatal depression in comparison with other population groups. Old people (32.9%) were the group least likely to develop the disorder.

6.3.4 Beliefs about recovery

Journalists' beliefs about outcomes after receiving professional help and outcomes without professional help are presented in table 6.5.

The majority of journalists thought that a person receiving appropriate help would make either a full recovery (56.3%) or a full recovery with later relapse (26%). Without professional help, journalists thought the person with postnatal depression would get worse (35.2%).

Table 6.3

Percentage (and 95% Confidence Intervals) of journalists giving each cause as likely (combines 'very likely' and 'likely' responses) and unlikely (combines 'very unlikely' and 'unlikely' responses) for the person described in the postnatal depression vignette

Cause	Likely	Unlikely
Virus or infection	11.4 (7.1-15.8)	75.7 (69.9-81.6)
Allergy	12.9 (8.3-17.4)	72.4 (66.3-78.5)
Day-to-day problems	88.2 (83.8-92.6)	7.1 (3.6-10.6)
Death of someone close	83.4 (78.4-88.5)	10.4 (6.3-14.6)
Traumatic event	81.5 (76.2-86.8)	11.9 (7.5-16.2)
Problems from childhood	82.9 (77.7-88.0)	9.5 (5.5-13.5)
Inherited or genetic	71.0 (64.8-77.1)	11.4 (7.1-15.8)
Nervous person	37.4 (30.9-44.0)	35.1 (28.6-41.6)
Weakness of character	10.0 (5.9-14.0)	71.6 (65.4-77.7)

Note: 'Just as Likely' and 'Don't Know' responses are not shown

Table 6.4

Percentage (and 95% Confidence Intervals) of journalists rating each group in the population as 'more likely' or 'less likely' to experience the problem described in the vignette

Group	More likely	Less likely
Women	55.5 (48.7-62.3)	1.9 (0-3.8)
Young	23.8 (18.0-29.6)	11.4 (7.1-15.8)
Old	14.0 (9.2-18.8)	32.9 (26.4-39.3)
Poor	21.4 (15.8-27.0)	3.3 (0.9-5.8)
Unemployed	56.7 (49.9-63.4)	1.4 (0-3.1)
Divorced/ separated	51.0 (44.1-57.8)	1.9 (0-3.8)
Single	23.3 (17.6-29.1)	4.8 (1.9-7.8)

Note: 'Just as Likely' and 'Don't Know' responses are not shown

Table 6.5

Percentage (and 95% Confidence Intervals) of journalists giving each outcome as likely for the person described in the postnatal depression vignette with and without professional help

Likely outcome	With professional help	Without professional help
Full recovery	56.3 (49.5-63.1)	2.4 (0.3-4.4)
Full recovery with relapse	26.0 (20.0-32.0)	6.6 (3.2-9.9)
Partial recovery	4.8 (1.9-7.7)	6.6 (3.2-9.9)
Partial recovery with relapse	2.4 (0.3-4.5)	19.7 (14.3-25.1)
No improvement	0	5.6 (2.5-8.8)
Get worse	0	35.2 (28.7-41.7)
Don't know	10.6 (6.4-14.8)	23.9 (18.2-29.7)

Note: 'Just as Likely' and 'Don't Know' responses are not shown

Table 6.6 presents journalists' beliefs about the likelihood that people will engage in a number of negative and positive behaviours after they have received professional assistance for their problem.

Journalists thought that a person who had received help for postnatal depression would be less, rather than more likely to engage in all five negative behaviours described in Table 6.6. Attempt suicide (18%) was the most frequently endorsed negative outcome measure. However, similar to the suicidal depression vignette, attempt suicide also received the highest less likely rating for postnatal depression (38.4%) by journalists. These results, although appearing contradictory, demonstrate that people hold strong opinions either way about suicide and were unlikely to choose a depends, dont know or no difference/same response category. Only a minority of journalists thought that the person described in the postnatal depression vignette would be more likely to be violent (1.4%) after receiving treatment.

In terms of positive outcomes, being understanding of others feelings (63.0%) was the most frequently endorsed statement. Being a caring parent (47.9%) was also believed to be a more likely long term outcome after receiving treatment for postnatal depression.

6.3.5 Personal and perceived stigma

Personal stigma scores of journalists who received the postnatal depression vignette ranged from 0 to 22 ($M=8.4$, $SD 4.7$). Perceived stigma scores were considerably higher than personal stigma scores and ranged from 0 to 36 ($M=20.3$, $SD=6.1$).

Table 6.7 shows the percentage of journalists who agreed with each statement from the Personal and Perceived Stigma Scales.

Table 6.6

Percentage of journalists rating each outcome as "more likely" or "less likely" after the person described in the postnatal depression vignette has received professional help

Outcome	More likely	Less Likely
Negative behaviours		
Be violent	1.4 (0-3.0)	31.3 (25.0-37.5)
Drink too much	8.6 (4.8-12.4)	29.1 (22.9-35.2)
Take illegal drugs	3.8 (1.2-6.5)	29.2 (23.0-35.4)
Have poor friendships	10.0 (5.9-14.1)	32.4 (26.0-38.8)
Attempt suicide	18.0 (12.8-23.2)	38.4 (31.8-45.0)
Positive behaviours		
Understand others' feelings	63.0 (56.5-69.6)	4.3 (1.5-7.0)
Have good marriage	34.6 (28.1-41.1)	7.6 (4.0-11.2)
Be caring parent	47.9 (41.1-54.7)	2.8 (0.6-5.1)
Be productive worker	34.1 (27.7-40.1)	4.7 (1.9-7.6)
Be creative	21.1 (15.5-26.6)	1.4 (0-3.1)

Note: "Just as Likely" and "Don't Know" responses are not shown

Table 6.7

Percentage (and 95% Confidence Intervals) of journalists regarding postnatal depression who 'agree' or 'strongly agree' with each statement from the Personal and Perceived Stigma Scales

	Personal Stigma Scale I believe that ...	Perceived Stigma Scale Most other people believe that...
Person could snap out of the problem	2.3 (0.3-4.4)	53.1 (46.3-59.9)
Problem is a sign of personal weakness	3.7 (1.2-6.3)	52.4 (45.6-59.2)
Problem is not a real medical illness	2.4 (0.3-4.4)	59.1 (52.3-65.8)
People with this problem are dangerous	17.0 (11.9-22.1)	40.5 (33.8-47.2)
Avoid people with this problem	0.9 (0-2.2)	23.8 (18.0-29.6)
People with this problem are unpredictable	47.0 (40.2-53.7)	68.6 (62.2-74.9)
If I had this problem I wouldn't tell anyone	8.9 (5.1-12.8)	56.3 (49.5-63.1)
I would not employ someone with this problem	7.5 (3.9-11.2)	49.5 (42.7-56.4)
I would not vote for a politician with this problem	6.1 (2.9-9.3)	41.4 (34.6-48.1)

The two items most commonly endorsed by journalists from the personal stigma scale were that people with this problem are unpredictable (47.0%) and people with this problem are dangerous (17.0%). The remaining personal stigma statements received only low levels of agreement from journalists.

Journalists generally agreed that others in the community would hold more stigmatising attitudes toward people with mental disorders than themselves. This was evidenced by their high level of agreement with several items from the Perceived Stigma Scale. The percentage of journalists endorsing a statement from the Perceived Stigma Scale ranged from 23.8% to 68.6%. The items most commonly endorsed by journalists were that other people believe that people with this problem are unpredictable (68.6%) and that the problem is not a real medical illness (59.1%). The least endorsed item for postnatal depression by journalists was that others would avoid a person with this problem (23.8%).

Discrimination

To gauge journalists' beliefs about potential discrimination facing the person with postnatal depression, journalists were asked if they thought the person 'would be discriminated against by others in the community, if they knew about her condition?' Around half of the journalists (49.5%) believed that the person in the vignette had a chance of being discriminated against by others in the community.

6.3.6 Attitudinal social distance

Table 6.8 presents the results from the Social Distance Scale showing the percentage of journalists who were willing or unwilling to have social contact with a person with postnatal depression.

Table 6.8

Percentage (and 95% Confidence Intervals) of journalists who would be willing (combines 'definitely willing' and 'probably willing') and unwilling (combines 'definitely unwilling' and 'probably unwilling') to have various types of social contact from the person in the vignette

Social Contact	Willing	Unwilling
Move next door	91.5 (87.7-95.3)	2.3 (0.3-4.4)
Spend evening socialising	91.0 (87.0-94.9)	3.8 (1.2-6.4)
Make friends	88.2 (83.8-92.6)	3.8 (1.2-6.4)
Babysit children	35.1 (28.6-41.6)	53.9 (47.0-60.7)
Marry into family	69.5 (63.3-75.8)	13.3 (8.7-18.0)
Stay with current partner	92.4 (88.8-96.0)	2.9 (0.6-5.1)

Note: 'Don't Know' responses are not shown

Journalists were most willing to stay with their current partner (92.4%), move next door (91.5%) or spend an evening socialising (91.0%) with a person who had postnatal depression. They were least willing to have the person in the vignette babysit children (53.9%) or marry into family (13.3%).

6.4 Discussion

Postnatal depression was correctly identified by the majority of journalists. As with suicidal depression in the previous chapter, and the literature reviewed in earlier chapters, journalists endorsed lifestyle/psychosocial interventions and sources of information in preference to medications for the treatment of postnatal depression. Similarly, social environmental causes and risk factors were endorsed over biological factors in the development of the disorder. Journalists were optimistic in their prognosis for postnatal depression when treatment was sought for the condition. They displayed low personal stigma scores. Journalists displayed greater social distance for closer, compared to more casual social contacts with a person with postnatal depression.

6.4.1 Recognition of mental disorder

Journalists (96%) demonstrated a high level of recognition of postnatal depression from the vignette. Their ability to correctly name the disorder was higher than that of a sample of 525 postnatal women in 2002, where only 32% recognised postnatal depression from an unlabelled vignette (Buist, et al., 2005). Journalists' ability to identify the disorder was similar to that of GPs – 95% of GPs selected a depression diagnosis from an unlabelled vignette of postnatal depression in 2002 (Buist, et al., 2005).

6.4.2 Recommendations for help-seeking and treatment

People who could help

Journalists nominated GPs, counsellors and close friends as the people most likely to be helpful for postnatal depression. Previous surveys of postnatal women and GPs indicated a similar preference for assistance from partners and counsellors for antenatal and postnatal depression (Buist, et al., 2005). Actual help-seeking behaviour by women with and without postnatal depression for issues ranging from crying babies to not coping revealed that 50% of women sought help from their family, 29% from their partner and 29.2% from a GP (Buist, et al., 2005). A sub-group of 84 postnatally depressed women in the same study found that only 17% of women sought help from a GP for the disorder (Buist, et al., 2005).

The previous chapter demonstrated that close friends were seen as a helpful intervention for suicidal depression by journalists and suggested that informal sources of help from the lay system, such as friends, are an important source of support for a person experiencing depression. However, journalists also recognised the potential helpfulness of health professionals, such as a GP and counsellor and gave moderate helpfulness ratings to health professionals such as a psychiatrist, psychologist or social worker, suggesting that they have good knowledge about different people a person with postnatal depression can access for help.

Dealing with postnatal depression alone received the highest harmful ratings from journalists. Similar results for early schizophrenia and suicidal depression were described in Chapter 5 and suggest that journalists recognised the seriousness of all three disorders and that assistance was warranted.

Medications that could help

Interventions for all mental disorders were listed in Chapter 4 (methodology chapter) according to their evidence base. For postnatal depression, antidepressants were indicated as having strong evidence of efficacy. However, only 56.5% of journalists thought that antidepressants, would be helpful for the person in the postnatal depression vignette. Vitamins, minerals or tonics (36.2%) were also nominated as being helpful for the disorder. A study of 525 postnatal Australian women also demonstrated a preference for natural remedies, such as vitamins and minerals for the treatment of the disorder, despite the fact that there is no evidence of efficacy of vitamins for the treatment of postnatal depression (Buist, et al., 2005). Of the 84 women who rated themselves depressed in the study, only 14% used antidepressant medication to manage their postnatal depression (Buist, et al., 2005). A further 10% used herbs/natural remedies while 58% sought no help at all (Buist, et al., 2005).

Concerns about potential side effects of antidepressants, worry that antidepressant medication may pass through breast milk to the infant, concerns that antidepressants would make a mother drowsy and reduce her ability to parent, the stigma attached to taking antidepressants and the belief that antidepressants are habit forming may go part way to explaining people's reluctance to accept treatment with antidepressants (Turner, Sharp, Folkes, & Chew-Graham, 2008). Indeed, women themselves are often unwilling to take antidepressants for postnatal depression (Appleby, Warner, Whittin, & Faragher, 1997), so it is of little surprise that other groups in society have concerns about this medication. A study of breastfeeding mothers taking the antidepressant fluoxetine linked the drug with irritability, sleep disturbance, and poor feeding in some

infants (Burt, Suri, Altshuler, Stowe, Hendrick, & Muntean, 2001). Other antidepressants, such as sertraline and paroxetine, may be more suitable for breastfeeding and can be used safely by mothers of healthy full term infants (Hendrick, Fukuchi, Altshuler, Widawsky, Wertheimer, & Brunhuber, 2001). Until there are some conclusive studies considering the long term effects of exposure to antidepressants on the child's developing brain (Hendrick, 2003), and people are informed of these results, it is unlikely that people's views on the use of antidepressants during the postnatal period will change significantly .

Lifestyle/psychosocial intervention that could help

Journalists identified a number of lifestyle/psychosocial interventions as likely to be helpful for depression and schizophrenia, such as physical activity, getting out more, learning relaxation and reading about the problem.

Only 7.1% of journalists thought that admission to a psychiatric ward, an evidence-based intervention for the treatment of postnatal depression would be helpful. In fact, more journalists thought it would be harmful rather than helpful. Although it is an evidence-based treatment for the disorder, hospital admission for postnatal depression is generally only suggested if a person has severe symptoms, complicated medical problems, is at risk of harming themselves or others, or needs more intensive treatment and monitoring (beyondblue: the national depression initiative, 2008). Certainly, if these conditions are met, admission to a psychiatric ward would be helpful rather than harmful.

These results suggest that educating journalists about the helpfulness of antidepressants and admission to a psychiatric ward would lead to a much better understanding of the value of these medical and lifestyle/psychosocial interventions for postnatal depression.

Sources of information that could help.

All sources of information were deemed to be more helpful than harmful for the person in the postnatal depression vignette. As with the previous chapter, this is an unsurprising finding since journalists' access electronic and paper-based information in their day-to-day production of newspaper articles.

6.4.3 Knowledge about causes and risk factors

Social environmental factors, particularly the death of someone close, problems from childhood, day-to-day problems, or a traumatic event were nominated by more than 80% of journalists as causes of postnatal depression.

These findings accord strongly with the literature which demonstrates an especially robust interplay between psychological and psychosocial risk factors in the development of postnatal depression. Although it is unclear exactly what causes postnatal depression, several risk factors for the disorder have been identified in the literature including psychological, psychosocial, and biological factors. The following risk factors feature prominently – past history of psychopathology and psychological disturbance during pregnancy (anxiety or depression), presence of the ‘baby blues,’ life stress, marital conflict, low maternal self-esteem, unemployment, a history of abuse, being a single parent, moving house, sleep deprivation, family history of mental disorders, having an unsettled baby, sleep deprivation, labour or delivery complications, problems with the baby’s health, problems breastfeeding, being young, having unrealistic expectations of motherhood and lack of social support, particularly from spouse, family and friends (beyondblue: the national depression initiative, 2009; Cooper & Murray, 1997; Dennis, 2005; O’Hara & Swain, 1996; Robertson, Grace, Wallington, & Stewart, 2004).

Journalists thought that women, unemployed people and divorced or separated people were more likely to develop the disorder than other groups. However, the absolute numbers indicated that only around half of the journalists thought that women and unemployed people, two groups known to be at the highest risk of developing the disorder, would develop the disorder. This finding is not unexpected. Although journalists had access to material on appropriate reporting of mental health and suicide when the survey was conducted in 2003/2004, these materials focused almost exclusively on depression, schizophrenia and suicide. More recently, postnatal depression information has been added to the online materials available to journalists and a future surveys may well yield better knowledge on this measure.

One in ten journalists also thought that weakness of character was a likely cause of postnatal depression. However, the literature explicitly states that this is not the case.

Postnatal depression is

every bit as serious [as the needs of the child] and because of its potential chronicity and long-term negative effects on the next generation, needs to be viewed as such, and not a ‘weakness of character’ (Buist, 2004 p.24).

Despite these anomalies, journalists were adept at discriminating many of the important causes and risk factors for developing postnatal depression. Journalists accurately endorsed common psychological and psychosocial risk factors and had a good knowledge of the role of personal vulnerability traits.

6.4.4 Beliefs about recovery

Journalists were clear that the person in the vignette did need help and that if appropriate help was accessed, better outcomes would be achieved. Journalists were optimistic about the likelihood of a full recovery from postnatal depression after treatment. The literature also supports this view. For example, a range of biopsychosocial interventions, such as antidepressant medication, in-patient hospital treatment, short and long-term counselling and support groups have been shown to significantly reduce the symptoms of the disorder (Zittel-Palamara, Rockmaker, Schwabel, Weinstein, & Thompson, 2008). In contrast, if left untreated, one in four women will continue to suffer with postnatal depression one year after the birth of their baby (Gregoire, Kumar, Everitt, Henderson, & Studd, 1996)

6.4.5 Personal and perceived stigma

Across the stigma items, perceived stigma was considerably higher than personal stigma for postnatal depression. Journalists were more likely to state that others held stigmatising beliefs. This finding is similar to the results reported for journalists and the Australian public for suicidal depression and early schizophrenia. As in the previous chapter, this most likely represents a propensity of people to overestimate stigma in the community, reflects a social desirability bias in that journalists are reluctant to reveal their true attitudes toward the person with the mental disorder or that journalists have actually answered the stigma questions honestly, and truly believe that stigma in the community is high (Griffiths, et al., 2006).

As with journalists' responses about suicidal depression and early schizophrenia, beliefs about the unpredictability and dangerousness of people with postnatal depression were higher than for any other statements from the Personal Stigma Scale. The literature suggests that unpredictability in postnatal depression is linked with pre-existing borderline traits or borderline personality disorder (Stein & Wilkinson, 2007). However, it is doubtful that journalists have such a sophisticated knowledge of the interplay between these disorders. It is possible that their beliefs have been influenced by some of their own media reports linking postnatal depression with infanticide – an unpredictable illness that can lead to violence with tragic results. However, the reasons for this differential remain largely unclear. Further investigation regarding journalists'

attitudes about postnatal depression and unpredictability and dangerousness is warranted.

6.4.6 Attitudinal social distance

As with the results for early schizophrenia and suicidal depression in Chapter 5, the level of social distance displayed by journalists toward a person with postnatal depression appeared to be related to the degree of intimacy suggested by the relationship. More than half (53.9%) of the journalists would not want a person with postnatal depression to babysit their children. This finding potentially links with the finding from the stigma section, where journalists thought women with postnatal depression were likely to be unpredictable. Given the vulnerability of young children, and their reliance on an adult for their survival, this finding is perhaps unsurprising. As with the stigma findings, this result requires more investigation.

6.5 Conclusion

This chapter has described the mental health literacy of journalists with respect to their ability to recognise postnatal depression from an unlabelled vignette, their recommendations for help-seeking and treatment, knowledge about causes and risk factors, beliefs about recovery, levels of personal and perceived stigma and levels of attitudinal social distance.

Journalists demonstrated good recognition of postnatal depression from an unlabelled vignette but were not good at recognising some evidence based treatments such as antidepressant medication and admission to a psychiatric ward. Journalists recognised that the person in the vignette needed treatment and agreed that the prognosis for recovery was better if appropriate treatment was accessed.

Journalists had a good knowledge of some common risk factors. Although they were able to nominate the groups of people that are most at risk of developing the disorder, such as women, the absolute number of journalists nominating women was lower than expected. Interventions to raise their mental health literacy regarding the groups of people most vulnerable to the disorder may improve their knowledge regarding this component of mental health literacy.

As with the finding for early schizophrenia and suicidal depression, the level of social distance displayed by journalists appeared to be related to the degree of intimacy suggested by the relationship. Journalists displayed increasing reluctance to interact with people with postnatal depression the closer the social contacts were suggested, such as having a person with postnatal depression babysit their children.

In conclusion, when compared with other groups of the public that have been sampled regarding postnatal depression, the mental health literacy of journalists was good. However, their mental health literacy could be further enhanced by improving their knowledge of some evidence-based treatments, such as antidepressants and admission to a psychiatric ward and improving their knowledge of the groups of people most at risk of developing the disorder.

CHAPTER SEVEN

FACTORS PREDICTING JOURNALISTS' RESPONSES REGARDING HELPFUL TREATMENTS FOR MENTAL DISORDERS

7.1 Introduction

Chapters 5 and 6 presented descriptive data about the mental health literacy of journalists regarding suicidal depression, early schizophrenia and postnatal depression. Chapter 5 compared journalists' knowledge of suicidal depression and early schizophrenia with that of the Australian public and identified several significant differences between the samples. One area where these differences were pronounced was in the types of treatments that journalists thought would be helpful for mental disorders.

The beliefs held by the Australia Japan journalists regarding treatments for depression and schizophrenia, predictors of the public's intentions for mental health first aid responses, and the changes in the public's help-seeking preferences have been described previously for samples of the Australian public (Jorm, et al., 2005a; Jorm, et al., 2006d; Jorm, et al., 2005e) and were described in Chapter 2.

However, we know little about the factors that predict the types of treatment journalists believe would be helpful for a person with a mental disorder. This chapter seeks to build on the mental health literacy knowledge base by investigating factors which predict views about the helpfulness of various treatments for three disorders: suicidal depression, early schizophrenia and postnatal depression. Ultimately, understanding the factors that predict their responses may be useful in the design of interventions that would improve their mental health literacy and knowledge of evidence-based treatments. This may then have a positive effect on their mental health literacy and may lead to better outcomes in the stories they present on these issues.

As reported in Chapter 5, previous surveys of the Australian public have linked higher education to better depression literacy (Highet, et al., 2006). As journalists had a much higher level of educational attainment than the Australia sample this chapter tests the assumption that better education will be linked to better knowledge about treatments for the three mental disorders. This chapter will also consider what other factors, if any, may explain any differences in mental health literacy between the samples. For example, predictors of the public's intentions for mental health first aid were investigated (Jorm, et al., 2005a) by conducting logistic regressions to examine the levels of association between participants suggesting specific treatment options and

their sociodemographic and health experience attributes (Jorm, et al., 2005a). The researchers considered whether age, gender, previous experience of a mental disorder, type of vignette provided, correct identification of the disorder from the vignette, whether a person was a carer, whether a person was a professional, whether or not professional help was obtained and levels of personal or perceived stigma predicted treatment options (Jorm, et al., 2005a). They found that most variables had at least one significant association but that female gender, correct identification of the disorder and low personal stigma were the most potent predictors (Jorm, et al., 2005a).

7.2 Hypotheses

It is hypothesised that the factors predicting journalists' responses regarding helpful treatments for mental disorders will be influenced by the vignette they were shown, their age, gender, level of education, stigma and previous experience with a mental disorder.

7.3 Data Analysis

All data were analysed using version 14.0 of SPSS (SPSS, 2005).

The proportions of journalists responding to each question were calculated using the Frequencies command of SPSS 14.0 for each sample. Ninety-five percent confidence intervals were estimated using the Explore procedure in SPSS 14.0. Dichotomous variables were then created for response categories for some questions. For example, there were initially five response categories regarding the helpfulness of various treatments for the disorders represented in the survey. These were collapsed into two response categories – helpful and other. All analyses used unweighted data, excluded missing cases and included journalists from all age categories.

Multiple binary logistic regression analyses were then conducted to examine the levels of association between predictor variables and ratings of the helpfulness of treatments. The predictor variables included which vignette journalists received (suicidal depression, early schizophrenia or postnatal depression), their age (18-39 years, 40-59 years or 60 years or older), gender (male or female), level of education (no university education, bachelor's degree or higher level of education), previous personal experience of a mental disorder (previous experience with a mental disorder or no previous experience of a mental disorder) and level of personal stigma (continuous variable). Significant predictors are reported for all treatments.

The previous chapters indicated that people who could help represent a different class of intervention descriptor to other treatments for mental disorders because many of the people who could potentially help a person with a mental disorder are trained to deliver more than one of the interventions considered, such as prescribing medication and counselling. Therefore, the results section describes the interventions separately – people who can help, medications that can help, lifestyle/psychosocial interventions that can help and sources of information that can help. However, the discussion section considers the interplay between all treatments for mental disorders, incorporating people who could help.

7.4 Results

Odds ratios from multiple logistic regression analyses predicting the helpfulness of a range of different interventions for mental disorders were calculated. The resulting tables provide the odds ratio, 95% confidence interval, level of significance, Nagelkerke R Square and Hosmer and Lemeshow Test statistic. Predictors were considered significant when $p < 0.05$. Results are reported at three significance levels, $p < 0.05$, $p < 0.01$ $p < 0.001$. Results are considered more significant when the p value is smaller and provide greater confidence in the determination of significance. However, excluding values where the p value was greater than 0.001 may have meant that important predictors were excluded, thus a three tiered level of significance was adopted.

Due to the large number of regressions that were performed, the Hosmer and Lemeshow Test statistic is reported and commented on. A Hosmer and Lemeshow Test statistic that is not statistically significant ($p > 0.05$) indicates that the model fit the data adequately. Although the Hosmer and Lemeshow Test may have limited power, as it depends on arbitrary cut points on predicted probabilities, it provides a broad basis on which to assess the success of the models. In addition, a statistically significant Hosmer-Lemeshow test does not necessarily mean that a predictive model is not useful or that the model does not fit the data adequately (Kramer & Zimmerman, 2007), but rather, such data should be interpreted with caution. The Hosmer and Lemeshow Test statistic indicated that the models fit the helpfulness data well for 29 of the 34 treatments presented. The treatments where the models did not fit the data well included counsellor, psychiatrist, antipsychotics, tranquilisers and psychotherapy.

7.4.1 Predictors of helpfulness of people

Table 7.1 shows the odds ratios from multiple logistic regression analyses predicting helpfulness of professionals and lay people for the three mental disorders. Predictors of

helpfulness of professionals for mental disorders were identified for 12 of the 13 people who could potentially help with mental disorders.

Using a significance level of $p < 0.05$, the main predictors of responses about the helpfulness of various health professionals mental disorders were related to the type of vignette journalists were shown, age, gender, previous experience of a mental disorder and level of personal stigma.

Vignette

Journalists who received the postnatal depression vignette were significantly more likely to suggest that a social worker (OR 1.6) would be helpful and less likely to endorse the helpfulness of a psychiatrist (OR 0.5) than those who received the suicidal depression vignette. Journalists who received the early schizophrenia vignette were significantly more likely than those who received the suicidal depression vignette to believe that a psychiatrist (OR 1.8) would be helpful for mental disorders and less likely to endorse phone counselling (OR 0.5) and a naturopath/herbalist (OR 0.4).

Age

Journalists aged from 40 to 59 years were less likely than younger journalists (aged 18-39 years) to believe in the helpfulness of a counsellor (OR 0.4), social worker (OR 0.7), close family (OR 0.5) or close friends (OR 0.5) for mental disorders. Journalists aged 60 years and over were significantly less likely than those aged 18-39 years to perceive a counsellor (OR 0.2), or a naturopath/herbalist (OR 0.3) as helpful for mental disorders.

Gender

Female journalists were more likely than males to rate a naturopath/herbalist (OR 1.7) as helpful for mental disorders.

Table 7.1

Odds ratios (and 95% confidence intervals) from logistic regression analyses predicting helpfulness of professionals by journalists

Predictor	GP	Chemist/ Pharmacist	Counsellor	Social worker	Phone counselling	Psychiatrist	Psychologist	Close family	Close friends	Naturopath/ herbalist	Police Officer	Clergy/ minister	Deal with it alone
Type of vignette													
Suicidal depression	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Postnatal depression	1.329 (.616- 2.867)	1.683 (.978- 2.896)	1.139 (.503- 2.583)	1.605* (1.028- 2.505)	1.109 (.649- 1.894)	.502** (.310-.814)	.822 (.498-1.354)	.886 (.460- 1.705)	1.280 (.582- 2.814)	1.102 (.678- 1.792)	1.557 (.679- 3.572)	1.446 (.917- 2.281)	.858 (.355- 2.076)
Schizophrenia (Early)	.686 (.349- 1.349)	.652 (.351- 1.213)	.517 (.250- 1.066)	1.359 (.872- 2.115)	.493** (.301-.805)	1.851* (1.062- 3.225)	1.117 (.664-1.877)	.546 (.292- 1.020)	.534 (.268- 1.065)	.364** (.202-.654)	2.067 (.928- 4.606)	.978 (.606- 1.577)	.879 (.376- 2.054)
Sociodemographic characteristics													
Age 18-39 years	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0
Age 40-59 years	.595 (.316- 1.120)	.813 (.498- 1.325)	.420* (.209- .843)	.650* (.442- .955)	.755 (.491- 1.160)	.926 (.597- 1.435)	.893 (.575-1.386)	.505* (.294- .668)	.479* (.254- .905)	.668 (.425- 1.052)	.695 (.363- 1.331)	.913 (.613- 1.359)	1.275 (.583- 2.786)
Age 60+ years	.507 (.189- 1.355)	.569 (.218- 1.485)	.207** (.080- .536)	.657 (.336- 1.284)	.738 (.350- 1.554)	1.178 (.527- 2.635)	.815 (.384-1.729)	.784 (.291- 2.113)	.546 (.193- 1.545)	.294* (.098-.883)	.706 (.224- 2.227)	.995 (.482- 2.056)	1.855 (.590- 5.830)
Male gender	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0
Female gender	1.181 (.639- 2.182)	.792 (.487- 1.287)	1.691 (.885- 3.232)	1.306 (.892- 1.912)	1.525 (.995- 2.338)	.758 (.487- 1.172)	1.366 (.884-2.112)	1.428 (.843- 2.416)	1.739 (.845- 3.200)	1.727* (1.090- 2.735)	.582 (.304- 1.114)	1.213 (.816- 1.804)	.565 (.255- 1.251)
No university degree	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0
Bachelors degree or higher	1.432 (.798- 2.569)	.975 (.603- 1.575)	.711 (.384- 1.314)	.885 (.606- 1.293)	1.133 (.746- 1.721)	1.119 (.727- 1.723)	1.487 (.975-2.266)	1.338 (.807- 2.218)	1.526 (.861- 2.705)	.816 (.516- 1.290)	.794 (.425- 1.482)	.856 (.578- 1.268)	1.058 (.508- 2.206)
Experience with mental disorders													
Consumer	.887 (.409- 1.921)	.928 (.524- 1.643)	1.193 (.493- 2.888)	1.029 (.647- 1.636)	1.632 (.904- 2.944)	1.269 (.752- 2.142)	.903 (.536-1.523)	.755 (.399- 1.427)	1.358 (.592- 3.116)	1.516 (.925- 2.482)	.895 (.387- 2.068)	1.881** (1.191- 2.969)	1.100 (.420- 2.879)
Stigma													
Personal stigma (high)	.934* (.877- .994)	.983 (.934- 1.034)	.992 (.930- 1.058)	.994 (.955- 1.035)	.960 (.919- 1.003)	.959 (.916- 1.005)	.972 (.929-1.017)	1.015 (.962- 1.071)	1.034 (.973- 1.099)	1.010 (.962- 1.060)	.999 (.936- 1.067)	1.034 (.992- 1.077)	1.100* (1.017- 1.189)
Nagelkerke R²													
	6.9	4.4	9.6	3.8	10.1	7.8	3.6	5.7	9.4	11.7	3.2	3.8	6.3
Hosmer & Lemeshow (p value)													
	.336	.593	.270	.249	.679	.043	.113	.611	.781	.943	.249	.565	.417

¹ Reference category, *p<0.05, **p<0.01, ***p<0.001

Education

Level of education did not predict the helpfulness of various people for mental disorders.

Experience with mental disorder

Journalists who had experienced a mental disorder themselves, were almost twice as likely as people with no personal experience of a mental disorder, to rate the clergy as helpful (OR 1.9).

Stigma

High personal stigma was associated with significantly lower helpfulness ratings for a GP (OR 0.9) and significantly higher helpfulness ratings for dealing with it alone (OR 1.1)

7.4.2 Predictors of helpfulness of other interventions: medications, lifestyle/psychosocial interventions and sources of information

Tables 7.2, 7.3 and 7.4 show the odds ratios from multiple logistic regression analyses predicting helpfulness of a range of different medical, lifestyle/psychosocial and information interventions for mental disorders. Predictors of helpfulness were identified for:

- five of the seven medications;
- ten of the eleven lifestyle/psychosocial interventions; and
- all four sources of information.

Taking predictors with $p < 0.05$, the main predictors of responses about the helpfulness of various interventions for mental disorders were related to type of vignette journalists were shown, age, gender, level of education, previous experience of a mental disorder and level of personal stigma.

Table 7.2

Odds ratios (and 95% confidence intervals) from logistic regression analyses predicting helpfulness of medications by journalists

Predictor	Vitamins/ minerals	Pain relievers	Antidepressants	Antibiotics	Sleeping Pills	Antipsychotics	Tranquilisers
Type of vignette							
Suicidal Depression	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0
Postnatal depression	.883 (.565-1.380)	1.223 (.505-2.954)	.525** (.333-.826)	3.831 (.402-36.326)	.639 (.337-1.211)	.488* (.244-.972)	.839 (.405-1.740)
Schizophrenia (Early)	.436** (.270-.705)	.662 (.256-1.706)	1.069 (.671-1.703)	3.047 (.328-28.281)	.902 (.484-1.683)	8.308*** (4.882-14.138)	2.472** (1.294-4.725)
Sociodemographic characteristics							
Age 18-39 years	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Age 40-59 years	.969 (.628-1.450)	.939 (.420-2.099)	.733 (.498-1.081)	.672 (.137-3.297)	.789 (.455-1.368)	.908 (.563-1.464)	1.656 (.936-2.928)
Age 60+ years	.698 (.328-1.488)	1.327 (.396-4.442)	1.730 (.838-3.573)	2.059 (.328-12.959)	.590 (.191-1.817)	1.025 (.434-2.424)	2.528* (1.014-6.307)
Male gender	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Female gender	1.843** (1.230-2.761)	1.264 (.578-2.762)	1.358 (.925-1.994)	1.267 (.304-5.279)	1.359 (.783-2.360)	1.124 (.702-1.801)	1.021 (.587-1.779)
No university degree	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Bachelors degree or higher	.595* (.399-.888)	.808 (.376-1.735)	1.152 (.787-1.686)	.292 (.066-1.285)	.825 (.476-1.431)	.770 (.480-1.235)	.593 (.347-1.013)
Experience with mental disorders							
Previous mental disorder	2.114** (1.344-3.327)	.375 (.108-1.304)	1.553 (.957-2.521)	.000 (.000)	1.809 (.990-3.307)	.655 (.340-1.264)	1.925 (.987-3.752)
Stigma							
Personal stigma (high)	1.037 (.994-1.082)	1.053 (.970-1.144)	.946** (.908-.986)	1.060 (.913-1.230)	1.031 (.973-1.092)	1.016 (.966-1.068)	1.021 (.965-1.081)
Nagelkerke R²	11.7	3.6	8.0	12.9	3.6	35.7	8.4
Hosmer & Lemeshow (p value)	.222	.541	.198	.671	.092	.284	.540

¹ Reference category, *p<0.05, **p<0.01, ***p<0.001

Table 7.3

Odds ratios (and 95% confidence intervals) from logistic regression analyses predicting helpfulness of lifestyle/psychosocial modifications by journalists

Predictor	Physical activity	Read about problem	Get out more	Learn relaxation	Cut out alcohol	Psychotherapy	Hypnosis	Psychiatric ward	ECT	Occasional drink	special diet
Type of vignette											
Suicidal depression	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Postnatal depression	.376** (.204-.695)	3.048** (1.459-6.368)	1.276 (.786-2.072)	1.573 (.866-2.859)	.911 (.589-1.409)	.848 (.546-1.316)	.740 (.404-1.356)	1.399 (.604-3.240)	3.351 (.649-17.289)	.838 (.532-1.319)	.932 (.568-1.528)
Schizophrenia (Early)	.337*** (.184-.618)	1.077 (.605-1.917)	.996 (.620-1.602)	.728 (.430-1.234)	2.445*** (1.578-3.799)	2.687*** (1.714-4.213)	1.295 (.719-2.332)	7.553*** (3.615-15.781)	7.503* (1.542-36.513)	.287*** (.168-.490)	.838 (.505-1.391)
Sociodemographic characteristics											
Age 18-39 years	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Age 40-59 years	.739 (.466-1.170)	.682 (.388-1.202)	.646* (.431-.968)	.880 (.546-1.416)	.802 (.552-1.165)	1.606* (1.096-2.345)	1.077 (.648-1.789)	1.138 (.671-1.930)	2.351 (.819-6.748)	2.074*** (1.340-3.210)	1.128 (.734-1.732)
Age 60+ years	.758 (.341-1.687)	.481 (.203-1.136)	2.648 (.984-7.128)	1.137 (.491-2.631)	.603 (.299-1.214)	2.890** (1.445-5.778)	.914 (.325-2.571)	.251 (.055-1.137)	.958 (.104-8.789)	5.207*** (2.557-10.605)	.588 (.243-1.423)
Male gender	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Female gender	1.104 (.705-1.730)	1.494 (.860-2.597)	.738 (.492-1.107)	2.039** (1.260-3.300)	1.187 (.819-1.719)	.937 (.642-1.367)	1.397 (.837-2.332)	.777 (.456-1.323)	.566 (.202-1.586)	1.063 (.694-1.628)	.826 (.537-1.271)
No university degree	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Bachelors degree or higher	1.122 (.719-1.750)	1.027 (.603-1.751)	.975 (.649-1.464)	1.170 (.739-1.851)	.907 (.626-1.315)	1.237 (.848-1.803)	.984 (.590-1.643)	1.116 (.654-1.904)	1.044 (.400-2.723)	1.159 (.762-1.764)	1.150 (.748-1.769)
Experience with mental disorders											
Previous mental disorder	3.066** (1.526-6.158)	2.904* (1.177-7.166)	1.708* (1.016-2.871)	2.002 (.996-4.025)	1.361 (.874-2.122)	2.672*** (1.687-4.231)	1.892* (1.080-3.315)	1.132 (.547-2.341)	2.667 (.831-8.555)	1.647* (1.019-2.661)	1.173 (.706-1.949)
Stigma											
Personal stigma (high)	1.058* (1.008-1.109)	.986 (.931-1.044)	1.019 (.976-1.064)	.981 (.934-1.030)	.994 (.956-1.034)	.970 (.932-1.009)	.984 (.933-1.039)	1.012 (.958-1.069)	1.032 (.935-1.139)	1.035 (.990-1.083)	1.018 (.973-1.065)
Nagelkerke R²	11.1	10.2	5.4	9.2	7.4	12.0	3.5	18.4	9.7	15.1	1.3
Hosmer & Lemeshow (p value)	.098	.193	.955	.217	.967	.253	.457	.388	.761	.688	.912

¹ Reference category, *p<0.05, **p<0.01, ***p<0.001

Table 7.4

Odds ratios (and 95% confidence intervals) from logistic regression analyses predicting helpfulness of sources of information by journalists

Predictor	Consult a website	Email an expert	Consult a book	Consult a health educator
Type of vignette				
Suicidal depression	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Postnatal depression	1.872* (1.151-3.044)	1.927** (1.251-2.968)	2.305** (1.303-4.078)	3.265** (1.358-7.848)
Schizophrenia (Early)	1.014 (.645-1.593)	1.364 (.887-2.098)	.833 (.509-1.365)	1.662 (.814-3.395)
Sociodemographic characteristics				
Age 18-39 years	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Age 40-59 years	.697 (.465-1.045)	.884 (.610-1.281)	.432*** (.272-.685)	.440* (.210-.918)
Age 60+ years	.831 (.409-1.689)	.814 (.420-1.579)	.470 (.220-1.004)	.329* (.115-.942)
Male gender	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Female gender	1.048 (.702-1.564)	.897 (.620-1.298)	1.668* (1.064-2.616)	1.926 (.949-3.908)
No university degree	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹
Bachelors degree or higher	1.082 (.728-1.607)	1.278 (.887-1.841)	1.147 (.743-1.770)	.672 (.346-1.305)
Experience with mental disorders				
Previous mental disorder	1.759* (1.033-2.995)	1.622* (1.030-2.553)	2.374* (1.226-4.597)	2.120 (.766-5.871)
Stigma				
Personal stigma (high)	.963 (.923-1.005)	.990 (.952-1.029)	1.020 (.963-1.058)	.991 (.923-1.063)
Nagelkerke R²	6.9	4.2	14.7	10.7
Hosmer & Lemeshow (p value)	.189	.925	.745	.418

1 Reference category, *p<0.05, **p<0.01, ***p<0.001

Vignette

Journalists who received the postnatal depression vignette were less likely to believe in the helpfulness of antidepressants (OR 0.5), antipsychotics (OR 0.5) and physical activity (OR 0.3) than journalists who received the suicidal depression vignette.

Journalists who received the postnatal depression vignette were more likely than those who received the suicidal depression vignette to rate reading about people with similar problems (OR 3.0) and to endorse the helpfulness of all sources of information (OR 1.9-3.3) than people who received the suicidal depression vignette.

Journalists who received the early schizophrenia vignette were significantly more likely than those who received the suicidal depression vignette to suggest that cutting out alcohol (OR 2.4), psychotherapy (OR 2.7) admission to a psychiatric ward (OR 7.6) and undergoing ECT (OR 7.5) would be helpful lifestyle/psychosocial interventions. The same journalists were less likely to believe that having an occasional alcoholic drink to relax (OR 0.3) would be helpful.

Age

Journalists aged 40-59 years were more likely than those aged 18-39 years to endorse psychotherapy (OR 1.6) and having an occasional alcoholic drink to relax (OR 2.1) as helpful lifestyle/psychosocial interventions for mental disorders and less likely to believe that getting out and about more (OR 0.6), consulting a book (OR 0.4) or health educator (OR 0.4) would be helpful.

Similarly, journalists aged 60 years or older were significantly more likely than journalists aged 18-39 to endorse psychotherapy (OR 2.9) and having an occasional alcoholic drink to relax (OR 5.2) and less likely to consider contacting a health educator (OR 0.3) as helpful for mental disorders.

Journalists aged 60 years and over were more likely than those aged 18-39 years to endorse the helpfulness of tranquilisers (OR 2.5), psychotherapy (OR 2.9) and occasional alcoholic drink to relax (OR 5.2) for mental disorders.

Gender

Female journalists were more likely than males to rate vitamins/minerals (OR 1.8) and attending courses on relaxation (OR 2.1) as helpful for mental disorders.

Experience with a mental disorder

Journalists with previous experience of a mental disorder were up to three times more likely to rate some lifestyle/psychosocial interventions as helpful for mental disorders when compared with people who had not experienced a mental disorder. Vitamins/minerals (OR 2.4), more physical activity (OR 3.1), reading about people with similar problems (OR 2.9), getting out and about more (OR 1.7), psychotherapy (OR 2.7), hypnosis (OR 1.9) and having an occasional alcoholic drink to relax (OR 1.6) were all rated as likely to be helpful by journalists with previous experience of a mental disorder.

Journalists with previous experience of a mental disorder were significantly more likely than people who had not experienced a mental disorder to suggest that consulting a website (OR 1.8), emailing an expert (OR 1.6) and consulting a book (OR 2.4) would be helpful for mental disorders.

Education

Journalists with a Bachelor's degree or higher level of education were less likely to rate vitamins and minerals (OR 0.6) as helpful for mental disorders compared with those who had no university education.

Stigma

Journalists with high personal stigma scores were less likely to rate antidepressants (OR 0.9) as helpful treatments and more likely to assign helpfulness ratings to more physical activity (OR 1.1) for mental disorders than people with low personal stigma.

7.4.3 Summary of significant results

Table 7.5 provides a summary of significant results which are colour coded by type of treatment; grey for people who could help, blue for medications that could help, red for lifestyle/psychosocial interventions that could help and green for information sources that could help.

Table 7.5

Summary of results for journalists by predictor

	More likely to be helpful	Less likely to be helpful
Vignette	<p>Journalists rated the following interventions as significantly more likely to be helpful for postnatal depression than suicidal depression:</p> <ul style="list-style-type: none"> ·Social worker ·Reading about people with similar problems ·Consult a website ·Email an Expert ·Consult a book ·Consult a health educator <p>Journalists rated the following interventions as significantly more likely to be helpful for early schizophrenia than suicidal depression:</p> <ul style="list-style-type: none"> ·Psychiatrist ·Antipsychotics ·Tranquilisers ·Cutting out alcohol altogether ·Psychotherapy ·Admitted to the psychiatric ward ·Undergoing ECT 	<p>Journalists rated the following interventions as significantly less likely to be helpful for postnatal depression than suicidal depression:</p> <ul style="list-style-type: none"> ·Psychiatrist ·Antidepressants ·Antipsychotics ·More physical activity <p>Journalists rated the following interventions as significantly less likely to be helpful for early schizophrenia than suicidal depression:</p> <ul style="list-style-type: none"> ·Phone counselling ·<i>Naturopath/herbalist</i> ·Vitamins/minerals ·Having an occasional alcoholic drink to relax
Age	<p>Journalists aged 40-59 years rated the following interventions as significantly more likely to be helpful for mental disorders than those aged 18-39 years:</p> <ul style="list-style-type: none"> ·Psychotherapy ·Having an occasional alcoholic drink to relax <p>Journalists aged over 60 years rated the following interventions as significantly more likely to be helpful for mental disorders than those aged 18-39 years:</p> <ul style="list-style-type: none"> ·Tranquilisers 	<p>Journalists aged 40-59 years rated the following interventions as significantly less likely to be helpful for mental disorders than those aged 18-39 years:</p> <ul style="list-style-type: none"> ·Counsellor ·Social worker ·Close family ·Close friends ·Getting out and about more ·Consult a book ·Consult a health educator <p>Journalists aged over 60 years rated the following interventions as significantly less likely to be helpful for mental disorders than those aged 18-39 years:</p> <ul style="list-style-type: none"> ·Counsellor

Medications that could help, **Lifestyle/psychosocial interventions that could help**, Information sources that could help, People who could help

Table 7.5 continued

Summary of results for journalists by predictor

	More likely to be helpful	Less likely to be helpful
Age	<ul style="list-style-type: none"> ·Psychotherapy ·Having an occasional alcoholic drink to relax 	<ul style="list-style-type: none"> ·Naturopath/herbalist ·Consult a health educator
Gender	<p>Females rated the following interventions as significantly more likely to be helpful for mental disorders than males:</p> <ul style="list-style-type: none"> ·Naturopath/herbalist ·Vitamins/minerals ·Attending courses on relaxation ·Consult a book 	<p>Females did not rate any interventions as significantly less likely to be helpful for mental disorders than males:</p>
Education	<p>Journalists with a Bachelors Degree or higher level of education rated the following interventions as significantly more likely to be helpful for mental disorders than people with no tertiary education:</p> <ul style="list-style-type: none"> ·Attending courses on relaxation 	<p>Journalists with a Bachelors Degree or higher level of education rated the following interventions as significantly less likely to be helpful for mental disorders than people with no tertiary education:</p> <ul style="list-style-type: none"> ·Vitamins/minerals
Previous experience of a mental disorder	<p>Journalists with previous experience of a mental disorder rated the following interventions as significantly more likely to be helpful for mental disorders than people with no experience of a mental disorder:</p> <ul style="list-style-type: none"> ·Clergy/minister ·Vitamins/minerals ·More physical activity ·Reading about people with similar problems ·Getting out and about more ·Psychotherapy ·Hypnosis ·Having an occasional alcoholic drink to relax ·Consult a website ·Email an expert ·Consult a book 	<p>Journalists with previous experience of a mental disorder did not rate any interventions as significantly less likely to be helpful for mental disorders people with no experience of a mental disorder.</p>
Personal Stigma	<p>Journalists with high personal stigma rated the following interventions as significantly more likely to be helpful for mental disorders than journalists with low personal stigma</p> <ul style="list-style-type: none"> ·Deal with it alone ·More physical activity 	<p>Journalists with high personal stigma rated the following interventions as significantly less likely to be helpful for mental disorders than journalists with low personal stigma</p> <ul style="list-style-type: none"> ·GP ·Antidepressants

Medications that could help, Lifestyle/psychosocial interventions that could help, Information sources that could help, People who could help

Compared with suicidal depression, the majority of interventions preferred for postnatal depression were to seek out and read different sorts of information. Those least likely to be helpful were medications. For schizophrenia, medications and lifestyle/psychosocial interventions were preferred whilst natural therapists and natural medicines were not considered helpful.

Older journalists were more likely to suggest lifestyle/psychosocial interventions would be helpful and less likely to seek help from professionals or to source information for their disorders.

Women suggested interventions from all sources, the majority of which were related to dealing with mental disorders naturally.

People with a Bachelor's degree or higher level of education thought that attending courses on relaxation (lifestyle/psychosocial intervention) but not vitamin/minerals would be helpful.

Journalists with previous experience of a mental disorder were more likely to suggest that lifestyle/psychosocial interventions and information seeking would be helpful for mental disorders.

People with high personal stigma rejected medications and health professionals and suggested that lifestyle/psychosocial interventions and dealing with it alone would be more helpful.

7.5 Discussion

7.5.1 Predictors of helpfulness of interventions: people, medications, lifestyle/psychosocial interventions and sources of information

Chapters 5 and 6 reported that journalists perceived several different types of interventions as being helpful for mental disorders. Lifestyle/psychosocial interventions and information sources were commonly suggested as helpful treatments for suicidal depression, early schizophrenia and postnatal depression. In addition, medications and health professionals were considered more helpful for schizophrenia than the other disorders. The factors predicting these responses have been reported in this chapter and include vignette respondent was shown, age of respondent, gender of respondent, level of education of respondent, previous experience with a mental disorder and level of personal stigma. These predictors are now discussed.

Vignette

Although few studies have investigated which professionals women with postnatal depression approach for treatment, there is evidence to suggest that the overall rates of treatment amongst this group are low (O'Mahen & Flynn, 2008). The review of literature in Chapter 2 demonstrated that Australian women showed a preference for seeking help from their family, partner, GP or maternal and child health nurse for these issues (Buist, et al., 2006). However, journalists who received the postnatal depression vignette in the HAMP survey indicated that a social worker would be more helpful for postnatal depression and a psychiatrist much less helpful. The data from the regression analysis showed that the type of vignette evaluated by the respondent influenced the extent to which the social worker category was endorsed. Those with the postnatal vignette endorsed it more. The finding that a social worker was more likely to be helpful for postnatal depression may be due to the fact that journalists perceive the primary role of a social worker as a professional who helps with family problems and hence, would be an appropriate professional to help women and their families who experienced postnatal depression.

Journalists' reluctance to suggest seeking help from a psychiatrist for postnatal depression was most likely related to the fact that psychiatrists have the ability to prescribe medication for mental disorders. Indeed, when we look at the results for predictors of medications, we see that both antidepressants and antipsychotics were nominated as significantly less likely to be helpful for postnatal depression. In addition, seeking information through the Internet or a book was seen as helpful for postnatal depression. Such results are congruent with other studies which have demonstrated a preference for informal treatments by women themselves, such as seeking help from a partner, friends and family, or seeking out information which are deemed more 'acceptable' treatments for postnatal depression (Buist, et al., 2005; O'Mahen & Flynn, 2008). Concerns about the potential impact of medication on the baby of breastfeeding mothers are likely to have influenced this result and were discussed in the previous chapter. Unfortunately, such views amongst journalists may mean that treatment with antidepressant medication, an evidence-based intervention for moderate to severe postnatal depression (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression, 2004), may not be considered if they, or someone close to them, experiences postnatal depression.

The fact that journalists suggested seeking out information about postnatal depression via the Internet or a book may reflect the fact that these are the types of media they use on a daily basis, and feel most comfortable with, to source information for stories.

Indeed, a recent survey of 745 American journalists found that they are heavily dependent on The Web and that more than 90% use it as their primary tool in editing and reporting (Bates & Arno, 2009). Journalists' quest to access information about the disorder may reflect the fact that they view postnatal depression as a serious illness and the fact that different sources of information are readily available to them in the workplace. The challenge will be to ensure that they are accessing appropriate sites with accurate information about the illness.

Journalists also suggested that physical activity is less likely to be helpful for postnatal depression when compared with suicidal depression. Although this is an evidence-based treatment for depression, journalists' perception that is less likely to be helpful may reflect the fact that women with postnatal depression have young babies and that journalists recognise the fact that it takes the body some time to readjust to its pre-pregnancy state prior to commencing an exercise regime.

In contrast to postnatal depression, a psychiatrist was seen as significantly more helpful for early schizophrenia compared with suicidal depression. Similarly, antipsychotics and tranquilisers were seen as significantly more helpful. Belief in the helpfulness of a psychiatrist for early schizophrenia by journalists may reflect the fact that schizophrenia is viewed as a more serious and disabling illness compared with suicidal depression and that medical treatment is warranted. The general public have traditionally demonstrated a preference for non-standard treatments such as the lay system, GPs and counsellors for the treatment of schizophrenia, so the fact that journalists have identified psychiatrists as more helpful indicates that there is some other mediating factor. It is difficult to conclusively identify what this factor may be, however it is possible that, as suggested in previous chapters, the *Mindframe* intervention to raise awareness of depression and schizophrenia amongst journalists, through the provision of resources and education for media professionals, has been successful at raising their awareness of some of the appropriate treatments for mental disorders.

The fact that journalists thought that treatment with antipsychotics and tranquilisers would be more helpful for schizophrenia than depression is in line with current Australian treatment guidelines and potentially suggests that journalists have a deeper understanding of schizophrenia than the general public. Again, it is highly possible that the *Mindframe* initiative has been successful at raising aspects of journalists' mental health literacy.

Cutting out alcohol, psychotherapy, being admitted to the psychiatric ward of a hospital and undergoing ECT were all perceived as being more helpful for early schizophrenia than for suicidal depression. There is strong evidence for the efficacy of ECT, admission to a psychiatric ward and psychotherapy (in combination with medication) for the treatment of early schizophrenia (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders, 2005a). Phone counselling, having an occasional alcoholic drink to relax and visiting a naturopath/herbalist were significantly less likely to be viewed as helpful for the person in the schizophrenia vignette. These findings compliment journalists' beliefs in the importance of medical interventions for schizophrenia. The fact that phone counselling was seen as less likely to be helpful for schizophrenia and psychiatrists and admission to a psychiatric ward as more helpful than for suicidal depression suggests that journalists have a strong preference for face-to-face interventions from qualified medical professionals and reject the idea of alternative treatments or self medicating through illicit drugs or alcohol for the illness. Journalists' beliefs about schizophrenia appear to be more closely aligned with the beliefs of health professionals such as GPs rather than the general public and reflect a good understanding of appropriate evidence-based treatments for the illness. Unfortunately, they are less well informed about the best treatments for postnatal depression, and this was reflected in their limited knowledge about some evidence-based treatments, such as antidepressants and physical activity, for the disorder.

Age

Journalists aged between 40 and 59 years were less likely than younger journalists (aged 18-39 years) to believe in the helpfulness of some talking therapies such as a visiting a counsellor or social worker or talking with close family or close friends for mental disorders. These findings differ from the results of a study of the Australian public, which demonstrated that both middle aged and younger members of the general public were more likely to suggest talking to a counsellor or social worker for mental disorders than older members of the general public (Farrer, Leach, Griffiths, Christensen, & Jorm, 2008).

Older journalists also believed that taking tranquilisers and having an occasional alcoholic drink to relax were significantly more helpful for mental disorders. Although tranquilisers are useful for schizophrenia, they are no longer a preferred treatment for postnatal depression. Reasons that older journalists nominated tranquilisers for mental disorders are unclear but may reflect past personal experience, or knowledge of family

or friends who were prescribed different medications, such as tranquilisers, for the treatment of mental disorders, prior to the development of newer medications.

Journalists aged over 60 years were also less likely to endorse visiting a counsellor or naturopath/herbalist for mental disorders and more likely to suggest that psychotherapy would be helpful than journalists aged 18-39 years. The finding that older journalists are reluctant to visit a counsellor was in-line with results obtained when the Australian public were asked to nominate the helpfulness of a counsellor (Farrer, et al., 2008). Reluctance to seek help from alternative practitioners can almost certainly be explained by the fact that visiting a naturopath or herbalist is a relatively new phenomenon in Australia and older generations are less likely to have been exposed to these types of practitioners.

Journalists aged 40-50 years and those aged 60 years or older rated psychotherapy as significantly more likely to be helpful for mental disorders and a counsellor as less likely to be helpful. This is an interesting finding since “differences between counselling and psychotherapy are slight and depend on context and perception rather than content, skill or process” (Kwiatkowski, 1998 p. 5). It is difficult to explain the reasons for this finding, and further research may be needed to elucidate this relationship. Previous research has suggested that psychotherapy is perceived as being delivered by medical professionals of high standing, whereas psychologists are perceived as being rather more ‘woolly’ and not really considered as professionals (Kwiatkowski, 1998 p. 5). Regardless of the reasons, it is clear that psychotherapy is a preferred treatment for mental disorders amongst journalists aged over 40 years and that if our goal is to achieve greater uptake of psychotherapy, an evidence-based intervention, it needs to be delivered by a professional other than a counsellor.

Gender

Female journalists were more likely to rate a naturopath/herbalist as helpful for mental disorders than their male counterparts. Women also demonstrated a strong preference for vitamins/minerals and tonics and attending courses on relaxation in the HAMP survey. Although there is no consistent relationship between gender and treatment choices described in the literature (Angermeyer & Dietrich, 2006), a comparison of Australian GPs and postnatal women established that women were more likely to favour natural therapies for postnatal depression (Buist, et al., 2005). According to the Australian Longitudinal Study on Women’s Health (Adams, Sibbritt, & Young, 2007), the use of herbal medicines and remedies by women for all types of illnesses is high in Australia. The Longitudinal study also found that women appear to be supplementing,

rather than replacing conventional treatments with those offered by herbalists or naturopaths and that these people had a tendency towards poorer health (Adams, et al., 2007). This is of concern because some natural remedies prescribed for depression, such as St Johns Wort, may interfere with traditionally prescribed medications, such as antidepressants, to either increase or reduce the effects of the prescribed medications (Centre for Mental Health Research (CMHR), 2001).

Reasons for greater use of naturopaths/herbalists by women may be that women believe that the types of treatments delivered by a naturopath or herbalist, such as vitamins or minerals, are more natural and therefore less likely to be harmful than traditional medications. Another explanation is that an increase in natural therapy training through universities in Australia has been accompanied by an increase in popularity of natural medicines as journalists with previous experience of a mental disorder have more confidence in the role of university educated naturopaths (Evans, 2000).

Education

The only intervention where education was a predictor was for vitamins/minerals which were deemed significantly less helpful for mental disorders by journalists with a Bachelor's degree or higher educational qualification. There is no evidence for the efficacy of vitamins or minerals for the treatment of mental disorders (except folate for depression), so this finding is in line with current guidelines.

Previous experience of a mental disorder

Journalists who had previously experienced a mental disorder were significantly more likely to nominate the clergy as more helpful for mental disorders than people who had never experienced a mental disorder. This finding is interesting as it suggests that people who have experienced a mental disorder are perhaps seeking a spiritual or faith component to their recovery. Although not an evidence-based treatment for mental disorders, prayer is often used in times of personal illness. In 88 non-clinically depressed Christian adults, there was a significant decrease in depressive symptoms in people who recited the Jesus prayer for 10 minutes each day for 30 days, compared with a control group (Stavros, 1998). Although formal help-seeking is low amongst people with mental disorders in Australia, informal sources of help are frequently nominated as useful by people with mental disorders. An affirming relationship with a priest or minister, especially one that is trusted, may be perceived as an important social support by people with mental disorders. However, Chapter 5 indicated that while the clergy potentially play a role in the treatment of mental disorders, most are

not trained in the area of mental disorders and do not refer parishioners to appropriate mental health professionals (Farrell & Goebert, 2008).

Journalists with previous experience of a mental disorder also suggested that vitamins/minerals and several lifestyle/psychosocial interventions including: physical activity; reading about people with similar problems; getting out and about more; psychotherapy; hypnosis; and having an occasional alcoholic drink would be significantly more helpful for mental disorders than journalists with no experience of a mental disorder. Their strong preference for lifestyle/psychosocial interventions, including those which have little or no evidence of efficacy is interesting. These results suggest that people with experience of a mental disorder are seeking a combination of treatments that address more than just their medical needs, such as their social and lifestyle needs. Journalists with experience of a mental disorder appear to be well versed in evidence-based interventions, but also advocate a number of non-standard interventions for mental disorders. Similar findings were reported in a study of 133 American consumers who had been diagnosed with severe mental illness which found that consumers view their lives and management of mental disorders holistically (Klein, Rosenberg, & Rosenberg, 2007). The researchers argued that treatment compliance improved when their social and personal needs were considered (Klein, et al., 2007). They concluded that facilitating consumer participation in their own treatment plan and working collaboratively with consumers to identify and address their self-perceived needs, regardless of whether such interventions have efficacy, improved their quality of life (Klein, et al., 2007). Regardless of efficacy, perhaps these results also suggest that journalists with experience of a mental disorder have an idea of what works for them, and are seeking to address their problems with a range of interventions. A strong reliance on non-evidence based interventions for mental disorders may also reflect consumer dissatisfaction with traditional treatments for mental disorders and a preference for treatments that they perceive do not have some of the potentially unpleasant side-effects experienced when some interventions, such as medication are taken.

Stigma

Journalists with high personal stigma were more likely to suggest that a person should deal with it alone and engage in more physical activity and less likely to hold favourable views about visiting a GP and taking antidepressants. These are unsurprising responses from a person with high stigma and probably reflect the fact that people with high levels of personal stigma are unlikely to acknowledge that a problem exists and therefore are unlikely to seek help or, if they did acknowledge a problem existed,

believe in working it out themselves. Similar results were obtained from surveys of the Australian public and showed a preference for dealing with depression alone in 1995 (25%) (Jorm, et al., 1997a) and 2003/2004 (12%) (Jorm, Kelly, Wright, Parslow, Harris, & McGorry, 2006e). Although physical activity has been shown to help with some mental disorders, it is doubtful that people with high personal stigma chose this intervention based on their superior knowledge of treatments. It is more plausible to suggest that people with high personal stigma chose this intervention because it was something that would not require disclosure about their disorder.

7.6 Conclusion

This chapter investigated the factors which predicted the types of treatment journalists think would be most helpful for suicidal depression, early schizophrenia and postnatal depression. Treatments nominated varied as a function of characteristics including type of vignette, age, gender, level of education, previous experience with a mental disorder and level of personal stigma.

In terms of mental health literacy, the data revealed gaps in journalist's knowledge about appropriate evidence-based treatments for mental disorders.

Older journalists most often suggested lifestyle/psychosocial interventions for mental disorders. This group thought that help from professionals or information sources would be less helpful for mental disorders. Women, on the other hand, suggested a range of different, non evidence-based interventions especially dealing with mental disorders naturally.

People with a Bachelor's degree or higher level of education and those with previous experience of mental disorders were more likely to nominate lifestyle/psychosocial interventions as being helpful. Journalists who had previously experienced a mental disorder were also likely to nominate different sources of information for mental disorders. This group nominated the most diverse range of treatments and appeared to favour a 'holistic' approach to managing mental disorder.

People with high personal stigma rejected medications and health professionals and suggested that lifestyle/psychosocial interventions and dealing with it alone would be more helpful.

CHAPTER EIGHT

WHAT DO THE GENERAL PUBLIC RECALL ABOUT DEPRESSION FROM THE MEDIA IN AUSTRALIA?

8.1 Introduction

The literature review in Chapter 3 consistently demonstrated that the media were an important source of information about mental illness for the general public and that reports about mental health and illness were common in the Australian media. In addition, the review concluded that, with a few exceptions, portrayal of mental health and illness tended to be negative overall and that media representations of mental illness promoted negative images and stereotypes (Francis, et al., 2001) and often linked mental illness with violence and crime. As a consequence, audiences may draw incorrect conclusions about mental disorders and the people who have them.

Although research detailing the content of mental health stories has been plentiful, there has been little investigation of what people actually recall about mental illness stories in the media. A survey by *beyondblue: the national depression initiative* (Hight, et al., 2006) demonstrated that about 70% of people recalled mental health stories, but to the researcher's knowledge, no research on the content of these remembered stories has been undertaken. What is remembered, as well as what is reported by the media, may be significant in influencing people's attitudes to mental disorders. Consequently, this chapter describes the themes recalled by the Australian public from the 2003/2004 Australia Japan survey. In this chapter, themes recalled by the general public are compared with themes identified from a study of items in Australian newspapers (Pirkis, et al., 2001a). In addition, levels of association between participants' recall of specific items from the media and their sociodemographic attributes, experience with mental disorders, attitudes and beliefs and the type of vignette they received were explored. This chapter explores the frequency with which specific items about depression are recalled by respondents in the Australia Japan survey. The chapter also considers whether the specific items recalled by respondents match up with the frequency with which these items appeared in the media.

The items of interest for the present chapter relate to the following questions:

'Have you seen, read or heard anything about depression in the media in the last 12 months?' and 'Can you tell me what you recall?'

8.2 Hypotheses

This chapter provides a descriptive account of the content that the Australian public recall from media stories about depression and describes how well the specific items recalled by respondents match up with the frequency with which these items appeared in the media.

A number of factors have previously been identified from multiple logistic regression analyses as predictors of mental health first aid responses amongst the Australian general public (Jorm et al., 2005). In particular, encouraging professional help seeking, listening to/talking with and having family supports, and giving or seeking information were strongly correlated with receiving a schizophrenia vignette, being female, having previously experienced a mental disorder but not seeking help, and high personal stigma (Jorm et al., 2005).

Therefore, the hypothesis was tested that participants' recall of specific items from the media will be influenced by a variety of factors including:

- a. The vignette they received;
- b. Sociodemographic variables including their age, gender and level of education;
- c. Previous experience of a mental disorder; and
- d. Level of personal stigma.

8.3 Data analysis

Open-ended responses were coded into 13 categories as described in the methodology chapter (Chapter 2). These categories were: individual's experience; causes, symptoms and/or treatment of mental illness; statistical overview; mental health care and/or services; policy or program initiative; research Initiative; opinion piece; language (identified either positive or negative use of language); mental health/illness issues associated with the workplace (or school); mental health/illness issues associated with physical health; mental health/illness mentioned in the context of suicide; mental health/illness mentioned in the context of crime; or other. Up to three responses were coded for each respondent. The coding sheet is attached at Appendix 6.

Binary multiple logistic regressions were conducted to examine the levels of association between participants' recall of specific items from the media and their sociodemographic attributes (age group, highest level of education), experience with

mental disorders (previous mental disorder or not), attitudes and beliefs (personal and perceived stigma) and the type of vignette received.

Data were analysed using version 14.0 of SPSS (SPSS, 2005).

8.4 Results

8.4.1 Recall of media stories on depression

Of the 3998 respondents to the Australia Japan survey, 2427 (61%) indicated that they had seen, read or heard something about depression in the media in the last 12 months. Of these 2427 respondents, 695 (28.6%) did not nominate what they recalled from the media, 1442 (59.4%) recalled at least one item from the media, 262 (10.8%) recalled two items from the media and 28 (1.2%) recalled three or more items from the media. The demographic characteristics of all people who had seen, read or heard something about depression in the media are shown in Table 8.1 as a function of vignette.

8.4.2 Type of items recalled

Table 8.2 shows the frequency and percentage recall for each category and each vignette. Note that since an item could be allocated to more than one category type, the overall total differs from the number of participants recalling an item.

Table 8.1

Demographic characteristics for those recalling a media item on depression (number and percentage)

Sociodemographic characteristics	Depression Vignette (n=595)	Depression/Suicidal Vignette (n=600)	Early Schizophrenia Vignette (n=625)	Chronic Schizophrenia Vignette (n=607)
Age				
Age 18-39 years	253 (42.5)	219 (36.5)	226 (36.2)	228 (37.6)
Age 40-59 years	208 (35.0)	244 (40.7)	261 (41.8)	244 (40.2)
Age 60+ years	134 (22.5)	137 (22.8)	138 (22.1)	135 (22.2)
Education				
No university degree	428 (71.9)	435 (72.5)	471 (75.4)	445 (73.3)
Bachelors degree or higher	167 (28.1)	165 (27.5)	154 (24.6)	162 (26.7)
Gender				
Male	219 (36.8)	264 (44.0)	241 (38.6)	240 (39.5)
Female	376 (63.2)	336 (56.0)	384 (61.4)	367 (60.5)
Personal Experience with mental disorder				
Previous mental disorder	215 (36.1)	213 (35.5)	94 (15.0)	50 (8.2)

Table 8.2

Number and percentage (%) of responses in each category as a function of vignette type*

Item Categories	Depression Vignette N (%)	Suicidal Depression Vignette	Early Schizophrenia Vignette	Chronic Schizophrenia Vignette
Individual's experience	36 (7.6)	30 (5.9)	48 (8.9)	31 (6.1)
Causes, symptoms and/or treatment of mental illness	113 (24)	141 (27.8)	158 (29.5)	152 (29.9)
Statistical overview	35 (7.4)	42 (8.3)	45 (8.4)	44 (8.6)
Mental health care and/or services	42 (8.9)	44 (8.7)	42 (7.9)	39 (7.7)
Policy or program initiative	42 (8.9)	40 (7.9)	42 (7.9)	26 (5.1)
Research initiative	5 (1.1)	10 (2.0)	6 (1.2)	5 (1.0)
Opinion piece	0	1 (0.2)	1 (0.2)	1 (0.2)
Language	0	0	0	0
Mental health/illness issues associated with the workplace	14 (3.0)	22 (4.3)	13 (2.4)	12 (2.4)
Mental health/illness issues associated with physical health	2 (0.4)	2 (0.4)	3 (0.6)	2 (0.4)
Mental health/illness mentioned in the context of suicide	40 (8.5)	59 (11.6)	49 (9.2)	44 (8.6)
Mental health/illness mentioned in the context of crime	16 (3.4)	17 (3.3)	11 (2.1)	22 (4.3)
Other	125 (26.6)	100 (19.7)	117 (21.9)	131 (25.7)
TOTAL	470 (100)	508 (100)	535 (100)	509 (100)

* Up to 3 categories permitted for each response

The most common type of item recalled from the media by respondents related to stories about the causes, symptoms and/or treatment of depression for all vignettes. Overall, the type of items recalled was similar across the four vignette types.

Language, opinion pieces and mental health/illness issues associated with physical health were infrequently or not recalled at all.

8.4.3 Predictors of recalled response categories

Table 8.3 shows the odds ratios from logistic regression analyses predicting response categories for depression information recalled from the media by the Australian public. Excluding the 'other' category (for which no data are available), predictors were identified for nine of the 12 categories for depression information recalled from the media by the Australian public.

Taking predictors with $p < 0.05$, the main predictors of response categories for depression information recalled from the media by the Australian public were related to type of vignette journalists were shown, age, level of education, previous experience of a mental disorder and level of personal stigma.

Vignette

Respondents who received the early schizophrenia and chronic schizophrenia vignettes were significantly more likely than those who received the depression vignette to recall stories about the causes, symptoms and/or treatment of depression (early schizophrenia OR 1.5, chronic schizophrenia OR 1.5). Respondents who received the chronic schizophrenia vignette were significantly less likely than those who received the depression vignette to recall stories about policy or program initiatives (OR 0.6).

Age

Respondents aged 60 years or older were less likely than those aged 18-39 years to recall stories related to mental health and the workplace (OR 0.1).

Education

Respondents with a Bachelors degree or higher level of education were significantly more likely than those with no university degree to recall stories about statistical overviews (OR 1.7), policy or program initiatives (OR 2.0) and mental health and physical health (OR 4.0) and less likely to recall stories about mental health and crime (OR 0.5).

Table 8.3

Odds ratios (and confidence intervals) from logistic regression analyses predicting response categories for information recalled from the media by the Australian public

Predictor	Individual's experience	Causes, symptoms, treatments	Statistical overview	Mental health care or services	Policy or program initiative	Research initiative	Opinion piece	Language	Mental health and workplace	Mental health and physical health	Mental health and suicide	Mental health and crime	other
Vignette													
Depression	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0	n/a [^]	1.0	1.0	1.0	1.0	1.0
Schizophrenia (early)	1.360 (.857-2.158)	1.478** (1.116-1.956)	1.423 (.997-2.284)	1.072 (.679-1.693)	.925 (.584-1.466)	1.334 (.391-4.543)	2220634.8 (n/a) [^]	n/a [^]	.752 (.344-1.643)	.993 (.163-6.066)	1.085 (.697-1.689)	.548 (.249-1.209)	.915 (.685-1.222)
Depressed/ suicidal	.826 (.501-1.362)	1.308 (.989-1.731)	1.232 (.772-1.967)	1.086 (.698-1.691)	.947 (.600-1.496)	2.011 (.680-5.951)	2026268.1 (n/a) [^]	n/a [^]	1.486 (.748-2.954)	.944 (.130-6.866)	1.517 (.996-2.309)	1.014 (.505-2.038)	.770 (.574-1.032)
Schizophrenia (chronic)	.894 (.534-1.495)	1.466** (1.101-1.953)	1.455 (.897-2.360)	1.053 (.656-1.690)	.568* (.337-.959)	1.154 (.316-4.214)	2556413.6 (n/a) [^]	n/a [^]	.388 (.314-1.567)	.599 (.083-4.351)	.971 (.615-1.533)	1.145 (.582-2.254)	1.113 (.834-1.486)
Sociodemographic characteristics								n/a [^]					
Age 18-39 years	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	n/a [^]	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0
Age 40-59 years	.865 (.597-1.225)	1.077 (.870-1.333)	.960 (.678-1.358)	.746 (.524-1.063)	1.350 (.923-1.973)	1.041 (.455-2.383)	.892 (.055-14.521)	n/a [^]	1.126 (.667-1.901)	1.569 (.369-6.677)	.831 (.596-1.159)	.939 (.544-1.621)	.781* (.619-.984)
Age 60+ years	.646 (.395-1.058)	.906 (.693-1.183)	.765 (.473-1.235)	.818 (.522-1.282)	1.315 (.805-2.150)	.653 (.175-2.435)	1.131 (.063-20.369)	n/a [^]	.105** (.025-.451)	.452 (.044-4.648)	.752 (.497-1.138)	.543 (.265-1.109)	.985 (.750-1.295)
Male gender	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	n/a [^]	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0
Female gender	.967 (.849)	1.078 (.884-1.315)	.912 (.655-1.271)	.966 (.693-1.348)	.765 (.541-1.083)	.691 (.311-1.538)	.434 (.037-5.091)	n/a [^]	.722 (.427-1.220)	3.239 (.645-16.274)	.996 (.732-1.357)	.883 (.533-1.461)	1.122 (.907-1.389)
No university degree	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	n/a [^]	1.0 ¹	1.0 ¹	1.0 ¹	1.0 ¹	1.0
Bachelors degree or higher	.946 (.681-1.372)	1.188 (.956-1.478)	1.860*** (1.328-2.605)	1.066 (.747-1.521)	2.030*** (1.431-2.879)	2.025 (.903-4.542)	.000 (.000)	n/a [^]	1.117 (.633-1.971)	4.022* (1.003-16.126)	.846 (.594-1.205)	.490* (.45-.980)	.788 (.618-1.005)
Experience with mental disorders								n/a [^]					
Previous mental disorder	1.229 (.818-1.847)	1.204 (.950-1.524)	1.259 (.853-1.860)	1.062 (.723-1.561)	.522** (.327-.834)	1.225 (.504-3.128)	.424 (.179-21.129)	n/a [^]	.721 (.376-1.385)	.000 (.000)	.738 (.501-1.087)	.694 (.356-1.351)	1.151 (.897-1.478)

¹ Reference category, [^] Could not be calculated, *p<0.05, **p<0.01, ***p<0.001

Table 8.3 continued

Odds ratios (and confidence intervals) from logistic regression analyses predicting response categories for information recalled from the media by the Australian public

Predictor	Individual's experience	Causes, symptoms, risk factors	Statistical overview	Mental health care or services	Policy or program initiative	Research initiative	Opinion piece	Language	Mental health and workplace	Mental health and physical health	Mental health and suicide	Mental health and crime	other
Stigma								n/a [^]					
Personal stigma (high)	1.008 (.972-1.046)	1.007 (.967-1.028)	.963* (.929-.997)	.938*** (.903-.969)	.915*** (.881-.951)	.937 (.860-1.021)	1.150 (.891-1.484)	n/a [^]	1.045 (.991-1.102)	1.140 (.995-1.306)	1.011 (.979-1.044)	1.062* (1.007-1.120)	.985 (.963-1.007)
Perceived stigma (high)	.987 (.955-1.019)	1.013 (.994-1.032)	1.002 (.972-1.033)	1.007 (.977-1.037)	1.017 (.985-1.050)	1.027 (.952-1.107)	.895 (.701-1.143)	n/a [^]	.996 (.946-1.049)	.955 (.827-1.103)	1.019 (.989-1.050)	.978 (.931-1.027)	1.007 (.988-1.027)
Maximum % of Variance explained (Nagelkerke R Square)	1.1%	1.2%	2.9%	2.1%	6.9%	4.3%	13.9%	n/a [^]	5.9%	12.1%	1.1%	3.5%	1.3%
Hosmer and Lemeshow Test (p-value)	.582	.422	.204	.634	.024	.978	.879	n/a [^]	.421	.034	.704	.235	.449

[^] Reference category, [^] Could not be calculated, *p<0.05, **p<0.01, ***p<0.001

Experience with a mental disorder

Respondents who had previously experienced a mental disorder were significantly less likely than those who had never experienced a mental disorder to recall stories about policy or program initiatives (OR 0.5).

Stigma

Respondents with high personal stigma scores were significantly less likely than those with low personal stigma to recall stories about statistical overviews (OR 0.9), mental health care or services (OR 0.9), and policy and program initiatives (OR 0.9) and more likely to recall stories about mental health and crime (OR 1.1).

8.5 Discussion

This chapter investigated the Australian public's recall of newspaper articles on depression. Overall, almost two-thirds of the public could recollect an item on depression and of these, 71% could recall some of the content of a depression item. Age, education, level of stigma and experience with a previous mental disorder affected the type of item recalled as did a previously administered vignette. The rate of recall is similar to that reported by a *beyondblue* survey in 2004/2005 which demonstrated that 69% of respondents surveyed could recall stories about depression from the media for the preceding 12 months (Highet, et al., 2006).

The finding that people with tertiary qualifications recalled items related to policy and program initiatives statistical overviews and mental and physical health significantly more often than those who held no tertiary qualifications while recalling fewer items on mental health and crime is of interest. Previous research has suggested that higher levels of education may predict better mental health literacy (Jorm, 2000). This may translate into a greater interest in, or better understanding of, more complex reports about mental health and therefore superior recall of these types of stories by people with tertiary qualifications. Such factors may also reduce the tendency to be influenced by more sensational media representations of mental illness, such as those linking mental illness and crime. Alternatively, newspapers may differ in the type of mental illness content in them and people of higher educational background may read those newspapers which focus less on mental illness and violence and more on policy and other more complex issues.

The study found an association between high personal stigma and the likelihood of recall of stories about mental health/illness mentioned in the context of crime. High stigma was associated with reduced recall of stories about mental health care or

services and policy and program initiatives. The explanation of this association is not clear. It may suggest either that media reports on crime and mental illness promote stigma or that stigma promotes recall of negative media material. Stigma has been identified as an important issue in studies of mental health and illness (Hocking, 2003; McNair, Hight, Hickie, & Davenport, 2002; Sartorius, 1998), especially in relation to stories in the media (National Media and Mental Health Group, 2006) because some stories may promote misconceptions about people with mental illness. Another explanation is that there is a shared factor mediating the relationship between stigma and recall of negative information. For example, those with lower education may be both stigmatising and likely to be exposed to more negative media. It is difficult to think what such a factor may be. Further research, using experimental paradigms where media content is manipulated, may help explore the relationship between personal stigma and media representation.

The finding that previous experience with a mental disorder did not predict higher recall of any category of depression material is surprising given that most participants who identified themselves as people who had previously experienced a mental disorder would have suffered from depression and have selective interest in some of the categories (for example, those involving treatment). Further research is needed to elucidate this relationship. The fact that people with a previous mental disorder were less likely to recall policy or program initiatives suggests that this information may not be as relevant to them as other information.

The study demonstrated an association between the vignette respondents were shown and the content they recalled. Specifically, this study found that respondents who received either the early or chronic schizophrenia vignettes were more likely to recall stories about causes, symptoms and treatments of depression. One reason for this may be related to the perceived seriousness of schizophrenia, as described in the vignettes. The intense nature of the symptoms described in the schizophrenia vignettes may have sensitised, encouraged or prompted respondents to recall any mental health stories that could help the person in the vignettes to recover, namely those related to causes, symptoms or treatments. This also concurs with the results obtained in the study conducted by Jorm and colleagues (2005), who found that respondents who were shown either the chronic or early schizophrenia vignettes were more likely to want to give or seek information, encourage help seeking or support the person with schizophrenia.

A relatively high percentage of respondents recalled a media story on depression. This may reflect the large number of media articles on the topic of mental disorders as well as a high level of public interest in mental health information (Pirkis, et al., 2001a). Overall, the most common items recalled by respondents in this study related to stories about causes, symptoms and treatments of depression (27.9%). It is possible that this result is a simple function of the relative frequency of the type of stories appearing in the media. However, a comparison of recall data from the current study and data on the frequency of published items in newspapers reported by Pirkis et al (2001) suggests that this is not the case. Rather, the public may selectively recall some types of material. However, these results should be interpreted with some caution as the current study examined respondent's recall of items about depression whereas the Pirkis et al (2001) study evaluated items concerning all mental disorders. Table 8.4 lists the 13 categories of content as a function of the recall and by media stories and Figure 8.1 provides a graphical representation of these data.

The causes, symptoms and treatment category were recalled by Australians twice as often as they were reported in newspapers. Similarly, although 10% of Australians recall was about stories related to mental health and suicide, this category accounted for only 3% of newspapers articles on mental disorders. Policy and program initiatives made up 18.7% of items extracted from newspapers in 2001 but were only recalled by 7.7% of Australians in this study.

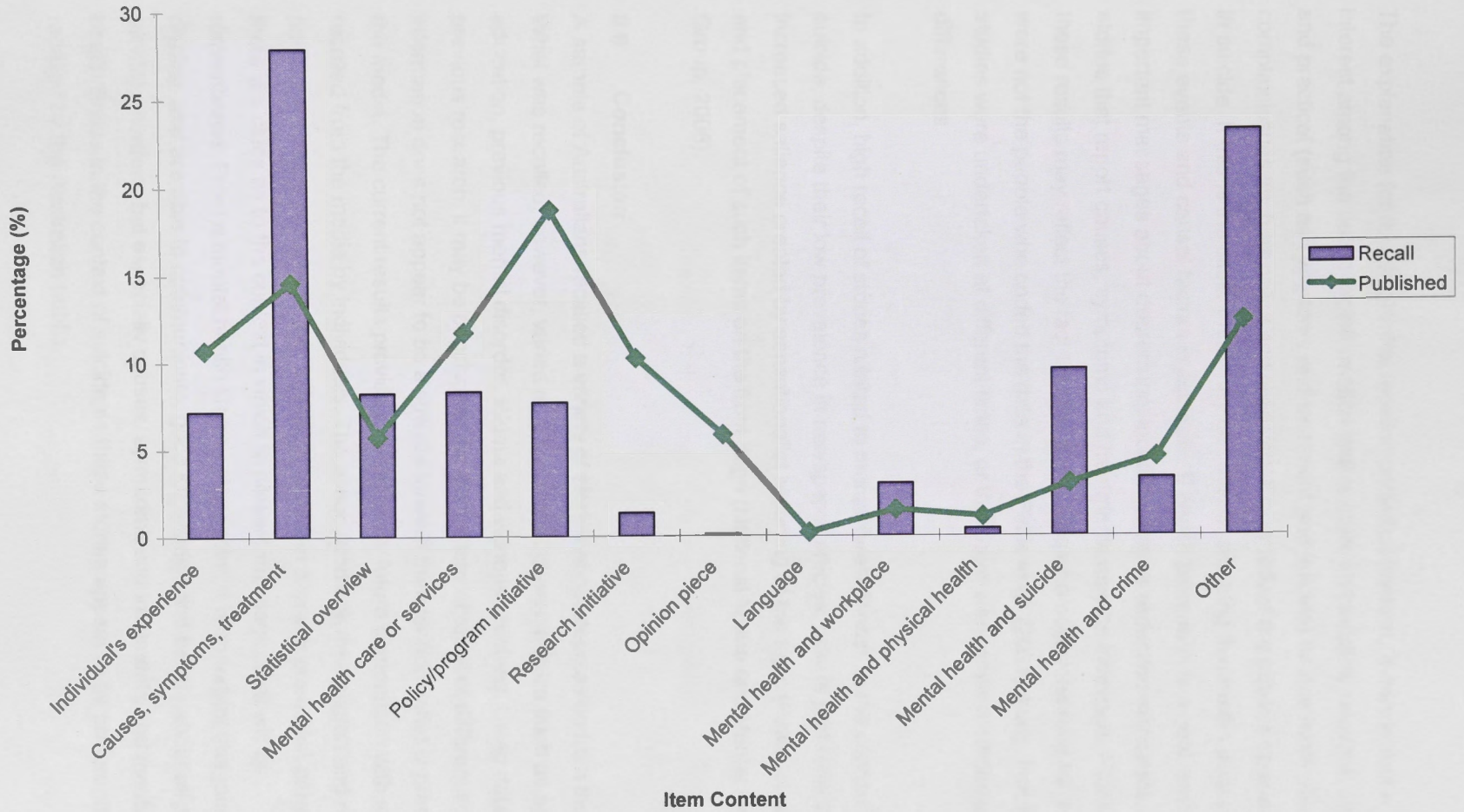
Table 8.4*Comparison of recall and publication percentages* for each content category*

Item Content	Recall This study Frequency (%)	Published Pirkis et al . (2001) Frequency (%)*
Individual's experience	145 (7.2)	852 (10.7)
Causes, symptoms, treatment	564 (27.9)	1165 (14.6)
Statistical overview	166 (8.2)	455 (5.7)
Mental health care or services	167 (8.3)	934 (11.7)
Policy/program initiative	155 (7.7)	1489 (18.7)
Research initiative	26 (1.3)	817 (10.2)
Opinion piece	3 (0.1)	466 (5.8)
Language	0 (0)	18 (0.2)
Mental health and workplace	61 (3.0)	117 (1.5)
Mental health and physical health	9 (0.4)	89 (1.1)
Mental health and suicide	192 (9.5)	235 (3.0)
Mental health and crime	66 (3.3)	363 (4.5)
Other	468 (23.1)	984 (12.3)
Total	2022 (100)	7984 (100)

expressed as a percentage of all items recalled or published

Figure 8.1

Content category recall and publication percentage



The explanation for this differential recall is unclear. However, it may reflect a greater interest among the public for information that is more immediately relevant, concrete and practical (such as symptoms and treatment and suicide) than in more abstract or complex issues such as policy and research. It may reflect the public's special interest in suicide. If this is the case, there may be value in ensuring that media portrayal of these events and causal factors is accurate. If health promotion is a goal, embedding important messages about depression, including stigma reduction messages, into stories that report causes, symptoms and treatments may be indicated. Alternatively, these results may reflect the fact that the individuals who coded the data for this thesis were not the people who coded the data in the Pirkis et al. (2001) study, that the two studies were undertaken at different times, or that there were other methodological differences.

In addition, high recall of stories related to mental health/illness in the context of suicide, despite their low prevalence in newspaper articles, may in part reflect increased salience created by sensationalist reporting of the topic (Pirkis, et al., 2001a) and placement of such items on the front page (National Media and Mental Health Group, 2006).

8.6 Conclusion

A sample of Australians recalled a variety of stories about depression from the media. What was recalled, however, varied as a function of characteristics such as age, education, previous mental disorder, stigma and vignette received. Using data from previous research, it may be concluded that the pattern of recall of different sorts of information does not appear to be a straight forward transfer from what is presented in the media. The current results provide a baseline for future comparison with stories recalled from the media by individuals. The association between stigma and recall of particular content requires further investigation. From a health promotion perspective there are clues as to the context in which to present messages that will be remembered. From a mental health literacy standpoint, it is important that journalists display, and are able to communicate, good knowledge and beliefs about all aspects of mental disorders, but especially causes, symptoms and treatments and mental health/illness in the context of suicide as these stories appear to be preferentially recalled by the Australian public.

CHAPTER NINE
GENERAL DISCUSSION AND CONCLUSION

9.1 Introduction

This thesis investigated the mental health literacy of Australian newspaper journalists, compared their mental health literacy with a representative sample of the Australian public, identified similarities and differences in mental health literacy within the journalist group and documented the messages Australians recall from the media. This concluding chapter summarises the key findings of the thesis, describes the contribution of the thesis to the field of mental health literacy, details the practical implications of the research findings, notes the limitations of the research and concludes with suggestions for future research.

9.2 Summary of research findings

9.2.1 Mental health literacy of newspaper journalists compared to the Australian public regarding suicidal depression and early schizophrenia

In this thesis, the mental health literacy of Australian journalists regarding suicidal depression and early schizophrenia was measured using a modified version of the mental health literacy survey developed by Jorm and colleagues (1997a) and was compared with the mental health literacy of the Australian public.

As a group, journalists were more sophisticated in their knowledge of mental disorders than the Australian public. Journalists were better at identifying suicidal depression from an unlabelled vignette, were more likely to nominate evidence-based treatments for both disorders, and were more similar to health professionals in their beliefs about treatments.

The Australian public demonstrated a preference for lifestyle/psychosocial interventions and social support for mental disorders. Journalists also thought that these treatments would be helpful for mental disorders. In contrast with the Australian public, journalists were also much more positive about the helpfulness of a range of medical and psychological treatments for mental disorders, such as antidepressants for suicidal depression and antipsychotics for early schizophrenia. The Australian public were wary of medications and were significantly more likely to view medications as harmful. Journalists were also more likely to nominate a range of health professionals and lay people as helpful for mental disorders compared to the Australian public. In addition, both groups thought that sources of information provided on websites, in books, by

health educators and through emails would be helpful for both suicidal depression and early schizophrenia.

Both journalists and the Australian public demonstrated a sound knowledge of many important causes and risk factors of suicidal depression and early schizophrenia. Both groups endorsed common psychosocial factors as causes of suicidal depression. Journalists also thought that genetic factors were important in the development of the disorders.

Both groups believed recovery from mental disorders was probable, as long as treatment was sought for the conditions. Long-term prognosis was considered better for the person with suicidal depression.

Journalists demonstrated significantly lower personal stigma scores than the Australian public. Both journalists and the Australian public thought that others in the community would be more stigmatising toward people with mental disorders. In addition, level of social distance was related to the degree of intimacy suggested by the relationship in both groups. Specifically, journalists and the Australian public were less likely to want to interact with people where close personal contact, compared to more casual contact, was suggested. Stigma and social distance were greater for the person with schizophrenia in both groups.

9.2.2 Mental health literacy of newspaper journalists—postnatal depression

Journalists were presented with an additional vignette of a person with postnatal depression and their mental health literacy regarding the disorder was assessed. Journalists' ability to recognise postnatal depression from an unlabelled vignette, their recommendations for help-seeking and treatment, knowledge about causes and risk factors, beliefs about recovery, levels of personal and perceived stigma and attitudinal social distance were measured.

Journalists were excellent at recognising postnatal depression from the unlabelled vignette. However, they did not appear to have a good knowledge of some evidence-based treatments for postnatal depression, such as antidepressants and admission to a psychiatric ward. Journalists preferred lifestyle/psychosocial interventions for the disorder, such as physical activity, getting out more, learning relaxation and reading about the problem.

Journalists recognised that the person in the postnatal depression vignette needed treatment and were optimistic about long term outcomes, if appropriate treatment was accessed. In addition, they recognised that women and unemployed people were two groups at risk of developing the disorder – however, the number of journalists nominating these groups was lower than expected. Journalists accurately nominated several social environmental risk factors implicated in the development of postnatal depression that accord strongly with the literature, such as the death of someone close, problems from childhood, day-to-day problems, or a traumatic event.

As with suicidal depression and early schizophrenia, the level of social distance displayed by journalists was related to the degree of intimacy suggested by the relationship. Journalists were reluctant to have a person with postnatal depression babysit their children.

In summary, the mental health literacy of journalists regarding postnatal depression was good. However, improving journalists' knowledge of some evidence-based treatments, such as antidepressants and admission to a psychiatric hospital, and improving their knowledge of the most at-risk groups, would further enhance their mental health literacy.

9.2.3 Factors predicting journalists' responses regarding helpful treatments for mental disorders

This thesis measured the factors that predicted the types of treatment journalists thought would be most helpful for suicidal depression, early schizophrenia and postnatal depression. The factors that predicted the types of interventions journalists thought would be helpful were related to age, gender, level of education, previous experience with a mental disorder and level of personal stigma.

Journalists aged 40 years or older, those with a Bachelor's degree or higher level of education, and those with previous experience of a mental disorder were more likely to endorse lifestyle/psychosocial interventions as helpful treatments for mental disorders. Compared with older journalists, younger journalists, aged 18-39 years, thought that either assistance from health professionals or receiving information from books and health educators would be helpful for mental disorders. When compared with male journalists, female journalists thought that a range of non evidence-based interventions, especially dealing with mental disorders naturally, would be helpful. Journalists with previous experience of a mental disorder, rather than those who had never had a mental disorder, thought that receiving information from different sources

would be helpful for mental disorders. Journalists with previous experience of a mental disorder also nominated the most diverse range of treatments and appeared to favour a holistic approach to managing mental disorders.

Journalists with high personal stigma rejected medications and health professionals in favour of lifestyle/psychosocial interventions and dealing with mental disorders alone.

9.2.4 Recall of depression information from the media– Australian sample

The Australian public recalled a variety of stories about depression from the media. The content of stories about depression recalled by the Australian public was compared with data showing the frequency of published items in newspapers, as reported by Pirkis et al. (2001).

The Australian public recalled stories about causes, symptoms and treatments of depression more often than any other stories. Level of education, age, previous experience with a mental disorder, level of personal stigma and the vignette they received predicted what was recalled.

Members of the Australian public who received the schizophrenia vignettes preferentially recalled stories about causes, symptoms and treatments. Members of the Australian public with tertiary qualifications recalled stories about policy and program initiatives, statistical overviews and mental and physical health more often than those who held no tertiary qualifications. Tertiary qualified Australians also recalled fewer items about mental health and crime.

The sample of Australians aged over 60 years were less likely than those aged 18-39 years to recall stories about mental health and the workplace.

High personal stigma predicted higher recall of stories about mental health/illness mentioned in the context of crime and reduced recall of stories about mental health care or services and policy and program initiatives among the Australian public.

Members of the Australian public who had previously experienced a mental disorder themselves, rather than those who had never experienced a mental disorder, were less likely to recall stories about policy or program initiatives, suggesting that this information may not be as relevant to them as other information.

A comparison of recall data from the current study and data on the frequency of published items in newspapers reported by Pirkis et al (2001) suggests that the recall of information is not simply a straightforward transfer from what is presented in the media.

9.3 Contribution to the field

The introductory chapter of this thesis asserted that the media plays an important role in influencing social attitudes towards, and knowledge and perceptions of, mental disorders (Hunter Institute for Mental Health, 2007). This thesis argued that informed representations of mental disorders by the media may promote help-seeking behaviour by people with mental disorders and that informed representations also play an important role in the formation of national mental health literacy rates. Conversely, inappropriate or negative media portrayals of mental disorders have been shown to adversely influence community attitudes toward mental disorders (Domino, 1983; Wahl & Lefkowitz, 1989). Recognising the important role of the media, the Australian government funded the *Mindframe* National Media Initiative (Hunter Institute for Mental Health, 2007), which was developed to encourage responsible, accurate and sensitive portrayal of mental disorders.

However, despite acknowledging the importance of the media's role in influencing social attitudes towards mental illness, and the establishment of a national initiative to encourage responsible reporting of these issues, the knowledge, attitudes and beliefs about mental disorders held by Australian journalists themselves – their mental health literacy – had never been systematically measured and evaluated.

Therefore, this thesis makes an important contribution to the field of mental health literacy. The thesis adds to the previous body of research that has measured mental health literacy of the Australian general public, the general public in several other countries, and a number of groups of health professionals. It provides comprehensive information about journalists' knowledge and beliefs about mental disorders, describes the similarities and differences in mental health literacy between Australian journalists and the Australian general public, and describes the factors that predict types of treatment that journalists think would be most appropriate for mental disorders. In addition, the study details what the Australian public recall from the media and describes topics which are preferentially recalled by Australians providing clues as to where to embed important messages to achieve maximum recall by the Australian public.

9.3.1 Knowledge and beliefs about mental disorders

It is not possible to directly compare the findings of this research on journalists with other research because to date, no research of this kind and scope has been conducted. Prior to this thesis we had to rely on anecdotal evidence regarding journalists' knowledge and beliefs about mental disorders. At best, we were able to estimate their mental health literacy based on the stories they produced. However, this was problematic since there are a multitude of factors that may potentially influence how information is presented, as described in Chapter 3. However, some comparisons with other groups whose mental health literacy has been measured can be made.

Recognition of mental disorders

Journalists demonstrated better recognition of suicidal depression and postnatal depression than the general public in both Australia and overseas. In fact, rates of recognition were similar to some groups of health professionals. Rates of recognition of early schizophrenia by journalists, however, were low and were similar to those described in studies of the Australian public and the public in other countries.

Recommendations for help-seeking and treatment

In terms of beliefs about specific interventions for mental disorders, the results of this thesis demonstrate both similarities and differences to the results from several of the mental health studies of adults that were described in Chapter 2. As with national and international findings deriving from studies of the general public, GPs and counsellors were often viewed positively as a source of help, and people from the lay system, such as friends and family, were also thought to be helpful for mental disorders in this thesis, journalists were more positive about the helpfulness of a range of health professionals, such as psychiatrists and psychologists for the treatment of mental disorders. Journalists were more likely to endorse commonly used psychiatric interventions, such as antidepressants or psychotherapy for depression, and antipsychotics or admission to a psychiatric ward for schizophrenia. However, for postnatal depression, journalists were more similar to the general public in that they were reluctant to endorse antidepressants or admission to a psychiatric ward for the disorder, even though there is strong evidence of the efficacy of these interventions. Unlike the general public, non-standard treatments, such as vitamins and minerals, were not preferentially nominated for the treatment of suicidal depression. Across the board, and similar to other studies of adult populations, psychological treatments such as counselling were viewed positively. Journalists, like the general public, thought that lifestyle interventions, such as physical activity and getting out and about more would be helpful for mental disorders.

Knowledge about causes and risk factors

As with other studies, psychosocial stress was frequently nominated as a causal explanation for suicidal depression, schizophrenia and postnatal depression. Biological causal explanations were also frequently endorsed for schizophrenia, in line with findings from previous studies.

Beliefs about recovery

Journalists were optimistic about the outcome for people with mental disorders who received appropriate treatment, but were not optimistic about outcomes for people who do not receive treatment for their disorder. Again, such findings have commonly been reported from mental health studies around the world and are supported by evidence. Journalists were more optimistic about the outcome for postnatal depression and suicidal depression than for schizophrenia.

Personal and perceived stigma

Personal stigma amongst journalists was relatively low. Their perceived stigma was much higher than their personal stigma, a phenomenon that is commonly reported in the literature (Griffiths, et al., 2006) .

Attitudinal social distance

Journalists, like portions of the general public, perceive people with mental disorders as unpredictable. Unpredictability was high for all mental disorders in this thesis. Journalists also perceived that people with mental disorders were dangerous, although perceptions of dangerousness were considerably lower than previous studies of the general public throughout the world. As with previous studies, unpredictability and dangerousness were associated with greater social distance, especially toward people with schizophrenia and in relationships where greater closeness is implied (e.g. having a person with a mental disorder marry into the family or a person babysit one's child).

9.3.2 Factors predicting treatment preferences of journalists for suicidal depression, early schizophrenia and postnatal depression

This thesis also makes a contribution to the literature through its investigation of the factors that predict journalists' treatment preferences for suicidal depression, early schizophrenia and postnatal depression. Previous research has linked higher education with better mental health literacy (Jorm, 2000) but information on other factors that predict treatment preferences is scarce.

This thesis demonstrated that in addition to education, five further factors predicted journalists' responses regarding helpful treatments for mental disorders. These factors included the vignette respondents received, their age, gender, previous personal experience of a mental disorder and level of personal stigma.

This thesis provides the first known quantitative investigation of the influence of these variables on treatment preferences of journalists. Knowledge of these predictor variables provides important information about the role of socio-demographic, attitudinal and situational factors in treatment preferences. This information is of practical significance, since it provides direct evidence about the groups of people who may benefit from interventions to increase their knowledge of evidence-based treatments for mental disorders.

9.3.3 Recall of depression information from the media – Australian sample

Both the qualitative and quantitative components of this section of the thesis inform our understanding of the types of information the general public recall about depression from the media. There are some studies investigating journalists' and consumers' views about media representations of mental disorders, but none that consider what the general public remembers from the media. What is remembered, as well as what the media reports, may be significant in influencing people's attitudes to mental disorders. What the general public recall about depression from the media is also important in determining the types of stories that have the greatest impact. The thesis investigated whether what is recalled accords with the frequency with which stories appear in the media.

This thesis demonstrated that stories about causes, symptoms and treatments, were preferentially recalled by the Australian public. Chapter 8 shows that six factors predicted the recall of stories about depression from the media. These factors included the vignette respondents received, their age, gender, level of education, previous personal experience of a mental disorder and level of personal stigma.

This component of the thesis makes an important contribution to the literature by suggesting where to embed important messages about mental disorders that will have the greatest impact and be more likely to be remembered by readers.

9.4 Practical implications of the research findings

The findings from this research thesis in Chapters 5, 6, 7 and 8 indicate that interventions to raise the mental health literacy of Australian journalists and the

Australian public are warranted, and that these interventions should address the different components of mental health literacy. Interventions focusing on identifying low prevalence disorders, increasing knowledge of evidence-based treatments, identifying the groups of people most at risk of developing mental disorders and reducing stigma and social distance should be considered for journalists. A more comprehensive program for the Australian public is warranted. Such a program should address recognition of mental disorders, treatment of mental disorders, causes and risk factors for mental disorders, stigma reduction and negative attitudes that contribute to social distance.

It is also apparent that we need to consider how we can best communicate important information about mental disorders to the general public. The findings from this thesis demonstrated that what is remembered is not necessarily congruent with the frequency with which mental health information is reported in the media. This suggests that we may need to embed important public health messages into stories that are recalled most often by the public. For example, Chapter 8 highlights that around 30 per cent of respondents recall stories about causes, symptoms and treatments of mental disorders, even though these stories only comprise 15 percent of all published stories. Although the strength of this relationship requires further investigation, it suggests that important public health messages may have a better chance of being remembered if they are embedded within stories that are of interest to the general public.

9.5 Limitations of the research

There are limitations to the current thesis. Limitations were observed in both of the samples and were related to the absence of a gold standard for measuring mental health literacy, response rate, gender in vignette, response categories, recall of information by respondents, and the use of confidence intervals for reporting sample differences.

9.5.1 Absence of a gold standard for measuring mental health literacy

One of the limitations in the field of mental health literacy is that there is no gold standard for this construct. Consequently, this thesis compares journalists with a sample of the Australian public, rather than trying to determine the extent to which journalists meet an established level of mental health literacy.

9.5.2 Response rate

Although the Australia Japan survey was a large national survey and people from all age groups were sampled, the response rate was 34%. which biases the estimates of

population parameters (Jorm, et al., 2005b). Specifically, to achieve a sample size of 3998, 28947 households were visited (Jorm, et al., 2005a).

Similarly, the HAMPAsurvey was a national survey of all Australian newspaper journalists, but the response rate was 18%. The low response rate by journalists may mean they were a selective sample interested in mental health issues. Nevertheless, the response rate from journalists in this survey compared favourably with the response rates by journalists reported in the literature, which varied considerably from 1% to around 65% (Committee of Concerned Journalists, 2004; Dedman & Doig, 2003; Geisler, 2005; McCoy Roth, 2004).

9.5.3 Gender in vignette

Respondents were randomly shown either a male (John) or female (Mary) version of a vignette in the Australia Japan survey. In the HAMPAsurvey, all respondents received a female-only vignette. The reason for this was that the HAMPAsurvey also included an additional vignette of a person with postnatal depression – a disorder largely confined to women. These differences did not threaten the validity of comparing the outcomes for the two studies as previous studies have demonstrated no difference in responses based on whether a female or male was depicted in a vignette (Jorm, et al., 2006b).

9.5.4 Response categories

The categories in the two surveys were identical except for one difference where the survey of journalists omitted the ‘depends’ response category for all questions, while the Australia Japan survey included it. Despite this difference, the ‘depends’ and ‘don’t know’ categories were never included in any analyses. However, there is still the possibility that the proportions who endorsed other responses in the HAMPAsurvey would not have done so had they had the ‘depends’ option available to them. Conversely, reducing the denominator in the Australia Japan survey to include only those who endorsed alternative responses to ‘depends’ effectively assumes that this group would have endorsed the other responses in a proportional manner if the ‘depends’ option had not been available to them.

Secondly, some questions in the survey of journalists allowed for open-ended responses whereas the corresponding Australia Japan survey questions were forced-choice questions. Although open-ended questions did not constrain the respondents to particular alternatives, journalists’ responses needed to be coded to enable comparisons between the two samples. Response category recoding was handled by

adopting the same content categories as the Australia Japan survey and coding the data into these discrete categories.

9.5.5 Recall of information by respondents

In some cases, respondents were required to respond to two-part questions where the first part required a forced-choice response and the second part was open-ended. For example, respondents in the Australia Japan survey were asked if they had seen, read or heard anything about depression the media in the previous twelve months.

Respondents who indicated that they had seen, read or heard something about depression were asked to list what they recalled. Not all respondents who had seen, read or heard about depression in the media listed the content they recalled. Thus, these responses could not be coded for item content recalled.

9.5.6 Use of confidence intervals for reporting sample differences

The 95% Confidence Intervals were used as a proxy for reporting possible differences, patterns and trends between the two samples in Chapter 4. Although Confidence Intervals do not provide a direct test of any significant differences between the samples, a comparison of the confidence intervals provides information about potential differences. If the Confidence Intervals overlap, the difference between the samples is probably not significant. Where Confidence Intervals do not overlap, the difference between the estimates being compared is most likely statistically significant.

9.6 Future research

Further research could arise from this thesis in several ways.

“Section 9.5.1 identified that there are no gold standards against which mental health literacy of different groups of respondents can be assessed. Gold standards are based on consistency with scientific evidence or standard clinical practice guidelines. There are currently no universally agreed upon criteria for what constitutes gold standards in mental health literacy for depression, schizophrenia or postnatal depression. Ongoing research to develop gold standards for mental health literacy is supported.”

One potential project would be to measure the mental health literacy of journalists across a range of media, such as television, radio and online journalists. As a group, newspaper journalists were more sophisticated in their knowledge of mental disorders than the Australian public; however, we do not know what journalists from other media know about mental disorders. Such information would enable educational policy makers or public health bodies to develop interventions to raise mental health literacy.

Specifically, further research would provide valuable data about whether different interventions would need to be developed for the different types of media professionals or whether a broad-brush approach to psychoeducation could be adopted.

More research is needed on the recall of depression information by the general public. This thesis concluded that the pattern of recall of different sorts of information does not appear to be a straightforward transfer from what is presented in the media to what is remembered. However, this result requires further validation. A retrospective analysis of all items that appeared in the media over a 12 month period, coupled with a survey of the general public asking what they recalled about depression over the same 12 month period would provide more accurate data on the link between what is remembered versus what actually appeared in media. From a health promotion perspective, such a study would provide important clues as to the context in which to present messages that will be remembered.

There is also value in conducting some qualitative research. For example, some of the results relating to social distance and stigma may be best evaluated in a focus group setting with journalists and the Australian public. In particular, respondents had concerns about the unpredictability and dangerousness of people with mental disorders, and journalists with high personal stigma were less likely to suggest some evidence-based interventions for the treatments of mental disorders. Qualitative investigations could yield a comprehensive understanding of the underlying reasons for these beliefs. Rather than just addressing stigma generally, targeted interventions should be developed that counter harmful beliefs and support constructive beliefs.

A longitudinal study to measure journalists' beliefs at different times is warranted. Repeat mental health literacy surveys would be useful in determining whether journalists' knowledge and beliefs improved over time. Future research could also attempt to elicit the factors that influence any changes that occur.

There are also some broader issues that could be addressed in future research. We do not currently have any knowledge about the mental health literacy of the people who manage journalists, such as editors, senior editors, management personnel or producers. A program of research to determine the mental health literacy of this group is warranted. Interventions could then be addressed at multiple levels within the media which may further improve the quality of stories being produced across the range of media.

Finally, research considering the mechanisms thorough which journalists acquire knowledge about mental disorders, and by which their attitudes are shaped, may be of benefit. Models such as the Health Belief Model, developed in the 1950s (Hochbaum 1958) or the PRECEDE model (Green & Kreuter, 1999) could potentially provide the theoretical framework for developing a survey to elucidate this information. Such research may enable us to determine whether processes and procedures commonly used by journalists to gain knowledge may be of broader benefit if applied to other discreet groups

9.7 Conclusion

The present thesis revealed that the overall mental health literacy of journalists is superior to that of the Australian public. However, there are gaps in their knowledge that would benefit from interventions to raise their mental health literacy. In particular, interventions to increase their ability to recognise some mental disorders, to enhance their knowledge of evidence-based treatments for mental disorders and to reduce stigma would be appropriate. The knowledge obtained from this thesis, particularly with regard to the factors that predict the types of treatment journalists' believed would be most helpful for mental disorders, can be used to inform the development of future interventions to increase knowledge about treatments for mental disorders. A future longitudinal study, measuring the mental health literacy of journalists at different times, across a range of media, is also warranted.

This thesis also established that the pattern of recall of information about depression from the media by the Australian public did not reflect the frequency with which stories were presented in the media. These findings suggest that more research is needed to tease out the relationship between the types of stories presented in the media and the recall of stories by the public.

In conclusion, the results from this thesis have provided baseline data on the mental health literacy of journalists. The results can now be used to inform content of future policies and resources targeting the mental health literacy of Australian newspaper journalists and the Australian general public.

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Year	Study Design/Population	Location	Sample Size	Study Focus	Key Findings
1997	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...
2001	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...
2002	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...
2003	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...
2004	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...
2005	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...
2006	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...
2007	Survey of 1000 people in the general population	Victoria	1000	General mental health literacy	...

Appendix 1

Key Australian studies of mental health literacy in adult populations, 1997-2007

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
1995 national mental health literacy survey					
<p>The methodology for the 1995 national mental health literacy survey has been described by Jorm et al. (1997a). A national cross-sectional face-to-face survey of 2031 individuals aged 18-74 years was undertaken in 1995 by the Australian Bureau of Statistics as part of its Population Survey Monitor. Complex cluster sampling techniques were used to draw a sample of households from rural and urban areas (excluding sparsely populated areas), across all Australian states and territories. The mental health literacy survey was then carried out with one randomly selected person aged over 18 years from households where contact was made. Respondents were presented with a vignette of a person experiencing major depression (1010 people) or chronic schizophrenia (1021 people) and asked a series of questions about what was wrong with the person in the vignette and their knowledge and views about risk factors/causes, various people who could help, possible treatments, likely prognosis, and beliefs associated with stigma and discrimination.</p>					
[1] Jorm et al. (1997a)	Data from all 2031 members of the public (from 1995 national mental health literacy survey) were included in analysis to assess the general public's recognition of mental disorders and their beliefs about the effectiveness of various treatments	MDD Sch.(C)	Vignette	Recognition Treatment Recovery Social distance Stigma Own health	<ul style="list-style-type: none"> •Few respondents correctly labelled depression (39%) and schizophrenia (27%) •For depression vignette, general practitioners (83%) and counsellors (74%) most often rated as helpful, psychiatrists (51%) and psychologists (49%) less so. •For schizophrenia vignette, counsellors (81%), GPs (74%), psychiatrists (71%) and psychologists (62%) most often rated helpful •Many standard psychiatric treatments (antidepressants, antipsychotics, electroconvulsive therapy, admission to a psychiatric ward) more often rated as harmful than helpful •Some non-standard treatments were rated highly (increased social activity, relaxation and stress management, reading about people with similar problems) •Vitamins and special diets more often rated as helpful than antidepressants and antipsychotics •The public were optimistic about the long term outcome for people who received appropriate help for their disorders
[2] Jorm et al. (1997b)	Data from all 2031 members of the public (from 1995 national mental health literacy survey) were included in analysis to identify the perceived causes of mental disorders and whether various groups are considered at higher or lower risk of developing a mental disorder	MDD Sch.(C)	Vignette	Risk factors	<ul style="list-style-type: none"> •Social environmental factors often seen as likely causes of depression and schizophrenia •Genetic factors attracted more support as a cause of schizophrenia than of depression
[3] Jorm et al. (1997e)	Data from all 2031 members of the public (from 1995 national mental health literacy survey) were	MDD Sch.(C)	Vignette	Treatment	<ul style="list-style-type: none"> •A principal component analysis (factor analysis) of helpfulness ratings identified three factors – medical, psychological and lifestyle factors •Public generally had a negative view of medical treatments and a positive view of

Vignettes used: MDD=major depressive disorder, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, PND=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
	included in analysis to assess public beliefs about the appropriate treatments for mental disorders and the correlates of these belief systems				lifestyle and psychological treatments <ul style="list-style-type: none"> •Medical treatments rated more negatively for depression than schizophrenia •Psychological treatments rated more positively for schizophrenia •Lifestyle treatments rated more positively for depression •GPs (83%) and counsellors (74%) were most often rated as helpful for depression and counsellors (81%) and psychiatrists (71%) for schizophrenia
Mental health literacy survey of health professionals					
In 1996 a self-completion postal survey of 872 general practitioners, 1128 psychiatrists and 454 clinical psychologists was undertaken. Respondents were mailed a modified version of the national mental health literacy survey described above. All psychiatrists and a sample of GPs listed on the national register of medical practitioners (the Medicare Provider File) and all psychologists who were members of the College of Clinical Psychiatrists were invited to participate (see also Jorm, Korten, Jacomb, Rodgers, & Pollitt (1997c)).					
[4] Jorm et al. (1997d)	A comparison of the mental health literacy of the general public with that of health professionals. Data from all 2031 members of the public (from 1995 national mental health literacy survey) were compared with data collected in the mental health literacy survey of health professionals. Respondents asked to rate likely helpfulness of different professional and non-professional help and of pharmacological and non-pharmacological interventions	MDD Sch.(C)	Vignette	Treatment	<ul style="list-style-type: none"> •Professionals gave higher helpfulness ratings to antidepressants for depression and of antipsychotics and admission to a psychiatric ward for schizophrenia compared with the public •Public gave favourable ratings to vitamins and minerals and special diets for both depression and schizophrenia, and to reading self-help books for schizophrenia •Beliefs about mental disorders held by health professionals differ greatly from those of general public
[5] Jorm, Korten, Jacomb, Christensen, & Henderson (1999)	Data from all 2031 members of the public (from 1995 national mental health literacy survey) were compared with data collected in the mental health literacy survey of health professionals to determine respondent's attitudes toward people with a mental disorder. The public's attitudes were compared with that of health	MDD Sch.(C)	Vignette	Recovery Social distance Stigma	<ul style="list-style-type: none"> •Health professionals rated long term outcomes more negatively than the general public for both depression and schizophrenia, even after treatment •Poorer outcomes were rated as more likely for the person in the schizophrenia vignette than the depression vignette by both the public and health professionals •Clinical psychologists exhibited more favourable attitudes about depression than GPs and psychiatrists and were more optimistic about the outcome for treated depression •Respondents believed that the person with schizophrenia was more likely to be discriminated against than the person with depression

Vignettes used: MDD=major depressive disorder, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, PND=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
	professionals				
[6] Jorm et al. (1997c)	Data from all respondents collected in the mental health literacy survey of health professionals were analysed to compare responses between the three groups of health professionals – GPs, psychiatrists and clinical psychologists	MDD Sch. (C)	Vignette	Treatment	<ul style="list-style-type: none"> All three different groups of health professionals agreed that a person with schizophrenia would be helped by GPs, psychiatrists, clinical psychologists, antipsychotic medication and admission to a psychiatric ward. There was also agreement on the treatments for depression including GPs, psychiatrists, clinical psychologists, antidepressants, counselling and cognitive behavioural therapy There were also some differences in their recommendations such as: psychiatrists were less likely than GPs and psychologists to rate lifestyle and psychological interventions as helpful; a wider range of interventions were nominated by female and younger members of each professional group; and clinical psychologists were less likely to rate medical interventions such as antidepressant medication as helpful than psychiatrists

Mental health literacy survey of mental health nurses

This study used the data collected in studies 1 and 2 (methodologies described above). Additional data were collected from 673 members of the Australian and New Zealand College of Mental Health Nursing (ANZCMHN) who completed a postal mental health literacy survey, initially developed by Jorm et al. (1997a) but modified for use with this sample.

[7] Caldwell & Jorm (2000)	Data from 1128 psychiatrists, 454 clinical psychologists (from mental health literacy survey of health professionals), 2031 members of the general public (from 1995 national mental health literacy survey) and 673 members of ANZCHMN (from mental health literacy survey of mental health nurses) were compared to elucidate the similarities and differences in their beliefs about medical, psychological and lifestyle interventions for depression and schizophrenia	MDD Sch.(C)	Vignette	Recognition Treatment	<ul style="list-style-type: none"> Nurses responses were more closely aligned with those of psychiatrists about helpful interventions for depression (antidepressants) and schizophrenia (antipsychotics) Nurses more likely than psychiatrists to endorse some non-standard interventions such as vitamins Mental health nurses were more positive about medical interventions than the general public
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Albury mental health literacy survey

Self-completion postal mental health literacy survey (survey based on Jorm et al. 1997a & b) of 3109 adults aged 20-59, on the electoral role for the electorate of Farrer in NSW (includes the city of Albury and surrounding rural areas). Six-month follow-up postal survey of subset of 422 people with high initial depression or anxiety symptoms. The follow up

Vignettes used: MDD=major depressive disorder, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, PND=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
survey included additional questions related to what respondents had done in the past six months to cope with stress, anxiety, depression or other emotional problems. Respondents in the initial phase of the study were presented with a vignette of a person experiencing major depression (3109 people).					
[8] Jorm et al. (2000a)	Data from all 3109 adults from the Albury mental health literacy survey and 422 adults from the follow-up survey in the same study were analysed to assess attitudes about, and symptoms of, anxiety and depression	MDD	Vignette	Recognition Treatment Stigma	<ul style="list-style-type: none"> •59% of the full sample correctly identified depression in vignette •46% of total sample believed that discrimination was likely •Attitude measures did not predict patterns of help-seeking or outcomes for people with common psychiatric problems
[9] Jorm, Medway, Christensen, Korten, Jacomb, & Rodgers (2000b)	Data from all 3109 adults from the Albury mental health literacy survey and 422 adults from the follow-up survey in the same study were analysed to assess beliefs about helpfulness of interventions for depression	MDD	Vignette	Treatment	<ul style="list-style-type: none"> •Major discrepancies between ranking of interventions deemed likely to be helpful and those actually used by respondents •Interventions involving mental health professionals were often ranked as likely to be helpful but were rarely used •Less expensive, simple and readily available treatments were used most frequently, but were not the most likely to be rated as helpful •Belief in helpfulness of antidepressants predicted their use, but beliefs were not predictors of helpfulness ratings for all interventions

beyondblue community mental health literacy survey

Cross-sectional telephone survey of a representative community sample (900 randomly selected respondents aged 18 years or older) from four Australian states (NSW, Victoria, Queensland, South Australia) in 2001. The 25-item survey was designed by investigators to measure depression awareness, knowledge of symptoms, prevalence and effective interventions for depression, attitudes towards people with depression, treatment providers and methods of treatment and behaviours in treatment seeking for depression.

[10] Highet, Hickie, & Davenport (2002)	Data from all 900 respondents to the <i>beyondblue</i> community mental health literacy survey were analysed to determine community awareness, knowledge and attitudes to depression and its treatment in Australia.	MDD	Label	Recognition Risk factors Treatment	<ul style="list-style-type: none"> •Mental health is not viewed as a major general health issue •When asked specifically about the most common mental health problem in Australia, depression was spontaneously identified by 39% of respondents •Depression recognition and knowledge of its treatment was highest in younger people and women •Awareness of common risk factors (e.g. being unemployed, birth of a child or having a severe medical condition) versus protective factors (e.g. being married or in a relationship) was limited •GPs were nominated as the first point of contact by the general public for healthcare •Self-help (e.g. support from family and friends, exercise, yoga) and non-pharmacological interventions (e.g. psychological therapies and psychotherapy)
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Vignettes used: MDD=major depressive disorder, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, PND=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
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were preferred for depression
 •Contrary to earlier reports, 65% of respondents identified antidepressants as helpful

Postnatal depression mental health literacy survey

Self-completion postal mental health literacy survey based on the survey developed by Jorm et al. (1997a) of 246 GPs and 525 postnatal women in 2002. GPs were recruited through the Divisions of General Practice and received a mental health literacy questionnaire in the mail, while postnatal women were recruited through local maternal and child health services and filled in three different questionnaires (mental health literacy, Edinburgh Postnatal depression Scale, survey of services used) that were returned to the researchers by maternal and child health nurses (paper 11).

Self-completion postal mental health literacy survey based on the survey developed by Jorm et al. (1997a) of 338 maternal and child health nurses and 569 midwives in 2002. Midwives were recruited from hospitals participating in the National Postnatal Depression Program and maternal and child health nurses from surrounding regions were invited to participate.

[11] Buist, Bilszta, Barnett, Milgrom, Ericksen, Condon, Hayes, & Brooks (2005)	Data from all GPs (246) and postnatal women (525) from the postnatal depression mental health literacy survey were analysed to evaluate knowledge and awareness of perinatal depression (includes both antenatal and postnatal depression) and attitudes to its treatment.	POSTNA TAL DEPRES SION AND	Vignette	Recognition Treatment	<ul style="list-style-type: none"> •Significantly more general practitioners (95%) selected a depression diagnosis compared with only 32% of women •Perinatal depression (includes both antenatal and postnatal depression) more likely to be recognised by general practitioners than postnatal women •Treatments favoured by both general practitioners and women included help from partners and counselling •General practitioners were significantly more likely to endorse antidepressants as a treatment •Women significantly more likely to favour natural therapies
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[12] Buist, Bilszta, Milgrom, Barnett, Hayes, & Austin (2006)	Data collected from GPs (246), maternal and child health nurses (338) and midwives (569) in the postnatal depression mental health literacy survey were analysed and compared with regard to knowledge and awareness of perinatal depression	POSTNA TAL DEPRES SION AND	Vignette	Recognition Treatment	<ul style="list-style-type: none"> •Knowledge of perinatal disorders was high and similar for all professional groups •Depression most likely to be considered postnatally rather than antenatally by all groups •Both GPs and Maternal and Child Health Nurses (MCHNs) were more likely than midwives to recognise the need to provide help for emotional distress •Further education to increase awareness for antenatal depression is needed
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2003/2004 National mental health literacy survey: Australia Japan survey (hereafter referred to as the Australia Japan survey)

The methodology for this study has been described by the researchers (Jorm, Blewitt, Griffiths, Kitchener, & Parslow, 2005a). Mental health literacy questionnaires were developed for Australia and Japan to have a common core of questions that would allow for cross-cultural comparisons. There was also a country specific component, which enabled investigation of issues relevant to each country. The common core of questions was based on the interview used in an earlier Australia survey (see Jorm et al. (1997a)) and

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
described above in study 1 and there were also some additional measures and items.					
Australian survey. A national cross-sectional face-to-face survey of 3998 individuals aged over 18 years in 2003/04. Households were sampled from 250 census districts covering rural and urban areas in all Australian states and territories. In households where contact was made, the mental health literacy survey was carried out with the person that had the most recent birthday and was aged over 18 years. Respondents were presented with a vignette of a person experiencing major depression (1001), depression with suicidal ideation (999), early schizophrenia (997) or chronic schizophrenia (1001). The depression vignette in the 2003/2004 survey corresponded to the depression vignette in the 1995 survey, and the early schizophrenia vignette corresponded to the schizophrenia vignette of the 1995 survey. The Australian interview also included questions about awareness of depression in the media and about <i>beyondblue</i> , Australia's national depression initiative.					
Japanese survey. Will be described in cross cultural section of table 2.2.					
[13] Jorm et al.	Data from all 3998 respondents in the Australia Japan survey were included in analysis to assess the Australian public's mental health first aid responses to hypothetical cases of people with mental disorders.	MDD MDSI Sch. (E) Sch.(C)	Vignette	Mental Health First Aid (MHFA) Treatment	<ul style="list-style-type: none"> •Encouraging professional help-seeking (range 57.5%-66.0%) and listening/talking/supporting the person (range 65.6%-73.4%) were most common first aid responses for all vignettes •Most commonly mentioned professionals that could potentially help the person in the vignette was a GP/doctor (range 26.9%-40.1%) •32%-44% of respondents did not mention professionals as potential sources of help or listening/talking/supporting the person (27%-34%) •Less common responses were to assess the problem of risk or harm, to give or seek information, to encourage self-help or to support the family of the person with the mental disorder •Variables that most often predicted first aid responses were correct identification the disorder, women, and low personal stigma
[14] Jorm, Christensen, & Griffiths (2005b)	Data from people who received the depression with suicidal ideation vignette (999 people) in the Australia Japan survey were included in analysis to determine beliefs about the helpfulness or harmfulness of antidepressants by the Australian public	MDSI	Vignette	Treatment	<ul style="list-style-type: none"> •25% of respondents believed antidepressants would be harmful for depression and depression with suicidal thoughts •Respondents believing this were, on average, less educated, had less exposure to depression, showed poorer recognition of depression, were less favourable about other psychological interventions, were less pessimistic about long-term outcomes if person did not receive treatment (therefore underestimating its seriousness), and more likely to see depression as due to weakness of character and therefore under persons control
[15] Jorm, Christensen, & Griffiths (2005c)	Data from people who received the depression vignette in the 1995 national mental health literacy survey (1010 people) and in 2003-04 (Australia Japan survey) (910 people), were	MDD MDSI Sch. (E) Sch.(C)	Vignette	Recognition Treatment	<ul style="list-style-type: none"> •Respondents from states/territories that provided funding for <i>beyondblue</i> (high-exposure states) were twice as likely (19%) to be aware of the existence of <i>beyondblue</i> as respondents from states/territories that did not provide funding for <i>beyondblue</i> (low-exposure states) (9.4%) •High-exposure states had a greater change in beliefs about some treatments, especially counselling and medication, and about the benefits of help-seeking in

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
	analysed to evaluate whether a campaign (<i>beyondblue: the national depression initiative</i>) to increase public knowledge about depression influenced the public's ability to recognise depression and influenced beliefs about treatments. Data from the Australia Japan survey (3998 people) were also used to determine awareness of <i>beyondblue</i>				general •Recognition of depression improved across Australia, but was slightly better in high-exposure states
[16] Jorm et al. (2005d)	Data from people who received the depression and chronic schizophrenia vignettes in the 1995 national mental health literacy survey and 2003/04 Australia Japan survey were analysed to determine whether public beliefs about causes and risk factors had changed in the 8 years between the two studies	MDD Sch.(C)	Vignette	Risk factors	•Increase in belief about genetic causes for both depression and schizophrenia •Increase in beliefs about problems from childhood and the death of someone close as causes of depression •Decrease in belief that weakness of character is a cause of schizophrenia
[17] Jorm, Mackinnon, Christensen, & Griffiths (2005e)	Data from all 3998 respondents in the Australia Japan survey were included in analysis to assess the structure of beliefs about the helpfulness of interventions for depression and schizophrenia	MDD MDSI Sch. (E) Sch.(C)	Vignette	Treatment	•Exploratory factor analytic techniques found four clearly delineated factors to explain interventions/treatments for mental illnesses. •These four factors were lifestyle, psychological, medical and Information-seeking •The public favoured lifestyle and psychological interventions over medical ones
[18] Jorm, Nakane, Christensen, Yoshioka,	Data from all 3998 respondents in the Australia Japan survey were included in the analysis to determine whether there were any	MDD MDSI Sch. (E) Sch.(C)	Vignette	Recognition Treatment Recovery	•There are some major differences between Australia and Japan with regard to the recognition of mental disorders and beliefs about treatment •The Australian public used psychiatric labels more often than the Japanese public, especially for depression, were more positive about the benefits of seeking

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [, Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
Griffiths, & Wata (2005f) ¹	differences between the Australian and Japanese general public's beliefs about the treatment and outcome of mental disorders				<p>help, had a strong preference for lifestyle interventions, were positive about counsellors and GPs, but were negative about some medications</p> <ul style="list-style-type: none"> •The Japanese public were more reluctant to use psychiatric labels and to discuss mental disorders with others outside the family. They generally believed in treatment but were not optimistic about full recovery. They rated counsellors but not GPs as helpful. •ECT and hospitalisation in a psychiatric ward were viewed negatively by respondents in both countries
[19] Griffiths, Nakane, Christensen, Yoshioka, Jorm, & Nakane (2006)	Data from all 3998 respondents in the Australia Japan survey were included in the analysis to compare the nature and extent of stigma among the public in both countries.	MDD MDSI Sch. (E) Sch.(C)	Vignette	Stigma Social distance	<ul style="list-style-type: none"> •Stigmatising attitudes were common in both Australia and Japan •Negative attitudes were greater among the Japanese public •Personal stigma and social distance were greater among the Japanese •Perceived stigma and perceived discrimination were greater among Australians •Personal stigma was significantly higher than perceived stigma in both countries •Schizophrenia (especially chronic) attracted greater social distance, personal stigma and perceived stigma in both countries compared with depression
[20] Jorm, Christensen, & Griffiths (2006a)	Study assessed changes over 8 years in depression awareness and attitudes of general public, by comparing data from depression vignettes in the 1995 national mental health literacy survey (1010) and the Australia Japan survey (902 people). Changes were assessed in terms of the impact of <i>beyondblue: the national depression initiative</i>	MDD	Vignette	Social distance Stigma Own health	<ul style="list-style-type: none"> •Increase in people identifying themselves or a friend/family member as having had a mental disorder similar to vignette •This increase in disclosure was greatest in states and territories that funded <i>beyondblue</i> (high-exposure states) •In high-exposure states the data also showed: <ul style="list-style-type: none"> •No change self reported current psychological distress-suggesting greater depression awareness rather than a true increase in symptoms •Respondents were more likely to believe that people with depression were discriminated against •Respondents perceived that the person in the vignette would be more understanding of other people's feelings
[21] Jorm et al. (2006d)	Study assessed changes over 8 years in the Australian public's recognition and beliefs about treatment for depression and chronic schizophrenia. Data from	MDD Sch. (E)	Vignette	Recognition Treatment Recovery	<ul style="list-style-type: none"> •Public were better able to recognise depression and schizophrenia •Public gave more positive ratings to a range of interventions, such as help from mental health professionals, medications, psychotherapy and psychiatric ward admission •Despite the Australian public becoming more similar in their views to health professionals, major differences remained.

¹ This study is also described in the following table representing international mental health literacy studies

Vignettes used: MDD=major depressive disorder, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, PND=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
	people in the 1995 national mental health literacy survey were compared with data obtained in the Australia Japan survey				<ul style="list-style-type: none"> •Specifically, although admission to a psychiatric ward was considered more helpful than in the 1995 survey, 'harmful' ratings still outnumbered 'helpful' ratings •Similarly, although there was an increase in the belief about the helpfulness of antidepressants for depression (28.7% in 1995 to 47.8% in 2003/2004), the public still favoured vitamins, minerals or tonics and herbal medicines as a treatment for depression in 2003/2004 (50.4 %) •Respondents were optimistic about the chances of recovery if appropriate treatment was sought

South Australian mental health literacy surveys

Data were collected in a random representative Health Omnibus survey of metropolitan and rural dwelling South Australians in 1998 and 2004. The metropolitan sample was based on a sample of districts used by the Australian Bureau of Statistic in 1996 and the rural sample was selected from towns with a population of at least 1,000 people in the 1996 census. Face-to-face interviews were held with respondents aged 15 or older and mental health literacy was measured using the questionnaire developed by Jorm et al. (1997a). In households where contact was made, the mental health literacy survey was administered to the person aged over 15 years with the most recent birthday. There were 3010 responses to the 1998 survey and 3015 to the 2004 survey.

[22] Goldney, Fisher, & Wilson (2001)	Data from the 3010 respondents from the 1998 component of the South Australian mental health literacy survey were used. Specifically the mental health literacy of respondents with major depression (n=205) or other depression (n=319) were compared to the mental health literacy of respondents who had no personal experience of depression (n=2486) to examine whether the presence of depression influenced mental health literacy	MDD	Vignette	Recognition Treatment Own health	<ul style="list-style-type: none"> •Respondents with major depression were five times more likely than those who were not depressed to have had treatment for similar problems to those in the vignette •Respondents with major depression (55.6%) were not significantly more likely to correctly identify the disorder in the vignette than those with other depression (51.9%) or without depression (48.6%) •Consulting a GP was recommended most often in the open ended and forced-choice questions as the most helpful source of help for the person in the vignette by all groups •With respect to the open ended question "how do you think John/Mary could best be helped?" less than 10% of respondents from each group stated that seeing a psychiatrist would be of help and even fewer stated that taking medication or seeing a psychologist would be helpful •Close family and friends, and a counsellor were also seen as helpful for the person in the vignette by all groups •Herbal medicines, vitamins, minerals and tonics were considered helpful by a substantial number of respondents, with minimal harmful effects, which is in contrast to respondents' views on antidepressants
[23] Goldney,	Data from the 3010 respondents	MDD	Vignette	Recognition	•Respondents who identified having major depression and suicidal ideation had

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
Fisher, Wilson, & Cheek (2002)	from the 1998 component of the South Australian mental health literacy survey were used. Specifically the mental health literacy of respondents with major depression (without suicidal ideation) (n=155) and respondents with major depression (with suicidal ideation) (n=50) was compared to the mental health literacy of respondents who had neither major depression nor suicidal ideation (n=2769)			Treatment Own health	treatment for problems similar to those in the vignette eight times more often than those without major depression •There were no differences between the three groups in regard to choices of potential help, except that those with major depression without suicidal ideation were less likely to recommend seeing a doctor and more likely to suggest taking medication •Psychiatrists were more likely to be seen as helpful than harmful for all groups •Family and friends were more often perceived as helpful than psychiatrists, psychologists or telephone counselling services, but less helpful than counsellors or social workers for all groups •Despite greater contact with mental health professionals, people with major depression and major depression with suicidal ideation did not have significantly better mental health literacy than those without this contact
[24] Goldney et al. (2005)	Changes in adult mental health literacy about depression were measured in South Australia from 1998-2004. Data from all respondents to the 1998 and 2004 South Australian mental health literacy survey were used	MDD	Vignette	Recognition Risk factors Treatment Social distance Stigma Own health	•Significantly greater identification of depression in 2004 and increased use of antidepressants and help-seeking behaviour •In terms of help and treatments available, significantly more respondents recommending seeing a doctor, having counselling or talking their problems over with friends in 2004 •There were significant reductions in the number of people who assigned harmful ratings to a chemist, counsellor or social worker, telephone counsellor, psychiatrist or psychologist •Significantly more of the 2004 sample considered pharmacological treatments as helpful and significantly fewer considered them harmful •Overall, a significant increase in the mental health literacy of respondents between 1998 and 2004 • No significant change in psychiatrists and psychologists being perceived as therapists of choice

Rural Queensland mental health literacy survey

Community postal survey of 666 rural dwelling adults from eight selected Queensland towns in 2004. Survey used by researchers for the rural study was based on previous Australian surveys developed by Jorm et al. (1997a). Additional questions were included to assess respondents' awareness and perceptions of community mental health agencies, and the survey was completed prior to the implementation of the Australian Integrated Mental Health Initiative (AIMhi), which is directed to improving outcomes for people with chronic or recurring mental health problems.

[25] Bartlett, Data from all 666 respondents in MDD Vignette Recognition •A higher proportion of respondents correctly identified depression (81%), than

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ Sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
Travers, Cartwright, & Smith (2006)	the rural Queensland mental health literacy survey were analysed to determine respondents' mental health literacy.			Risk factors Treatment Recovery Social Distance Stigma Own health	<p>previously reported in other Australian studies</p> <ul style="list-style-type: none"> • Respondents who either currently, or previously, had known someone with depression were more likely to correctly label the disorder in the vignette • The majority of respondents (96%) felt that the person in the vignette needed professional help • Assistance from a GP (86.4%) or counsellor (88.2%) were considered helpful • Respondents believed that the person in the vignette would make a full recovery, if he received appropriate professional help (79%) • Lifestyle modifications most likely to be seen as helpful • ECT (65.8%) or being admitted to the psychiatric ward of a hospital (55.8%) were viewed as harmful • The prevalence of mental health problems in the community was underestimated by two-thirds of the respondents • Similarly, almost two-thirds (63%) of respondents were aware of agencies to assist people with mental health issues

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Appendix 2

Key studies of mental health literacy in adult populations in countries other than Australia, 1997-2007 by country

Paper Number [, Investigators]	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
Methodology: Nationwide face-to-face representative population survey of 1042 Austrians over 16 years of age in 1999. Additionally, 137 relatives of people experiencing mental illness and 460 non-medical mental health professionals completed the same survey as the general population, but as a postal survey.					
[26] Grausgruber, Meise, Katschnig, Schöny, & Fleischhacker (2007)	All respondents to the Austrian survey were included in the analysis to determine attitudes and social distance related to schizophrenia	Sch.(C)	Vignette and Label	Risk factors Treatment Recovery Social distance Stigma	<ul style="list-style-type: none"> •The general public, relatives of people with mental illness and health professionals showed significant differences in their attitudes and social distance towards people with schizophrenia •All aspects of schizophrenia were regarded more pessimistically by the general public •Relatives and staff members were twice as likely as the general public to perceive schizophrenia as a treatable condition •Perceived causes of schizophrenia rated as 'very often' included 'nervous strain' by relatives, 'genes' by the general public and 'unhappy family situation' by health professionals •Staff and relatives were more accepting of a person with schizophrenia than the general population •'Perceived dangerousness' was the most prominent factor determining levels of social distance for all respondents •Stated reluctance to interact with people with schizophrenia was higher where interaction involved closer social contact (see Angermeyer & Matschinger, 2003)
CANADA					
Methodology: Random digit telephone survey of people aged 15 or older (n=1653) living in two adjacent health regions in Canada to determine public attitudes toward people with schizophrenia as part of the WPA global campaign to fight stigma and discrimination associated with schizophrenia. A computer generated questionnaire was used to collect information.					
[27] Stuart & Arboleda-Florez (2001)	Data from all respondents (n=1653) were included in the analysis to measure public attitudes toward people with schizophrenia, including knowledge of causes and treatments, social distance and stigma	Sch.(C)	Label	Risk factors Symptoms Treatment Social distance Stigma	<ul style="list-style-type: none"> •Levels of knowledge were higher and attitudes were better than expected •67.5% of respondents were able to name causes for schizophrenia and most frequently nominated brain disease and other biological factors •15.8% of respondents reported learning something about schizophrenia from the media in the previous six months •83.2% of respondents believed that people with schizophrenia often or very often need prescription medication to control their symptoms and 33.2% believed that they can be treated without drugs, using psychotherapy or social interventions •Respondents displayed increasing reluctance to interact with people with schizophrenia the closer the social contacts were suggested (e.g. 75.2% would not marry a person with schizophrenia) •72% of respondents believed people with schizophrenia can work in regular jobs

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

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					<ul style="list-style-type: none"> •17.5% of respondents believed people with schizophrenia are dangerous to the public because of violent behaviour •15% of respondents reported learning something about schizophrenia from the media in the previous 12 months
<p>Methodology: A face-to-face survey of 1001 respondents, aged 18 or older, in Quebec, Canada. A random stratified sample by region ensured that all age groups and both sexes were equally represented. This paper presents results from respondents who were given a list of terms and asked to choose one in each category that they felt succinctly defined schizophrenia and its causes.</p>					
[28] Stip, Caron, & Lane (2001)	Public attitudes and perceptions about schizophrenia were measured by presenting respondents with a list of terms and asking them to choose one in each category that they felt succinctly defined schizophrenia and its causes. Data from all 1001 respondents were included in the analysis	Sch.(C)	Vignette	Recognition Risk factors recovery	<ul style="list-style-type: none"> •Respondents most often described the causes of schizophrenia as biological (54%) or genetic (40%) •73% believed that a friend with schizophrenia should consult a health care professional •24% said they would offer moral support, even though they knew it was less effective than contacting a professional •If the person refused treatment, 41% said they would insist on a consultation and 40% said they would accompany their friend to the consultation • 54% of respondents consider people with schizophrenia to be violent and dangerous •40% of respondents with 12 years or less education felt that schizophrenia could not be cured and 34% felt that a combination of medication and psychological counselling would be the most appropriate treatment •Young people who were more likely to see the benefits of combining medication with psychological counselling were also more likely to agree with rehabilitation in the community compared to older respondents (57% versus 29% respectively) •Younger people held more encouraging views about the treatment of schizophrenia in the community than older, less educated members of the public in Quebec

GERMANY

1990 German Mental Health Literacy Survey. The methodology for the 1990 German mental health literacy survey was described in Angermeyer & Matschinger (1999). A population survey was carried out in the eastern and western parts of Germany shortly after reunification in 1990. A representative survey of 3098 members of the German public (2118 individuals in the west and 980 in the east), living in private dwellings and aged 18 years or older was conducted. Respondents were chosen using a three-stage random sampling method. Sample points were identified in stage one (using electoral wards), households were identified in stage two (using a random route procedure), and individuals in target households in the third stage (interviewees selected by means of random digits). A fully structured face-to-face mental health literacy interview was held. Respondents were presented with a vignette of a person experiencing major depression or schizophrenia and asked a series of questions about what was wrong with the person in the vignette and their knowledge and views about risk factors/causes, various people who could help, possible treatments and likely prognosis.

Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[29] Angermeyer & Matschinger (1999)	Data from all 3098 respondents to the 1990 German mental health literacy survey (1990 German mental health literacy survey) were included in the analysis to determine whether the different social and cultural experiences of the public in the western and eastern parts of Germany influenced their beliefs about mental disorders	Sch.(C) MDD	Vignette	Recognition Risk factors Treatment Recovery	<ul style="list-style-type: none"> •19.2% (East) and 22.0% (Diefenbach & West) of respondents correctly identified the schizophrenia vignette •21.8% (East) and 28.0% (Diefenbach & West) of respondents correctly identified the depression vignette •There were more similarities than differences between the East and West with regard to causal attributions and treatments •Talking it over with a confidant was the most recommended treatment for both disorders and by respondents from the East and West •Psychotherapy was favoured over drug treatment for both disorders •Psychosocial stress was most frequently nominated as a cause of depression, and biological causal factors (such as brain disease) were most commonly nominated for schizophrenia. •The main differences between the East and West were that the residents of West were more likely to define depressive behaviour in psychiatric terms (as opposed to life crises) and to recommend evidence-based forms of treatment for its management
[30] Angermeyer, et al. (1999)	Data from all 1564 respondents to the 1993 German mental health literacy survey were included in the analysis to determine the general public's attitudes towards help-seeking. Two different methodologies were adopted after answers to the open ended question concerning problem definition were coded (rating versus ranking)	Sch.(C) MDD	Vignette	Treatment	<ul style="list-style-type: none"> •Using a rating approach, in the case of schizophrenia, respondents endorsed turning to a confidant (80%), seeing a psychiatrist (78%), psychotherapist (71%) or GP (67%) and mostly rejected seeing a priest, community nurse or public health department •Using a rating approach, in the case of depression, respondents endorsed turning to a confidant (86%), seeing a GP (64%), psychotherapist (62%) or psychiatrist (60%). Most rejected seeing a priest, community nurse or public health department •When a ranking system was used to select first and second choices of help for schizophrenia, a psychiatrist was chosen first, followed by a psychotherapist or confidant •For depression, a confidant was the first choice followed by a GP •Therefore the role of the lay system in support is emphasised

Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

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Paper Number [, Investigators]	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[31] Angermeyer, Matschinger, & Riedel-Heller (2001)	Data from all 1564 respondents to the 1993 German mental health literacy survey were included in the analysis to determine the general public's attitudes toward help-seeking (using a qualitative approach of primary and secondary recommendations)	Sch.(C) MDD	Vignette	Treatment	<ul style="list-style-type: none"> • Respondents identified that the person in the schizophrenia (86.2%) and depression (80.2%) vignettes needed help • Support from the lay system (friends most often mentioned) was primarily considered in depression (67%) whereas support from an expert (GP most often mentioned) was most often considered in schizophrenia (86.4%) • However, experts were nominated as important for depression (65.3%) • Few respondents recommended seeing a psychiatrist for depression (12.2%) compared with schizophrenia (26.2%) as a first recommendation
<p>2001 German Mental Health Literacy Survey: The methodology for the 2001 German mental health literacy survey has been described (see Angermeyer, et al., 1999). In 2001, a representative survey of 5,025 members of the German general public (4020 respondents from the former West Germany and 1005 from the former East Germany), living in private dwellings and aged 18 years or older was conducted. Respondents were chosen using the three stage sampling method described in Study 10 (Angermeyer & Matschinger, 1999). A fully structured face-to-face mental health literacy interview was held. Respondents were presented with a vignette of a person experiencing major depression or schizophrenia and asked a series of questions about what was wrong with the person in the vignette and their knowledge and views about risk factors/causes, various people who could help, possible treatments and likely prognosis.</p>					
[32] Angermeyer & Matschinger (2003)	Data from all respondents to the 2001 German mental health literacy survey were included in the analysis to determine similarities and differences in the German public's beliefs about schizophrenia and depression	Sch.(C) MDD	Vignette	Recognition Risk factors Recovery Social distance Stigma	<ul style="list-style-type: none"> • The majority of respondents identified the symptoms depicted in the schizophrenia (70.2%) and depression (62.2%) vignettes as an indication of mental illness • Respondents believed that the likely outcome for both disorders without treatment was poor, but with optimal treatment, outcome was viewed more favourably • Similarities were that in both disorders: <ul style="list-style-type: none"> -there was high agreement that the disorder exists (schizophrenia 70.2%, depression 62.2%) although correct naming of disorders was problematic; -acute stress was frequently endorsed as a cause; -without treatment, prognosis for both disorders was poor, but was favourable with treatment; -people with these disorders frequently evoke pity and a desire to help • Differences were: <ul style="list-style-type: none"> -Biological factors, such as brain disease or hereditary factors, were more frequently believed to be a cause of schizophrenia -Psychosocial factors, such as stress at work, were more frequently nominated as a cause of major depression -Person with schizophrenia was more frequently perceived

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Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
					<p>as dangerous and unpredictable and reacted to with fear, uneasiness and feelings of insecurity, whereas the person with depression elicited pro-social reactions, such as a desire to help and empathy</p> <ul style="list-style-type: none"> •Increasing the public's recognition of mental disorders may have contradictory effects. For depression, it appears to facilitate lower social distance and less stigma, but for schizophrenia, labelling is associated with increased use of the stereotype "dangerous lunatic"
[33] Beck, Matschinger, & Angermeyer (2003)	Data from all respondents to the 1990 (n=844) and 2001 (n=2544) German mental health literacy surveys who received the depression vignette, were included in the analysis to determine whether there were any changes in the public's social representation of depression in West and East Germany between the two surveys	MDD	Vignette	Recognition Risk factors Treatment	<ul style="list-style-type: none"> •In 1990, there were some marked differences between the East and West of Germany with regard to social representations of depression. In West Germany in 1990, depression was largely seen as a psychiatric problem and treatment recommendations were for established forms of psychiatric therapy •In East Germany in 1990, depression was largely attributed to a life crisis or personal problems and drug treatment was the least popular form of treatment •In 2001, most of the differences between the East and West had disappeared •There was a marked increase in attribution of depression to biological causes (brain disease and hereditary), although psychosocial stress was still the most cited causal explanation for depression •Psychotherapy was recommended by respondents most often as a treatment, followed by drug treatments and natural remedies •There was an increase in respondents nominating deviant behaviour (immoral lifestyle and drug use) as a cause of depression in East Germany
[34] Angermeyer, Beck, & Matschinger (2003)	Data from respondents to the 2001 German mental health literacy survey who received the schizophrenia vignette (n=2481) were included in the analysis to examine the extent to which beliefs about the disorder and stereotypes of those experiencing it influence the public's desire for social distance	Sch.(C)	Vignette	Social distance Stigma	<ul style="list-style-type: none"> •The public's desire for social distance from people with schizophrenia is influenced by labelling, beliefs about causes, and the perception that those suffering from it are unpredictable and dangerous •Beliefs about unpredictability and dangerousness were the most important predictors of social distance •Respondents who identified (labelled) schizophrenia as a mental illness expressed a stronger desire for social distance than those who did not recognise it as such •Respondents anticipating a poor prognosis, or who blamed the individual for the development of schizophrenia or who endorsed biological factors as a cause expressed a stronger desire for social distance •Concluded that endorsing causes supported by empirical evidence (biological) is associated with increased social distance

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[35] Angermeyer & Matschinger (2004a)	Data from all respondents to the 1990 (n=844) and 2001 (n=2544) German mental health literacy surveys who received the depression vignette were initially included in the analysis to determine whether there have been any changes in public attitudes to people with depression between the two surveys. Additional analyses were conducted on data for subset reporting higher social distance or emotional response to the vignette	MDD	Vignette	Social distance Stigma	<ul style="list-style-type: none"> •People most frequently reacted to the individual in the depression vignette with pity (desire to help, pity, empathy) in 1990 and 2001 •There was an increase in negative reactions, specifically anger, to the person in the vignette •The general public's desire for social distance from people with depression was as strong in 2001 as it was in 1990 •The authors concluded that although there was an increase in pity, this was cancelled out by an increase in anger toward people with depression and therefore the desire for social distance remained unchanged over the study period
[36] Angermeyer & Matschinger (2004b)	Data from respondents to the 2001 German mental health literacy survey who received the schizophrenia vignette (n=2481) were included in the analysis to assess the prevalence of different components of stigma among the general public and its impact on a proxy measure of discrimination (social distance)	Sch.(C)	Vignette	Stigma	<ul style="list-style-type: none"> •The authors identified five dimensions of stigma about schizophrenia-dangerousness (e.g. "people with schizophrenia commit particularly brutal crimes"), attribution of responsibility (e.g. "anyone who gets schizophrenia is a failure"), creativity (e.g. "genius and madness go hand in hand"), unpredictability/incompetence (e.g. "people with schizophrenia are completely unpredictable") and poor prognosis (e.g. "with modern methods these days, many patients with schizophrenia can be cured") •The most prevalent stereotype endorsed by the public was that people with schizophrenia are unpredictable and incompetent, which had the strongest link with desire for social distance but no effect on structural discrimination •This was followed by perceived dangerousness and again, desire for social distance and acceptance of structural discrimination against people with schizophrenia •Anticipation of poor prognosis increased tendency to discriminate and accept structural discrimination while a belief in creativity had the opposite effect , decreasing social distance and structural stigma •People who attributed responsibility for the development of schizophrenia to the individual were more accepting of structural discrimination but showed no increase in desire for social distance

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Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[37] Angermeyer, Matschinger, & Corrigan (2004b)	Data from all respondents (n=5025) to the 2001 German mental health literacy survey were included in the analysis to determine whether familiarity with mental illness influenced attitudes towards people suffering from severe mental disorders.	MDD Sch.(C)	Vignette	Social distance Stigma	<ul style="list-style-type: none"> •People who were more familiar with mental illness were less likely to believe that people with a mental illness were dangerous, reported less fear of people with a mental illness and less social distance •Perceived dangerousness was associated with a greater desire for social distance •Concluded that approaches which increase the public's familiarity with mental illness are likely to decrease stigma
[38] Angermeyer & Matschinger (2005a)	Data from respondents living in the former Federal Republic of Germany in the 1990 German mental health literacy survey who received the schizophrenia vignette (n=511) were compared with data from respondents living in the former West Germany (survey conducted after reunification) in the 2001 German mental health literacy survey who received the schizophrenia vignette (n=1987) to determine whether there had been any development in the general public's causal attributions for schizophrenia and their desire for social distance between 1990 and 2001	Sch(C)	Vignette	Risk factors Social distance	<ul style="list-style-type: none"> •In the 1990 survey, psychosocial stress was a common causal attribution for schizophrenia, with biological factors (brain disease and hereditary factors) ranking fifth and sixth respectively •The most pronounced change was an increase in the general public's endorsement of biological causes for schizophrenia •Endorsement of brain disease increased from 55% (1990) to 70% (2001) and hereditary factors increased from 45% to 60% over the same period •Endorsement of psychosocial factors remained the same •Readiness to blame the individual for the disorders decreased considerably over the same period •Although the authors hypothesised that an increase in biological attributions over time would be associated with a decrease in social distance the reverse occurred and the desire for social distance increased markedly for all social relationships (e.g., rejection of a person with schizophrenia as a neighbour rose from 19% in 1990 to 35% in 2001)
[39] Angermeyer &	Data from respondents	MDD	Vignette	Treatment	•There was an increase between 1990 and 2001 in the German public's

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Matschinger (2005b)	living in the former Federal Republic of Germany in the 1990 German mental health literacy (n=2118) were compared with data from respondents living in the former West Germany (survey conducted after reunification) in the 2001 German mental health literacy survey (n=4005) to determine whether there had been any changes in the public's attitudes towards psychiatric treatment disorders between 1990 and 2001	SC(C)			<ul style="list-style-type: none"> willingness to recommend help from a mental health professional for depression and schizophrenia •There was an increase between 1990 and 2001 in willingness to recommend therapy in general for mental health problems, especially medications (30.7% to 57.3%) and psychotherapy (67.9% to 83.5%) for schizophrenia •From 1990-2001 there was an increase in the public's recommendations for seeking help from psychiatrists and psychotherapists for depression and schizophrenia •For schizophrenia, the percentage of the public recommending a psychiatrist as helpful increased from 65.5% in 1990 to 82.1% in 2001. For depression, this rose from 50.7% to 65.0% over the same period •The percentage of respondents recommending a psychotherapist for schizophrenia rose from 65.6% (1990) to 83.0% (2001) and for depression rose from 52.7% to 74.5% •Natural remedies and meditation/yoga were endorsed for schizophrenia and depression in both surveys
[40] Angermeyer & Matschinger (2005c)	Data from respondents to the 1990 German mental health literacy survey who lived in the West of Germany (n=2118) and respondents to the 2001 German mental health literacy survey living in the western part of the country (n=1957) were included in the analysis to examine any changes in perceived stigma of mental illness over the 11 years between the two surveys.	MDD Sch.(C)	Vignette	Stigma	<ul style="list-style-type: none"> •In 1990, the majority of the public believed that patients with a past or current mental disorder were devalued and discriminated against on many fronts. •In 2001, the public was less likely to believe that former patients were exposed to the devaluation component of stigma, but the patterns of findings for discriminations were mixed, with half of the items showing somewhat more, rather than less, rejection. •For example, in 2001 respondents were more likely to report that 'most people' thought that mental patients would be disadvantaged when applying for a job (63.3% compared to 62.0% in 1990) or dating a young woman (61.1% compared to 57.7% in 1990) •In 2001, 29.8% of respondents (compared to 22.0% in 1990) answered that 'most people' believe that a former mental patient is just as trustworthy as the average citizen and 56.3% (compared to 63.4% in 1990) would think less of a person who has been in a mental hospital • People who were more familiar with psychiatric treatment (e.g. either they or a member of their family was undergoing psychiatric treatment), showed less perceived stigma.

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Paper Number [, Investigators	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[41] Angermeyer, Dietrich, Pott, & Matschinger (2005b)	Data from all respondents (n=5025) to the 2001 German mental health literacy survey were included in the analysis to determine whether there was a relationship between watching TV and reading the newspaper and a desire for social distance towards people with schizophrenia. Regardless of which vignette respondents received, they all completed the Social Distance Scale with regard to a person with schizophrenia	Sch.(C)	Label ¹	Social distance	<ul style="list-style-type: none"> •There is evidence that the presentation of people with mental disorders in the media is distorted. •Multiple regression analysis revealed that the desire for social distance towards people with schizophrenia increased as a function of the amount of TV consumption •However, when the major socio-demographic characteristics (age, education, marital status) and familiarity with mental illness were added to the regression equation, the regression co-efficient for TV consumption dropped by half. •There was no association between reading newspapers and desire for social distance. •It was postulated that pictures have greater impact than the written word resulting in greater stigma associated with television and tabloid newspapers which often include salient (sensationalist) headlines and photographs. •The authors suggested that representations of mental disorders in TV reports and tabloid newspapers should be the target of anti-stigma campaigns
[42] Riedel-Heller, Matschinger, & Angermeyer (2005)	Data from all respondents (n=5025) to the 2001 German mental health literacy survey were included in the analysis to determine the help-seeking and treatment preferences of the German public. The authors used a ranking approach (where first and second choices of help were ranked)	MDD Sch.(C)	Vignette	Treatment	<ul style="list-style-type: none"> •Health professionals (especially mental health professionals) are frequently recommended as sources of help •Health professionals were significantly more often endorsed as sources of help by people who correctly identified the disorders as mental illness •For schizophrenia, 75.7% of respondents recommended seeing a health professional as a first choice (psychiatrist 34.6%, psychotherapist 24.7%, GP 17.4%) •For depression, 63.7% of respondents recommended seeing a health professional as a first choice (psychotherapist 41.5%, psychiatrist, 21.2%, GP 20.1%) •When mental illness was attributed to biological factors (brain disease or hereditary), the lay support system (confidant, self-help group) was significantly less likely to be endorsed •If psychosocial stressors were perceived as a cause, a confidant was more likely to be endorsed as the first source of help

¹ The authors explicitly described this study using a label as stimulus. This is inconsistent with the methodology described in other papers arising from the 2001 German mental health literacy survey in which a diagnostically unlabelled vignette is described as the stimulus.

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					<ul style="list-style-type: none"> •Psychotherapy was the most favoured treatment for both depression (53.7%) and schizophrenia (64.7%) •Psychotropic drugs were rarely suggested as a first choice of treatment for depression (10.6%) and schizophrenia (14.7%)
[43] Dietrich, Matschinger, & Angermeyer (2006)	Data from all respondents (n=5025) to the 2001 German mental health literacy survey were included in the analysis to determine the relationship between biogenetic causal explanations and social distance toward people with mental disorders	MDD Sch.(C)	Vignette	Risk Factors Social distance	<ul style="list-style-type: none"> •Respondents who endorsed brain disease as a causal explanation for depression or schizophrenia also believed the person in the vignette would be more dangerous •Respondents who perceived the person in the vignette to be more dangerous demonstrated a higher degree of fear and a greater preference for social distance •Respondents endorsing heredity showed similar responses to those endorsing brain disease, however these responses were not as pronounced •Such biogenetic causal explanations appeared to increase the likelihood that people with depression and schizophrenia were considered as individuals lacking in control and who were unpredictable and dangerous, which was positively associated with fear and a greater desire for social distance
[44] Schomerus, Matschinger, & Angermeyer (2006b)	Data from all respondents to the 2001 German mental health literacy survey were included in the analysis to determine the German public's beliefs about the causes of mental disorders	Sch.(C) MDD	Vignette	Risk factors	<ul style="list-style-type: none"> •Brain disease was the most frequently nominated cause of schizophrenia •More than 40% of respondents to the schizophrenia vignette endorsed a biological cause (brain disease and heredity) •Life events and other psychosocial causes were most frequently nominated as causes of depression
[45] Schomerus, Borsche, Matschinger, & Angermeyer (2006a)	Data from respondents who answered the question on possible causes for schizophrenia (n=2723) in the 2001 German mental health literacy survey, were included in the analysis to determine the German public's knowledge about causes and treatment for schizophrenia	Sch.(C)	Label	Risk factors Treatment	<ul style="list-style-type: none"> •54.2% of respondents answered the question on possible causes for schizophrenia •Psychosocial stress (18%) was mentioned most often as a cause, followed by heredity (17.8%) and brain disease (11.9%) •When combined, biological causes were more often nominated than psychosocial causes for schizophrenia •Medication was the most often recommended treatment (18.3%) •Of respondents mentioning a provider of care, 17% mentioned someone within the medical system (GP, psychiatrist, other specialised physician, neurologist, psychologist) •1.6% mentioned someone in the lay system as a provider of care and 8.4% suggested hospital treatment

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<p>German mental health literacy study of six cities: Random telephone pre-intervention survey of people aged over 16 years (n=7246) living in private dwellings in six German cities (Berlin, Bonn, Düsseldorf, Munich, Essen and Cologne) in 2001. Questionnaire was based on a survey developed for the WPA anti-stigma program in Canada (see Stuart & Arboleda-Florez, 2001) to determine public attitudes toward people with schizophrenia.</p>					
[46] Gaebel, Bauman, Witte, & Zaeske (2002)	Data from all respondents (n=7256) in the German mental health literacy study of six cities were included in the analysis to determine public attitudes toward people with schizophrenia	Sch(C)	Label	Risk factors Symptoms Treatment Social distance Stigma	<ul style="list-style-type: none"> •33.1% of respondents named causes for schizophrenia, the most frequently nominated being psychosocial factors, such as 'traumatic experiences, upbringing or stress' (49.2% of people nominating a cause) •Biological or genetic causal factors were nominated by 47.3% of respondents, followed by brain disease (20.6%) •76.5% of respondents believed that people with schizophrenia often or very often need prescription medication to control their symptoms and 45% believed that they can be treated without drugs, using psychotherapy •The closer the social contact involved, the greater the reluctance to interact with people with schizophrenia (e.g. 77% would not marry a person with schizophrenia) •Respondents believed that patients would be rejected by most people, especially in regard to employment and child minding •15% of respondents reported having learned something about schizophrenia from the media in the previous 12 months •More than 80% of respondents believed that something should be done to improve acceptance of those with a mental illness
HOLLAND					
<p>Methodology: Postal survey of 812 members of the general public aged over 20 in 1997 to determine their willingness to interact with patients with a mental illness. Responses were compared with those obtained in the Dutch Annual Journal of Statistics for the same year. Respondents were either randomly selected from the Dutch national telephone book or were randomly sent a survey if they lived less than one kilometre from a psychiatric hospital. The survey measured demographic characteristics, social distance, beliefs about stereotypical characteristics of people with mental disorders and causal attributions.</p>					
[47] van 't Veer, Kraan, Drosseart, & Modde (2006)	812 members of the Dutch general public were included in the analysis to determine social distance, beliefs about stereotypical characteristics of people with mental disorders and causal attributions	MI	Label	Social distance Stigma Risk factors	<ul style="list-style-type: none"> •Respondents believed that the causes of mental disorders are often associated with psychosocial factors/stressful circumstances but also acknowledged that medical/genetic and individual/moral factors may be responsible •Respondents attributing mental illness to structural causes beyond a patient's control and responsibility, such as genetics, displayed less social distance than those attributing mental illness to individual factors such as drug abuse •Respondents did not show a marked negative attitude on the social distance scale but had a tendency to be 'cautious'. •When contact with a person with a mental illness was more intimate, the majority

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					<p>of respondents demonstrated greater social distance</p> <ul style="list-style-type: none"> •The majority of respondents (74%) endorsed the belief that people who are in psychiatric treatment are aggressive •People's beliefs about stereotypical characteristics of patients with a mental illness appeared to be most influential in explaining levels of social distance •The authors concluded that improvements may be obtained by emphasising the inaccuracies of the stereotypical beliefs and tackling associated discriminatory behaviour
ITALY					
<p>Italian Mental Health Literacy Study. The methodology for this study has been described (Magliano, De Rosa, Fiorillo, Malangone, Maj, & National Mental Health Project Working Group, 2004b). Beliefs about schizophrenia in Italy (n=1888) were measured in a nationwide survey of the general public, mental health professionals and patients' relatives. Thirty Italian geographic areas were randomly selected. The general public (n=714) were recruited from participating GP units, were between 18 and 70 years, had lived in the selected area for a least 2 years, were not related to another client in the study, and did not personally experience or live with a person experiencing a long term physical or mental illness. Mental health professionals (n=465) were recruited from local mental health centres and were eligible to participate if they had worked there for at least one year. Key relatives of people with schizophrenia (n=709) were recruited if they had attended the local mental health centre for at least six months with their relative, were aged between 18 and 70 years, had no history of psychosis or other major mental disorder requiring treatment, and did not live with persons suffering from chronic physical or psychiatric illness other than the patient. Respondents completed a questionnaire with a case vignette depicting a person with schizophrenia and a series of questions designed to elucidate their opinions about the causes, treatments and psychosocial consequences of schizophrenia</p>					
[48] Magliano, et al. (2004b)	Respondents from the Italian mental health literacy study were included in the analysis if they believed that patients with schizophrenia were unpredictable (n=536) (termed the 'unpredictable' group) or predictable (n=457) (termed the 'predictable' group)	Sch.(C)	Vignette	Recognition Risk factors Treatment Social distance	<ul style="list-style-type: none"> • 54% of the 'unpredictable' group and 46% of the 'predictable' group correctly labelled schizophrenia •54% of Italian respondents believed that people with schizophrenia are unpredictable and this belief was significantly associated with low education and living in southern Italy. •Concluded that this may be due to reduced access to reliable information about schizophrenia and an increased vulnerability to media messages emphasizing criminal acts committed by those with a mental illness •Stress, heredity and psychological traumas were the three factors most commonly mentioned by both groups as being involved in the development of schizophrenia •Respondents who believed that people with schizophrenia were unpredictable were significantly more likely to attribute misuse of alcohol or street drugs, frequenting bad company and occurrence of a disillusionment in love to the development of the disorder. They were also sceptical about the possibility of recovery and gave low acknowledgement of the social competence and affective and political rights of people with a mental illness. •Relatives and professionals were less likely to view people with schizophrenia as unpredictable

Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [, Investigators	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[49] Magliano, Fiorillo, De Rosa, Malangone, & Maj (2004c)	Data from all respondents to the Italian mental health literacy study were included in the analysis to compare beliefs about causes, treatments and psychosocial consequences of schizophrenia	Sch.(C)	Vignette	Recognition Risk factors Treatment Social distance Stigma	<ul style="list-style-type: none"> •Both groups held similar views on the treatability of schizophrenia, citing the usefulness of psychiatrists and psychotropic medication for the disorder •68% of relatives, 34% of the general public and 20% of professionals stated that schizophrenia was caused exclusively by psychosocial factors •61% of the general public, 73% of professionals and 25% of relatives attributed schizophrenia to a combination of psychological and biological factors •Psychiatrists and nurses most frequently cited heredity, stress and family conflicts as causes of schizophrenia and relatives most frequently mentioned stress, traumas and love breakdown •Relatives (48%) were significantly more likely to be convinced of the usefulness of drug treatment for schizophrenia than the other two groups •The public clearly favoured non pharmacological interventions for the treatment of schizophrenia •General public and professionals held similar views on patients' civil rights •85% of the general public, 74% of professionals and 64% of relatives believed that psychiatric patients are unpredictable
[50] Magliano, De Rosa, Fiorillo, Malangone, Guarneri, Marasco, Maj, & The Working Group of the Italian National Study on Families of Persons with Schizophrenia (2004a)	The following respondents from the Italian mental health literacy study were included in the analyses: <ul style="list-style-type: none"> •Key relatives of people with schizophrenia (n=709) •Nurses (n=190) and •Psychiatrists (n=110) (subsets of the mental health professionals group) 	Sch.(C)	Vignette	Risk factors Social distance Stigma	<ul style="list-style-type: none"> •Psychiatrists and nurses were most likely to attribute schizophrenia to heredity (75% and 74% respectively), stress (66% and 53% respectively) and family conflicts (46% and 48% respectively) •Relatives of people with schizophrenia were most likely to attribute it to psychological causes: stress (46%), psychological traumas (36%) and relationship breakdown (30%) •Nurses and psychiatrists had similar opinions on patients' ability to work and were more likely than relatives to believe in their ability to work •Nurses and psychiatrists had similar opinions about punishment for illegal acts by people with schizophrenia and were more likely than relatives to believe in punishment •Nurses and relatives had similar opinions on patients' unpredictability (more likely than psychiatrists to see unpredictability as completely true) and political rights (more likely than psychiatrists to believe that people with schizophrenia should not vote)
[51] Lauber, Nordt, Falcato, & Rössler (2004)	Data from key relatives of people with schizophrenia (n=709) in the Italian mental health literacy	Sch.(C)	Vignette	Risk factors Social distance Stigma	<ul style="list-style-type: none"> •70% of relatives attributed the development of schizophrenia to psychosocial factors (stress, psychological traumas, breakdown of a romantic relationship) •24% of relatives believed that both biological and psychosocial factors contributed to the development of schizophrenia

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [, Investigators]	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
	study were included in the analysis to assess beliefs about schizophrenia				<ul style="list-style-type: none"> •Most relatives (68%) agreed that people with schizophrenia should be allowed to vote •Relatives had stricter attitudes toward affective rights (eg. patient's right to have children (29%) •Relatives endorsing biological causal explanations were more pessimistic that their loved ones would recover, compared with those who endorsed psychosocial factors or a combination of causal factors •56% of respondents believed that their loved one was kept at a distance by other people

JAPAN

Methodology: Postal survey of adults aged over 18 (n=1211) living in the area covered by the K health centre in N prefecture, Japan in 1999. A mental health literacy survey was presented to respondents who represented the principal targets of educational programs conducted by health centres.

[52] Tanaka, Inadomi, Kikuchi, & Ohta (2005)	Community attitudes to people with schizophrenia in Japan were measured. Data from all respondents (1211) were included in the analysis were included	Sch.(C)	Vignette with Label	Risk factors Social distance Stigma	<ul style="list-style-type: none"> •Responses from the case vignette survey to hypothetical questions demonstrated that 80% of respondents agreed with a landlord's decision refusing to rent an apartment to a person with schizophrenia •However, around 80% of respondents would be happy for a person with schizophrenia to live in an apartment alone if they satisfied the following conditions-'periodic visits to the hospital', 'availability of a system where people can discuss and address any problem that might arise, and 'attending a sheltered workshop or making attempts to rehabilitate' •65% of respondents attributed schizophrenia to the psychosocial factor 'problems in interpersonal relationships' •There was a relationship between respondents who nominated biological and genetic factors as causes of schizophrenia and greater social distance. •Respondents attributing schizophrenia to psychosocial factors demonstrated lower rejection
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SOUTH AFRICA

Convenience sampling of 638 members of the general public at two locations in Cape Town, South Africa. A survey measuring attitudes toward mental illness was developed. A fully structured interview followed the survey and respondents were presented with one of eight vignettes depicting a person with a mental illness, and asked a series of questions common to mental health literacy questionnaires (including what was wrong with the person in the vignette, causes, symptoms, treatments etc.)

[53] Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein (2003)	All respondents (n=638) were included in the analysis to investigate their knowledge and attitudes about mental disorders,	MDD Sch.(C) SUD	Vignette: the 4 vignettes were presented	Risk factors Treatment	<ul style="list-style-type: none"> •Mental illnesses were most often seen as stress related or due to lack of will power rather than a medical disorder •Stress was most often cited as the cause of panic disorder (83.3%) and schizophrenia (81.7%), while weakness of character was also thought to cause schizophrenia (52.3%) and substance abuse (48.5%)
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Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other 237

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
	specifically regarding causes and treatments of the illnesses		with either subtle or obvious symptoms giving eight vignettes in all		<ul style="list-style-type: none"> • Favoured treatments involved talking it over with someone (84.8%), praying about it (69.7%) or psychotherapy (69.7%) rather than consulting professional medical experts such as a GP (54.5%), or taking medication which had the perceived disadvantage of causing dependency (67.6%) • Psychotherapy preferred treatment option, especially in vignettes where symptom presentation was subtle and for substance abuse
SWITZERLAND					
<p>Swiss Mental Health Literacy Survey. The methodology for the 1998/1999 Swiss mental health literacy survey has been described (Lauber, Nordt, Falcato, & Rössler, 2000). Computer assisted telephone interviewing (CATI) was conducted with a random sample of people aged between 16 and 76 years (n=1737), living in private household dwellings and listed in the Swiss phonebook. A person from each household was selected using the Kish method. Prior to the CATI, respondents were sent written material containing visual aids to facilitate the interview. People from three different Swiss linguistic areas were sampled in German (n=791), French (n=520) or Italian (n=426) (respondents chose which language the interview should be conducted in) to determine their mental health literacy. Questionnaires included three consecutive parts; general questions (eg. about perceived discrimination, attitudes to restrictions towards people with a mental illness, to community psychiatry, to lay helping in psychiatry and to psychotropic medications), vignette depicting major depression or schizophrenia (and associated questions to assess mental health literacy), and treatment recommendations (eg. acceptance of psychotropic medication side effects, contact with people with a mental illness, demographic factors). Approximately half of the respondents were presented with a vignette of a person with either major depression or schizophrenia and were not given any information on what was wrong with the person (n=844) and half were presented with a vignette of a person with either major depression or schizophrenia and were given a correct diagnosis or other details for the person in the vignette (n=893).</p>					
[54] Lauber, et al. (2000)	Data from all 1737 respondents to the Swiss mental health literacy survey were included in the analysis to assess a range of factors on public acceptance of three restrictions on people with a mental illness (withdrawal of driver's licence, withdrawal of right to vote, abortion)	MDD Sch.(C)	Vignette Vignette with Label	Social distance	<ul style="list-style-type: none"> • A systematic evaluation of the variables that influence attitudes to people with a mental illness, showed that age and education (demographic variables) were less important in explaining public acceptance of restrictions when sociological, psychological and cultural variables are considered • Greater social distance predicted greater acceptance of restrictions • Higher anomie (subjectively perceived loss of social values and orientation within society) and rigidity (individual's preference for clarity and stability in personal life and low ability to accept change) associated with a decrease in acceptance of restrictions • Cultural factors were also associated with acceptance of restrictions, but the findings were less strong
[55] Lauber, Nordt, Falcato, & Rössler (2001)	Data from all 1737 respondents to the Swiss mental health literacy survey were included in	MDD Sch.(C)	Vignette Vignette with Label	Treatment	<ul style="list-style-type: none"> • Most helpful sources of help for schizophrenia were a psychologist (69%), psychiatrist (57%) and a GP (55%) • Most helpful sources of help for depression were a psychologist (68%), fresh air (62%) and a GP (58%)

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
	the analysis to measure the general public's recommendations on treatments for mental disorders. Eighteen treatment proposals were presented to respondents				<ul style="list-style-type: none"> •Psychiatrists were significantly more likely to be rated as helpful for schizophrenia (57%) than for depression (44%) •Vitamins were seen as significantly more harmful for schizophrenia (26%) than depression (18%) •The general public's perception of whether a person is 'mentally ill' or experiencing a 'life crisis' influences the treatment proposed •Non-medical interventions (e.g. social workers, telephone counsellors, fresh air, vitamins) are favoured for a life crisis •Psychological intervention strategies (e.g. psychiatrist, psychotherapy) but not antidepressants were recommended for mental illness
[56] Lauber, Falcato, Nordt, & Rössler (2003a)	Swiss mental health literacy survey who received the depression vignette (n=873) were included in this analysis to determine their beliefs about the causes of depression	MDD	Vignette Vignette with Label	Risk factors	<ul style="list-style-type: none"> •Psychosocial factors were predominantly nominated as causal factors for depression (e.g. difficulties in family or partnership (56.6%), occupational stress (32.7%), stress not specified (19.9%) and traumatic events (17.9%) •Causal attributions were mainly independent of demographic factors
[57] Lauber, Nordt, Falcato, & Rössler (2003b)	Respondents to the Swiss mental health literacy survey who were presented with a vignette of a person with either major depression or schizophrenia and were not given any information on what was wrong with the person (n=844) were included in the analysis to determine whether they could correctly identify the disorder	MDD SC(C)	Vignette	Recognition	<ul style="list-style-type: none"> •Schizophrenia (73.6%) was more often recognised as a mental illness than depression (39.8%). •Depression is rarely recognised as a mental illness among the Swiss general public who view depression as a normal psychological state designated 'life crises' •Greater contact with people with mental disorders was associated with better recognition of depression •Respondents who had no contact with people with a mental illness and who did not correctly identify the disorder, were less likely to endorse medical treatment for depression and more likely to support non-medical interventions •Recognition of the vignettes was also linked to a positive attitude to psychopharmacology, which was associated with high mental health literacy in the sample, •A positive attitude to community psychiatry was negatively correlated with the recognition of a mental disorder. The authors attributed this to a lack of knowledge about the difficulties and problems faced by people with mental illness in the community
[58] Lauber, et al.	Data from respondents to	MDD	Vignette	Social distance	•The level of social distance increased as a function of closeness of social contact,

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
(2004)	the Swiss mental health literacy survey, who were presented with a vignette of a person with either major depression or schizophrenia and were not provided with the diagnostic status of the person (n=844) were initially included in the analysis.	Sch.(C)	Vignette with Label		<p>especially for schizophrenia</p> <ul style="list-style-type: none"> •Eg., respondents would be either 'willing' or 'definitely willing' to start working with (65.5%) or move next door to (61.2%) a person like the one in the vignette but were less willing to have their child marry a person (25.7%) or to trust a person to take care of their child (18.7%) if they had a mental illness •Attributing mental illness to a medical cause predicted greater social distance. People attributing mental illness to life crises showed less social distance •Authors concluded that more knowledge about mental illness, especially schizophrenia, may increase social distance. Recommended that transmission of knowledge about the illness be supplemented with other approaches such as personal contact and lay explanations of the illness
[59] Lauber, Carlos, & Wulf (2005)	Data from all 1737 respondents in the Swiss mental health literacy survey were included in the analysis to determine the factors influencing the public's attitude toward treatment recommendations and the implications of these beliefs for anti-stigma strategies	MDD Sch.(C)	Vignette Vignette with Label	Treatment Stigma	<ul style="list-style-type: none"> •From a list of 18 treatment suggestions, most often mentioned as helpful were: visiting a psychologist (68.7%) visiting a GP (57.3%), getting outside and becoming active (57.3%) •Factor analysis identified four factors; <ol style="list-style-type: none"> 1. pharmacological recommendations (tranquilizers, hypnotics, antidepressants and antipsychotics), 2. therapeutic recommendations (visiting a psychiatrist etc.), 3. alternative recommendations (visiting a naturopath, taking vitamins etc.), and 4. social recommendations (see a priest, social worker or telephone counselling). •ECT and GPs did not load on any factor •Therapeutic counselling best predicted treatment recommendations and was associated with positive attitude towards psychopharmacology, recognition of the person in the vignette as being ill, younger age and keeping more social distance from people with mental illness

TURKEY

Turkish Mental Health Literacy Survey. A face-to-face interview of 707 members of the general public, 15 years of age or older, in Istanbul, Turkey (year of survey unknown). The sample was determined in three stages, using a random route procedure. Sample points were determined in the first stage and households in the second stage. In the third stage, individual households which met the inclusion criteria were selected. Face-to-face interviews were conducted by an interviewer who assisted recorded participants' responses to a range of demographic questions and 32 items relating to attitudes about depression.

[60] Ozmen, Ogel, Aker, Sagduyu, Tamar, & Boratav	All 707 responses to the Turkish mental health literacy survey were	MDD	Vignette	Treatment Risk factors	<ul style="list-style-type: none"> •The Turkish public believed that psychological and social interventions were more effective than pharmacology for the treatment of depression •94.5% of respondents who viewed depression as a disease believed that it was a
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Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [, Investigators]	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
(2005)	analysed to gauge opinions, beliefs and attitudes about perception, causal attributions, treatment and social distance of depression				<p>treatable illness</p> <ul style="list-style-type: none"> • Respondents agreed that environmental change, such as taking a holiday to recover from depression (84.0%) and solving social problems (77.7%) were important in the treatment of depression but only a small proportion of respondents (12.4%) believed that 'hodjas' (faith healers) could treat depression • More than half of the participants who endorsed medicines as a treatment for depression believed that they may lead to addiction and have serious side-effects • Respondents from higher socio-economic groups were more likely to endorse the use of medication for the treatment of depression, but also viewed medication as potentially more addictive than those from lower socio-economic groups • Females were more likely to believe that depression could be treated with medications but older people were more likely to endorse addressing social problems for the treatment of depression • Personal experience with a mental disorder did not influence results • The public in Turkey rated psychiatrists as more likely to be helpful for depression (86.3%) than GPs (51.9%)
[61] Ozmen, Ogel, Aker, Sagduyu, Tamar, & Boratav (2004)	All 707 responses to the Turkish mental health literacy survey were analysed to gauge the influence of perceptions and causal attributions on social distance toward people experiencing depression	MDD	Vignette	Social distance	<ul style="list-style-type: none"> • Respondents' attitudes toward depression were negative • Depression was most often perceived as a condition of extreme worry (88.3%) or mental weakness (76.2%) • 77.1% of respondents believed that 'persons with depression cannot make correct decisions about their own lives' • People who attributed depression to social problems displayed higher levels of social distance • Participants who perceived depression as a somatic illness had more positive attitudes towards depression

UNITED KINGDOM

Methodology: Face-to-face survey of adults (n=1737) aged over 16 in 1998. Random stratified sampling techniques were used and in each household identified, one person aged 16 or over was randomly chosen and interviewed. Respondents were asked a series of questions designed to elicit their beliefs about stigma for seven mental disorders.

[62] Crisp, Gelder, Rix, Meltzer, & Rowlands (2000)	Data from all respondents (N=1737) were included in the analysis to determine opinions of the British public regarding stigma and mental illness	MDD Sch.(C) PD OTH x 4	Label	Recovery Stigma Social distance Own health	<ul style="list-style-type: none"> • Approximately 70% of respondents rated people with schizophrenia, alcoholism and drug addiction as dangerous to others ; 80 % rated them as unpredictable • People with schizophrenia were rated by 50.8% of respondents as 'will never recover' compared with 23.2% of people with depression • Respondents believed that people with Major Depressive Disorder, Chronic Schizophrenia, and Panic Disorder would improve with treatment, but those with dementia would not
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Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
					<ul style="list-style-type: none"> •People who reported knowing someone with a mental illness were no less likely than others to endorse negative statements about the dangerousness of people with mental disorders •Stigmatising opinions about people with mental disorders were widely held
UNITED STATES OF AMERICA					
<p>American General Social Survey (GSS) – the GSS was first conducted in 1972 to monitor Americans' attitudes, beliefs and behaviour about critical social issues. A Face-to face survey of a nationwide, representative sample of adults living in private dwellings, chosen using cluster sampling techniques, is held every two years. In 1996, the 'MacArthur Mental Health Module' (MMH) was introduced into the survey to determine the public's view of individuals with mental health problems (Croghan, Tomlin, Pescosolido, Schnittker, Martin, Lubell, & Swindle, 2003). Using a series of vignettes, the module includes items designed to evaluate recognition and knowledge of mental health problems, stigma, treatments and financial responsibility. 1444 respondents completed the MMH. In 1998 the 'Pressing Issues in Health and Medical Care Module' (PIHMC) was included. Attitudes towards psychiatric medications and willingness to use them were measured in the PIHMC (see Magliano, et al., 2004b; Magliano, et al., 2004c). 1387 respondents completed the PIHMC.</p>					
[63] Link, Phelan, Bresnahan, Stueve, & Pescosolido (1999)	Respondents to the 1996 GSS who completed the MMH module (n=1444) were included in this analysis about public conceptions of mental illness	MDD Sch.(C) OTH x 3	Vignette	Recognition Risk factors Social distance Stigma	<ul style="list-style-type: none"> •The majority of the public perceived schizophrenia (88.1%) and depression (69.1%) as mental illnesses, but fewer labelled alcohol dependence (48.7%), cocaine dependence (43.5%) or a troubled person (21.5%) as having a mental illness •Using closed questions, a mixture of stressful circumstances, biological causes and genetic factors were most often cited as causes of the problems in the vignettes •People with schizophrenia (61%), alcohol dependence (71%) and cocaine dependence (87%) were most likely to be perceived as violent •A strong desire for social distance from people with cocaine dependence (90%), alcohol dependence (70%) and schizophrenia (63%) was observed
[64] Pescosolido, Monahan, Link, Stueve, & Kikuzawa (1999)	Respondents to the 1996 GSS who completed the MMH module (n=1444) were included in this analysis considering the public's beliefs about the ability of people with different mental disorders to meet daily challenges and of their likelihood of violence	MDD Sch.(C) OTH x 3	Vignette	Social distance	<ul style="list-style-type: none"> •A minority of respondents believed that people with schizophrenia (25.7%) or drug dependence (27.9%) were capable of managing their own treatment decisions; 93.1% believed a troubled person was capable •Perceptions of the competence of people to make money management decisions varied. People with drug dependence were less often perceived as competent (8%) than people with schizophrenia (29.8%), alcohol dependence (41.2%) or depression (70.2%) •Levels of concern about dangerousness were high. Belief that a person would be violent toward someone else was high for drug (87.3% respondents) and alcohol dependence (70.9%) and schizophrenia (60.9%) and lower for depression (33.3%) •Respondents believed the likelihood of self-violence was high for all disorders
[65] Croghan, et al.	Respondents to the 1998	OTH x 4	Label	Treatment	<ul style="list-style-type: none"> •Respondents perceived psychiatric medications to be effective in improving

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [, Investigators]	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
(2003)	GSS who completed the PIHMC module (n=1387) were included in this analysis				<p>capacity to deal with day-to-day stresses (72.6%) and controlling the symptoms described in the vignettes (77.2%)</p> <ul style="list-style-type: none"> •However, the likelihood that they would actually take these medications was low •Authors concluded that concerns about side effects of these medications explains some of the unwillingness to take them but that the remainder of the gap between perceived benefit and willingness could not be explained by gender, race, rural-urban residence, health insurance, overall assessment from physicians or being forced to choose doctors from a list •Authors concluded that low willingness to use medications may reflect positive preferences for psychosocial interventions, may be influenced by the stigma associated with mental illness, or may reflect attitudes about autonomy, empowerment and control leading to the use of non-medical or self-treatment for mental disorders

INTER-COUNTRY COMPARISONS

GERMANY – RUSSIA (NOVOSIBIRSK) – MONGOLIA (ULAANBAATAR)

Germany – Novosibirsk (Russia) – Ulaanbaatar (Mongolia) Cross Cultural Mental Health Literacy Study. The methodology for this study has been described (see Deitrich, Beck, Bujantugs, Kenzine, Matschinger, & Angermeyer, 2003). The sampling procedure was the same for the surveys in all three countries as described previously. All individuals of the respective nationality over the age of 18, living in non-institutional settings could potentially be sampled. Respondents were chosen using a three-stage random sampling method. Sample points were identified in stage one (using electoral wards), households were identified in stage two (using a random route procedure), and individuals in target households in the third stage (interviewees selected by means of random digits). Fully structured face-to-face mental health literacy interviews (in target language) were held. Respondents were presented with a vignette of a person experiencing major depression or schizophrenia and asked a series of questions about what was wrong with the person in the vignette and their knowledge and views about risk factors/causes, various people who could help, possible treatments and likely prognosis.

Ulaanbaatar Survey: Conducted in 2002 with 950 people.

Novosibirsk Survey: Conducted in 2002 with 745 people.

German Survey: Conducted in 2001 with 5,025 people (as described in study 12), 4005 in the western part (old Federal Republic of Germany) and 1020 in the eastern part (former German Democratic Republic).

[66] Dietrich, Matschinger, & Angermeyer (2004)	Data from all respondents (n=6720) to the Germany – Novosibirsk (Russia) –	MDD Sch.(C)	Vignette	Risk factors Social distance	<ul style="list-style-type: none"> •Causal attributions for depression and schizophrenia were similar for all countries •Psychosocial causes (acute stress in the form of 'life events') were most frequently nominated as a cause for the disorders in all locations (72.3%-86.7% for
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Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[67] Angermeyer, Buyantugs, Kenzine, & Matschinger (2004a)	Ulaanbaatar (Mongolia) Cross Cultural Mental Health Literacy Study were included in the analysis to compare across countries the relationship between public causal beliefs and social distance toward people with schizophrenia and depression Data from respondents who received the schizophrenia vignette in Novosibirsk (Russia) (n=375) and Ulaanbaatar (Mongolia) (n=474) Cross Cultural Mental Health Literacy Study were included in the analysis to determine whether labelling schizophrenia as a mental illness had an impact on public attitudes towards people with schizophrenia	MDD Sch.(C)	Vignette	Social distance Stigma	schizophrenia, 80.7%-85.1% for depression) •Biological causes ('brain disease' and 'heredity') were more frequently selected for schizophrenia than depression •Respondents in Russia and Mongolia were more likely to attribute causes to the individuals themselves, such as 'lack of willpower,' when compared with German respondents •Across all locations, people who nominated biological causes for the disorders ('brain disease' and 'heredity') displayed greater social distance towards people with depression and schizophrenia, particularly for schizophrenia •Correctly labelling the vignette as representing a mental illness was positively correlated with endorsing the need for help for the person in the vignette in Russia and Mongolia •Labelling had no significant effect on the likelihood of endorsing the dangerousness stereotype in Russia and Mongolia in contrast with Germany where labelling was associated with perception of dangerousness

GERMANY – RUSSIA (NOVOSIBIRSK) – SLOVAKIA (BRATISLAVA)

Germany – Russia (Novosibirsk) – Slovakia (Bratislava) Cross Cultural Mental Health Literacy Study. The methodology for this study has been described (Angermeyer, Breier, Dietrich, Kenzine, & Matschinger, 2005a). The sampling procedure was the same for all three countries and is described in study 6 above. All individuals of the respective nationality over the age of 18, living in non-institutional settings could potentially be sampled. Respondents were chosen using a three-stage random sampling method. Sample points were identified in stage one (using electoral wards), households were identified in stage two (using a random route procedure), and individuals in target households in the third stage (interviewees selected by means of random digits). Fully structured face-to-face mental health literacy interview (in target language) were held. Respondents were presented with a vignette of a person experiencing major depression or schizophrenia and asked a series of questions about what was wrong with the person in the vignette and their knowledge and views about risk factors/causes, various people who could help, possible treatments and likely prognosis.

Bratislava Survey: Conducted in 2003 with 1,000 people.

Novosibirsk Survey: Conducted in 2002 with 745 people.

German Survey: Conducted in 2001 with 5,025 people (a sub-sample of 952 individuals living in cities with more than 500,000 inhabitants was selected for this study).

Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [, Investigators]	Study Sample/ sub-sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[68] Angermeyer, et al. (2005a)	Data from all respondents to the Bratislava (Slovakia) – Novosibirsk (Russia) – Germany Cross Cultural Mental Health Literacy Study were included in the analysis	MDD Sch.(C)	Vignette	Risk factors Treatment	<ul style="list-style-type: none"> •In all three countries, a confidant was most frequently recommended as a helping source •Respondents from Novosibirsk, Bratislava and Germany were equally likely to seek help from a psychiatrist for schizophrenia (72.5%, 82.6%, 75.1% respectively) and for depression (58.9%, 65.6%, 63.9% respectively) •Respondents from Novosibirsk and Bratislava were more likely to access help from other medical or non-medical professionals and lay supports (such as staying at a spa) •Psychotherapy was the most favoured treatment in all three countries, followed by psychotropic medication •People from all three countries were more willing to seek help from medical professionals (GP, psychiatrist) when brain disease was endorsed as a cause of the disorder
[69] Schomerus, Matschinger, Kenzin, Breier, & Angermeyer (2006c)	Data from all respondents to the Bratislava (Slovakia) – Novosibirsk (Russia) – Germany Cross Cultural Mental Health Literacy Study were included in the analysis. The analysis focused on perceived stigma and discrimination using the devaluation-discrimination scale (Pescosolido, et al., 1999)	MDD Sch.(C)	Vignette	Discrimination Stigma	<ul style="list-style-type: none"> •The perception of discrimination and devaluation of psychiatric patients was similar in all three locations •People at all three study locations believed that most people would not hire a former patient to take care of their children, and would not accept a fully recovered former patient as a teacher of young children in a state school •Actions aimed at reducing stigma should be tailored to the specific conditions in a particular country.

JAPAN – AUSTRALIA

The methodology for this study has been described by the researchers (Jorm, et al., 2005f; Nakane, Jorm, Yoshioka, Christensen, Nakane, & Griffiths, 2005). Mental health literacy questionnaires were developed for Australia and Japan to have a common core of questions that would allow for cross-cultural comparisons. There was also a country specific component, which enabled investigation of issues relevant to each country. The common core of questions was based on the interview used in an earlier Australia survey (see Jorm et al. 1997b and described above in study 1) and there were also some additional measures and items.

Australian survey. A national cross-sectional face-to-face survey of 3998 individuals aged over 18 years in 2003/04. Households were sampled from 250 census districts covering rural and urban areas in all Australian states and territories. In households where contact was made, the mental health literacy survey was carried out with the person that had the most recent birthday and was aged over 18 years. Respondents were presented with a vignette of a person experiencing major depression (1001), depression with suicidal ideation (999), early schizophrenia (997) or chronic schizophrenia (1001). The depression vignette in the 2003/2004 survey corresponded to the depression vignette in the 1995 survey, and the early schizophrenia vignette corresponded to the schizophrenia vignette of the 1995 survey. The Australian interview also included questions about awareness of depression in the media and about *beyondblue*, *Australia's national depression initiative*.

Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

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Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
<p>Japanese survey. The Australian sample was translated into Japanese. Home visit interviews were then conducted with 2000 individuals aged between 20-69 years in 2003. 25 geographical sites from five areas were sampled and included small and large cities, areas that had many psychiatric patients and areas that did not, and areas with and without high suicide rates. Respondents were presented with a vignette of a person experiencing major depression (500), depression with suicidal ideation (500), early schizophrenia (500) or chronic schizophrenia (500). The Japanese survey also asked questions about psychiatric health and welfare policy, the bodies implementing related services, the existence of action groups and the change in the Japanese name for schizophrenia.</p>					
[70] Nakane, et al. (2005)	Data from all Australian respondents to the 2003/04 Australia Japan survey (described in table 2.1) were included in the analysis along with data from the Japanese respondents to determine whether there were any differences between the Australian and Japanese general public's beliefs about the causes and risk factors for schizophrenia and depression	MDD MDSI Sch. (E) Sch.(C)	Vignette	Risk factors	<ul style="list-style-type: none"> •Social factors were predominantly nominated as causes of depression and schizophrenia in both Australia and Japan (eg, day-to-day problems, death of someone close, traumatic event and problems from childhood) •Personal vulnerability factors also commonly cited as possible causes of the disorders •The Japanese general public was more likely to attribute nervous disposition and weakness of character as causes of the illnesses, whereas Australians were more likely to attribute genetics as a cause •Beliefs about risk factors were similar between Australia and Japan and across all vignettes and included being unemployed and divorced/separated •There were some cross-cultural differences in beliefs about causes and risk factors • Japanese public was more likely to see the poor as having a lower risk of depression, while the Australian public believed that both the poor and young were at higher risk of depression
[18] Jorm, et al. (2005) ²	Data from all respondents to the Australia Japan survey (described in table 2.1) were included in the analysis to determine whether there were any differences between the Australian and Japanese general public's beliefs about the treatment and outcome for schizophrenia and depression	MDD MDSI Sch. (E) Sch.(C)	Vignette	Recognition Treatment Recovery	<ul style="list-style-type: none"> •There are some major differences between Australia and Japan with regard to the recognition of mental disorders and beliefs about treatment •The Australian public used psychiatric labels more often than the Japanese, especially for depression, were more positive about the benefits of seeking help, had a strong preference for lifestyle interventions, were positive about counsellors and GPs, but were negative about some medications •The Japanese public were more reluctant to use psychiatric labels and to discuss mental disorders with others outside the family. They generally believed in treatment but were not optimistic about full recovery. They believed in counsellors but not in GPs •ECT and hospitalisation in a psychiatric ward were viewed negatively by respondents in both countries

² This study is also described in the above table representing Australian mental health literacy studies

Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Paper Number [], Investigators	Study Sample/ sub- sample	Disorder	Stimulus	Main Study Focuses	Key Findings
[71] Griffiths, et al. (2006)	Data from all respondents to the Australia Japan survey (described in table 2.1) (n=3998) were included in the analysis along with data from the Japanese respondents (n=2000) to investigate and compare stigma between the two countries	MDD MDSI Sch. (E) Sch.(C)	Vignette	Social distance Stigma	<ul style="list-style-type: none"> •Personal stigma and social distance were greater among the Japanese public compared with the Australian public •Perceived stigma was greater among the Australian public •In both countries, the public reported more social distance and more personal and perceived stigma for schizophrenia than for depression •Both the Australian and Japanese public recorded the greatest social distance for 'marrying into the family' for all disorders (range: 28.8%-53.0% (Australia); range: 84.0%-93.0% (Japan))

SINGAPORE – AUSTRALIA

Methodology: Cross sectional mental health literacy survey of GPs in Australia (n=872) and Singapore (n=264) in 1996 and 1999 respectively. Data for the Australian component of the study were from GP responses to study 2 (see Table 2.1). Data for the Singaporean component of the study were from randomly selected private GPs and outpatient doctors employed by the Singapore Ministry of Health.

[72] Parker, Lee, Chen, Kua, Loh, & Jorm (2001)	Data from all Australian GPs (n=872) and Singaporean GPs (n=264) were analysed to determine their mental health literacy regarding depression and schizophrenia.	MDD Sch.(C)	Vignette	Recognition Treatment Recovery Stigma	<ul style="list-style-type: none"> •High diagnostic accuracy for depression and schizophrenia and high agreement in judging the likely helpfulness of a range of interventions •GPs, psychiatrists, clinical psychologists, counsellors and close family were rated as the most helpful sources of help for both disorders in both countries •Australian and Singaporean GPs favoured treatment with antidepressant medication for depression (94% for both) and treatment with anti-psychotic medication for schizophrenia (98% and 92% respectively) •Vitamins and minerals were generally not rated as helpful by GPs in either country • GPs in Australia (95%) and Singapore (89.1%) were optimistic that with professional help, a person with depression would 'make a full recovery' or 'make a full recovery, but problems may reoccur.' • GPs in Australia (58.9%) and Singapore (63.1%) were less optimistic that With professional help a person with schizophrenia would 'make a full recovery' or 'make a full recovery, but problems may reoccur.'
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Vignettes used: MDD=major depression, MDSI=major depression with suicidal thoughts, Sch.(E)=early schizophrenia, Sch.(C)=chronic schizophrenia/schizophrenia, POSTNATAL DEPRESSION=postnatal depression, AND=antenatal depression, PD=panic disorder, SUD=substance abuse disorder, MI=mental illness, ANX=anxiety, OTH=other

Study Focus: Recognition=recognition of mental disorder, Risk factors=causes/risk factors, Treatment=help-seeking or treatment recommendations, Recovery=beliefs about recovery, Social distance=social distance, Stigma=stigma/discrimination, Own health=Past history of own mental disorders/contact with others with mental health problems

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
Blood, McCallum, Pirkis, Martin, Holland & Williams (2005)	News media: newspapers	Discourse and news frame* analysis of schizophrenia from seven Australian newspapers between 2001-2004	<ul style="list-style-type: none"> •Schizophrenia is frequently linked to violence and community fear which may add to the discrimination and misunderstanding of schizophrenia and its consequences •Inappropriate use of the term 'schizophrenia' in non-medical, metaphorical contexts is common in some newspapers 	Schizophrenia <ul style="list-style-type: none"> •Violence •Fear 	<ul style="list-style-type: none"> •Generalisability of findings to the entire Australian media may be problematic due to the restricted sample
Francis, Pirkis, Blood, Dunt, Burgess, Morley & Stewart (2005)	News media: newspapers, radio and television	Content analysis of 1,123 non-fictional media items related to depression and other mental illnesses collected between March 2000 and February 2001. Items retrieved from Media Monitors, a media retrieval service	<ul style="list-style-type: none"> •Depression was portrayed more frequently than any other mental illness and commonly described policy or program initiatives •Individuals or symptoms or treatment were most often portrayed for people with schizophrenia •Most information was accurate, but a proportion of items conveyed misleading messages 	Depression <ul style="list-style-type: none"> •Frequently portrayed •Mostly accurate portrayal Schizophrenia <ul style="list-style-type: none"> •More inaccuracies in portrayals 	<ul style="list-style-type: none"> •Some relevant media coverage may have been overlooked by the media retrieval service
Francis, Pirkis, Blood, Dunt, Burgess, Morley, Stewart & Putnis (2004)	News media: newspapers, television and radio	A content analysis of non-fictional media items related to depression and other mental illnesses collected between March 2000 and February 2001 (retrieved from Media Monitors). A qualitative analysis of 10% of randomly selected items using a nine-dimension instrument based on <i>Achieving the Balance</i> (a journalism resource for appropriate reporting of mental health/illness and suicide)	<ul style="list-style-type: none"> •Reporting of mental health/illness was common •Media items were most frequently focused on policy/program initiatives in mental health •Most media items were of good quality on eight of the nine dimensions which is at odds with existing literature 	Mental Illness <ul style="list-style-type: none"> •Mostly accurate portrayals 	<ul style="list-style-type: none"> •Some relevant media coverage may have been overlooked by the media retrieval service
Rowe, Tilbury, Rapley & O'Ferrall (2003)	News media: newspapers	A systematic thematic analysis (type of discourse analysis) of 49 articles containing the word 'depression' that appeared in one newspaper in Western	<ul style="list-style-type: none"> •Stories about depression, unlike other mental illnesses, stressed the need for protection of the 'sufferer', rather than 'others' 	Depression <ul style="list-style-type: none"> •Protection for sufferer 	<ul style="list-style-type: none"> •Generalisability of findings to the Australian media in general may be problematic as the study focused on one

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
		Australia in 2000	<ul style="list-style-type: none"> •Three key discourses were identified which work to normalise depression by presenting it as beyond the control of the person experiencing it – the biomedical, the psychosocial, and the administrative/ managerial 	Schizophrenia <ul style="list-style-type: none"> •Protection for others 	newspaper only
Blood (2002)	News media: newspapers	A qualitative analysis of the reporting and portrayal of mental illness in two Queensland newspapers between December 2001 and February 2002.	<ul style="list-style-type: none"> •The dominant news frame involved the portrayal of people with mental illness as dangerous others – violent, unpredictable, criminal and dangerous •The other news frames identified were violence, horror, alarmist imagery, deviance, risk, fear and crisis •The news stories related to specific and relatively rare incidents but readers are likely to draw general inferences about people with mental illnesses 	Mental Illness <ul style="list-style-type: none"> •Happens to others •Dangerous •Violent •Unpredictable •Criminals •Horror •Risk •Fear •Crisis 	<ul style="list-style-type: none"> •Not known whether sample was representative of overall media portrayal of mental illness since only two newspapers were analysed
Blood, Putnis & Pirkis (2002)	News media: newspapers, radio, television	News frame analysis of news and feature stories in the Australian media collected between March 2000 and February 2001 from Media Monitors	<ul style="list-style-type: none"> •Dominant frames of violence, horror, alarmist imagery, deviance, risk, fear and crisis were identified •These news frames were evident in both national and regional news 	Mental Illness <ul style="list-style-type: none"> •Violence •Horror •Deviance, •Risk •Fear •Crisis 	<ul style="list-style-type: none"> •Although the sub-sample for this study was drawn from a national data set, the method of sample selection was not fully described
Pirkis, Blood, Francis, Putnis, Burgess, Morley, Stewart & Payne (2001a) ²	News media: newspapers, radio, television	Media monitors was given a list of search terms related to mental illness and suicide and identified 17,151 items that appeared in newspapers, on radio or on television in the 12 month period from 1 st March 2000 to the end of February 2001. Relevant news and current affairs broadcast summaries from all national radio and television networks were retrieved and all national metropolitan daily newspapers	<ul style="list-style-type: none"> •Reporting of mental illness and suicide was extensive •For all media items the extent of reporting varied by month •The nature of reporting was variable in terms of focus and content – mental health and illness items were typically about policy or program initiatives, causes, symptoms and treatment of mental illness, mental health care or services, research initiatives or an 	Mental Illness <ul style="list-style-type: none"> •Portrayal of disorders was variable and ranged from poor to good 	<ul style="list-style-type: none"> •The extent of media reporting was difficult to calculate since some items may have been reports of the same story (e.g. an individual's story about depression in different newspapers may have been actually describing the experiences of one individual)
Part one Quantitative analysis: Pirkis, Francis, Blood, Burgess,					

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
Morley, Stewart & Putnis (2001b) Part two Qualitative analysis: Blood, Putnis, Pirkis, Francis & Payne (2001)		and all Victorian suburban and regional newspapers were scanned for relevant items. Identifying information, descriptive information and quality ratings were extracted	individual's experience •Young people were given prominence in stories about mental health and illness •Quality of mental health and illness items was varied but generally performed well on the majority of dimensions •Items performed poorly against the promotion of help-seeking behaviour in that most items did not provide information on help services •The poorest quality mental health and illness stories were those describing an individual's experience or describing mental health care or services – often used mental health language inappropriately or out of context		
Bokey, Walter & Rey (2000) ¹	Entertainment media: literature	Quantitative analysis of 94 books selected from contemporary Australian adolescent literature	•The majority of texts (69%) referred to mental illness •Portrayal of mental illness was generally negative	Mental Illness •Portrayal negative	•The study used two instruments designed by the researchers to evaluate the books. Reliability and validity of these instruments was not established
Hazelton (1997) ¹	News media: newspapers	Discourse analysis of mental health-related items from two Australian newspapers throughout 1994 (490 items in total)	•The negative theme of “disorder, crisis and risk” was predominant The discourse analysis of articles in the study identified five semantic domains that included: ‘the bizarre and curious’ – for example, stories that emphasized the oddity, peculiarity and abnormality of mental illness; medical-scientific marvels’ – for example, the ‘magic bullet’ notion of medical-scientific development; ‘moral tales’ – for example, the dangers of self-indulgence	Mental Illness •Portrayal negative •Disorder •Crisis •Risk	•Sample selected from only two newspapers – one national, one regional. Therefore not known whether findings representative of overall media portrayal of mental illness

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
			or the aberrance of individuals or society at large; 'disorder, crisis and risk' – for example, the boundary between institutional and community care and the possible risks posed by mentally ill people who were not under appropriate care and control; and 'lay wisdoms and commonsense remedies' – for example, articles describing the benefits of lay remedies or low technology interventions such as massage and relaxation		
Rosen, Walter, Politis & Shortland (1997) ¹	Entertainment media: film	Description of 21 mental health-related films from Australia and New Zealand	<ul style="list-style-type: none"> •Recent films depicted mental illness more positively •Negative stereotypes of mental illness persist in certain films 	Mental Illness <ul style="list-style-type: none"> •Negative stereotypes 	<ul style="list-style-type: none"> •Films were analysed from the subjective perspective of a psychiatrist researcher. No discourse analysis or scientific analyses were conducted
United States of America					
Diefenbach & West (2007)	News and entertainment media: television	Content analysis of 84 hours of American television programs in April 2003 and a survey of community respondents to test attitudes toward mental health issues	<ul style="list-style-type: none"> •People with mental disorders are disproportionately portrayed as violent criminals (10 times more likely than people without a mental disorder) and having a negative impact on society •Negative portrayals impact attitudes and affect viewers beliefs about their level of safety if mental health services are moved into the community 	Mental Illness <ul style="list-style-type: none"> •Violent •Criminals •Negative impact on society 	<ul style="list-style-type: none"> •Not known whether sample was representative of overall media portrayal of mental illness since only one month of viewing was analysed
Wahl, Wood & Richards (2002)	News media: newspapers	Content analysis of stories from six newspapers in 1999 to determine dominant themes in the portrayal of mental illness – data compared with that collected in 1989	<ul style="list-style-type: none"> •'Dangerousness' most common theme of stories about mental illness •Stories about accomplishment or recovery were rare •Negative stories continue to far outnumber positive ones 	Mental Illness <ul style="list-style-type: none"> •Dangerous •Predominantly negative portrayals 	<ul style="list-style-type: none"> •Results may have been influenced by several design choices – •Articles selected through key term 'mental illness', may have missed other

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
					<ul style="list-style-type: none"> relevant stories •Used all articles from search regardless of length or focus •Only six papers chosen for study – may not be representative •Results may have been skewed by small number of high profile events
Flores (2002)	Entertainment media: film	Description and content analysis of 131 movies available on videotape in which a physician was the main character	<ul style="list-style-type: none"> •Physicians were portrayed negatively in 44% of movies •Since the 1960's, positive portrayals of physicians have declined and negative portrayals have increased •A recurrent theme is the "mad scientist" 	Mental Illness •Mad	<ul style="list-style-type: none"> •Only a single observer viewed and evaluated all films •Movies with physicians as the main character were not viewed if they could not be hired from selected video shops •The guide from which the movies were sourced did not list movies released after mid 1998
McDonald & Walter (2001)	Entertainment media: film	Description of the portrayal of ECT in 22 American films	<ul style="list-style-type: none"> •Portrayal of ECT in American films has become progressively more negative •ECT unrealistically portrayed as brutal, harmful and an abusive maneuver with no therapeutic benefit 	Mental Illness •Violent •Negative stereotype	<ul style="list-style-type: none"> •Not all movies identified were available for viewing, so themes may not be generalisable
Wahl (2000) ¹	News media: periodicals	Content analysis of all articles related to Obsessive Compulsive Disorder in popular magazines from 1983-1997 (107 items in total)	<ul style="list-style-type: none"> •Very few items related to OCD •Presentation of information was generally accurate regarding the demographics, symptoms, causes, and treatments of the disorder •Many articles about violence and crime (such as obsessive stalkers) have the potential to be inaccurately classified as 	Obsessive Compulsive Disorder •Portrayal of OCD accurate	<ul style="list-style-type: none"> •Use of computerized index (Readers' Guide to Periodical Literature) to identify articles may have resulted in some relevant articles being excluded

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
			relating to OCD		
Diefenbach (1997) ¹	Entertainment media: television	Content analysis of all prime-time programs from four television networks over a two-week period (184 programs in total)	<ul style="list-style-type: none"> •Almost one-third of programs portrayed mental illness •30% of characters with mental illness were associated with violence and negative images 	Mental Illness <ul style="list-style-type: none"> •Violent •Negative depictions 	<ul style="list-style-type: none"> •Study only looked at a short period of television portrayals of mental illness – may not be fully representative of media coverage in the longer term
New Zealand					
Coverdale, Nairn & Classen (2002)	News media: newspapers	Content and discourse analysis of selected print materials between 3 rd February and 2 nd March 1997. Items were analysed and categorized as positive, negative or neutral representations of mental illness. Researchers then considered how mental illness was represented within each item	<ul style="list-style-type: none"> •600 print items were retrieved •Mostly news items (93.7%) •Depictions were mostly negative •Dangerousness to others was depicted in more than half (61.3%) of all items •Positive depictions occurred in 27.0% of articles-main focus in these articles was on human rights, leadership and educational accomplishments •The negative depictions confirm stereotypical understanding of mental illness which is stigmatising 	Mental Illness <ul style="list-style-type: none"> •Dangerous (to others and self) •Criminals •Vulnerable •Unpredictable •Failure •Asocial •Negative depictions 	<ul style="list-style-type: none"> •Findings not generalisable to media outside of New Zealand due to the fact that this sample included two unusual events (one of which involved a multiple murder by a psychiatric patient in New Zealand)
Nairn, Coverdale & Claasen (2001)	News media: newspapers	Content and discourse analysis of selected print materials between 3 rd February and 2 nd March 1997 about mental illness to examine how legal opinion was transformed into news	<ul style="list-style-type: none"> •Four major themes were identified – “human rights, vulnerability, risk of dangerousness and threat, and mental illness/psychiatric patient “ •All of these themes were used to produce stigmatizing depictions of people with mental illness •Negative themes outnumbered positive themes •Although news stories were accurate in their depiction of the identified patient, they were substantially more negative than the source material depiction 	Mental Illness <ul style="list-style-type: none"> •Human rights issues •Vulnerable •Dangerous •A threat to others 	<ul style="list-style-type: none"> •Content and discourse analysis only looked at stories over a one month period, may not be fully representative of media coverage in the longer term
Wilson, Nairn, Coverdale &	Entertainment media:	Discourse analysis of a one-week sample of 128 children's television	<ul style="list-style-type: none"> •Almost half the programs portrayed mental illness 	Mental Illness <ul style="list-style-type: none"> •Negative 	<ul style="list-style-type: none"> •Study only looked at a short period of television

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
Panapa (2000) ¹	television	programs	•Portrayal of mental illness was generally negative	depictions	portrayals of mental illness – may not be fully representative of media coverage in the longer term
Nairn (1999) ¹	News media: newspapers	Follow-up study involving discourse analysis of seven items from previous study of one New Zealand newspaper	•Depiction of mental illness promoted negative stereotypes	Mental Illness •Aggressive •A threat to others •Unpredictable •Dangerous	•Very small sample selected for analysis which may not be truly representative of the media coverage for that period •Analysis conducted by only one researcher and not checked by others for reliability
Wilson, Nairn, Coverdale & Panapa (1999b) ¹	Entertainment media: television	Discourse analysis of 14 television drama programs relating to mental illness	•Depiction of mental illness was negative overall •Mental illness was generally associated with crime	Mental Illness •Criminals	•Programs chosen for inclusion were determined from reading television guides therefore some relevant programs may have been omitted •No measures of reliability were included for the discourse analysis
Wilson, Nairn, Coverdale & Panapa (1999a) ¹	Entertainment Media: television	Case study of one television drama program using discourse analysis	•Mental illness was strongly associated with violence and dangerousness in this example	Mental Illness •Violent •Dangerous	•Only one television program used for discourse analysis means that generalisability of results may be questionable
Allen & Nairn (1997) ¹	News media: newspapers	Discourse analysis of 12 newspaper items from a "Special Report" on mental illness from one New Zealand newspaper. Analysis focused on the category of "dangerousness"	•Mental illness was portrayed negatively, as a danger and threat to the community	Mental Illness •Dangerous •Threat to others	•Small sample selected which may not be representative of the media coverage on this issue
Rose (1998) ¹	Entertainment	Content analysis of primetime	•Only 4% of programs portrayed mental	Mental Illness	•Measure of reliability for

Investigators	Content Type	Method	Key Findings	Main Themes*	Study Limitations
	media and News media: television	programs from two television networks over an eight-week period in 1992 (147 hours in total)	illness •The most frequent themes relating to mental illness were danger and violence	•Dangerous •Violent	content analysis was not included •Methods used for data collection and analysis of second sample not described in detail
United Kingdom					
Kelly (2006)	Entertainment media: film	Qualitative analysis of four Irish films released between 1994-2004 to determine portrayals of psychiatry and psychiatrists	•Three of the four films depicted psychiatrists as caring and humane but occasionally conflicted •All films emphasized the role of alcohol in causing and perpetuating psychological distress •Films associated mental illness with dissocial behaviour	Mental Illness •Dissocial behaviour •Substance (alcohol) abuse	•Analysis was restricted to Irish films and sample size was small. Results may not be representative of films originating from other countries
Ward (1997) ¹	News media: newspapers	Content analysis of all mental health-related items from the UK print media throughout 1996 (1035 items in total)	•Almost half of the coverage related to violence and crime, and the majority of this was negative •Negative items were given greater prominence than positive items	Mental Illness •Dangerous •Criminals	•Method of media item sample selection not described. Thus, may not be representative of the media coverage for that period
Cross Cultural					
Huang & Priebe (2003)	News media: newspapers	Analysis of 118 articles on mental health care issues from two newspapers with high circulation rates from each of the three countries (USA, UK and Australia). Four months worth of stories were randomly selected in the year long period from May 2001 to April 2002	•The predominant tone of the articles in all three countries was negative •There were slightly more positive articles in the USA (28.2%) and Australian (26.8%) media than the UK media (15.7%) •Forensic issues were more commonly covered in USA and UK media •There were very few articles related to coverage of psychiatric diagnosis and treatment in all countries (UK 1.6%, USA 0.8%, Australia 0.8%)	Mental Illness •Negative stereotype •Forensic issues •Dangerous	•Articles were analysed by only one rater, although a random sample of 20 articles were analysed by two raters, which showed an 80% agreement in coding •Since only stories from two newspapers in each country were analysed, they may not be truly representative of broader media coverage for that period

¹Most information taken directly from Francis et al. (2001 p.34-38)

*Based on news frame theory which describes the devices employed by journalists to organise news discourse and is described in detail below.

*This category was added by the researcher, including into the studies taken directly from Francis et al. (2001 p.34-38)

Appendix 4 Australia Japan survey

AUSTRALIANS' VIEWS
ABOUT HEALTH PROBLEMS



AUSTRALIANS' VIEWS ABOUT HEALTH PROBLEMS



THE AUSTRALIAN NATIONAL UNIVERSITY

1. WHICH AGE GROUP DO YOU BELONG TO?

- | | | | | | |
|-------|--------------------------|---|-------|--------------------------|----|
| 18-19 | <input type="checkbox"/> | 1 | 50-54 | <input type="checkbox"/> | 8 |
| 20-24 | <input type="checkbox"/> | 2 | 55-59 | <input type="checkbox"/> | 9 |
| 25-29 | <input type="checkbox"/> | 3 | 60-64 | <input type="checkbox"/> | 10 |
| 30-34 | <input type="checkbox"/> | 4 | 65-69 | <input type="checkbox"/> | 11 |
| 35-39 | <input type="checkbox"/> | 5 | 70-74 | <input type="checkbox"/> | 12 |
| 40-44 | <input type="checkbox"/> | 6 | 75+ | <input type="checkbox"/> | 13 |
| 45-49 | <input type="checkbox"/> | 7 | | | |

2. WHAT IS YOUR SEX?

- Male ₁ Female ₂

3. WHAT IS YOUR CURRENT MARITAL STATUS?

- Never married ₁
Married, de facto ₂
Separated, divorced or widowed ₃

4. WHAT IS THE POSTCODE OF THE PLACE YOU USUALLY LIVE?

5. WHAT STATE OR TERRITORY IS THIS IN?

- | | | | | | |
|-----------------|--------------------------|---|------------------------------|--------------------------|---|
| New South Wales | <input type="checkbox"/> | 1 | Western Australia | <input type="checkbox"/> | 5 |
| Victoria | <input type="checkbox"/> | 2 | Tasmania | <input type="checkbox"/> | 6 |
| Queensland | <input type="checkbox"/> | 3 | Northern Territory | <input type="checkbox"/> | 7 |
| South Australia | <input type="checkbox"/> | 4 | Australian Capital Territory | <input type="checkbox"/> | 8 |

6. WHAT COUNTRY WERE YOU BORN IN?

- Australia ₁
Outside Australia ₂ (*Please specify country*) _____

7. WHAT IS THE HIGHEST LEVEL OF EDUCATION YOU HAVE COMPLETED?

- Still attending school ₁
Secondary school certificate ₂
Trade certificate/apprenticeship ₃
Other certificate ₄
Associate or undergraduate diploma ₅
Bachelor's degree or higher ₆
Other ₇

THE FOLLOWING QUESTIONS ARE ABOUT CERTAIN TYPES OF HEALTH PROBLEMS AND THE USEFULNESS OF VARIOUS HEALTH SERVICES.

8. Interviewer:

*Insert the random selection code as per the Interviewer Instructions.
(This must be done prior to interview)*

9. Sequence Guide:

- | | | | | |
|-----------------|---|----------|--------------------------|---|
| <i>If 8 = 1</i> | → | 10 | <input type="checkbox"/> | 1 |
| <i>If 8 = 2</i> | → | 11 | <input type="checkbox"/> | 2 |
| <i>If 8 = 3</i> | → | 12 | <input type="checkbox"/> | 3 |
| <i>If 8 = 4</i> | → | 13 | <input type="checkbox"/> | 4 |
| <i>If 8 = 5</i> | → | 14 | <input type="checkbox"/> | 5 |
| <i>If 8 = 6</i> | → | 15 | <input type="checkbox"/> | 6 |
| <i>If 8 = 7</i> | → | 16 | <input type="checkbox"/> | 7 |
| <i>If 8 = 8</i> | → | 17 | <input type="checkbox"/> | 8 |

10. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE WHO ARE VERY LIKE HIM. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HIM, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: *Hand Card 1*

JOHN IS 30 YEARS OLD. HE HAS BEEN FEELING UNUSUALLY SAD AND MISERABLE FOR THE LAST FEW WEEKS. EVEN THOUGH HE IS TIRED ALL THE TIME, HE HAS TROUBLE SLEEPING NEARLY EVERY NIGHT. JOHN DOESN'T FEEL LIKE EATING AND HAS LOST WEIGHT. HE CAN'T KEEP HIS MIND ON HIS WORK AND PUTS OFF MAKING ANY DECISIONS. EVEN DAY-TO-DAY TASKS SEEM TOO MUCH FOR HIM. THIS HAS COME TO THE ATTENTION OF JOHN'S BOSS WHO IS CONCERNED ABOUT HIS LOWERED PRODUCTIVITY.

→ Q.18

11. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE WHO ARE VERY LIKE HER. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HER, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: Hand Card 2

MARY IS 30 YEARS OLD. SHE HAS BEEN FEELING UNUSUALLY SAD AND MISERABLE FOR THE LAST FEW WEEKS. EVEN THOUGH SHE IS TIRED ALL THE TIME, SHE HAS TROUBLE SLEEPING NEARLY EVERY NIGHT. MARY DOESN'T FEEL LIKE EATING AND HAS LOST WEIGHT. SHE CAN'T KEEP HER MIND ON HER WORK AND PUTS OFF MAKING ANY DECISIONS. EVEN DAY-TO-DAY TASKS SEEM TOO MUCH FOR HER. THIS HAS COME TO THE ATTENTION OF MARY'S BOSS WHO IS CONCERNED ABOUT HER LOWERED PRODUCTIVITY.

—————→ **Q.18**

12. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE LIKE HIM. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HIM, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: Hand Card 3

JOHN IS 24 AND LIVES AT HOME WITH HIS PARENTS. HE HAS HAD A FEW TEMPORARY JOBS SINCE FINISHING SCHOOL BUT IS NOW UNEMPLOYED. OVER THE LAST 6 MONTHS HE HAS STOPPED SEEING HIS FRIENDS, AND HAS BEGUN LOCKING HIMSELF IN HIS BEDROOM AND REFUSING TO EAT WITH THE FAMILY OR TO HAVE A BATH. HIS PARENTS ALSO HEAR HIM WALKING ABOUT IN HIS BEDROOM AT NIGHT WHILE THEY ARE IN BED. EVEN THOUGH THEY KNOW HE IS ALONE, THEY HAVE HEARD HIM SHOUTING AND ARGUING AS IF SOMEONE ELSE IS THERE. WHEN THEY TRY TO ENCOURAGE HIM TO DO MORE THINGS, HE WHISPERS THAT HE WON'T LEAVE HOME BECAUSE HE IS BEING SPIED UPON BY THE NEIGHBOUR. THEY REALISE HE IS NOT

TAKING DRUGS BECAUSE HE NEVER SEES ANYONE OR GOES ANYWHERE.

—————→ Q.18

13. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE WHO ARE VERY LIKE HER. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HER, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: Hand Card 4

MARY IS 24 AND LIVES AT HOME WITH HER PARENTS. SHE HAS HAD A FEW TEMPORARY JOBS SINCE FINISHING SCHOOL BUT IS NOW UNEMPLOYED. OVER THE LAST 6 MONTHS SHE HAS STOPPED SEEING HER FRIENDS, AND HAS BEGUN LOCKING HERSELF IN HER BEDROOM AND REFUSING TO EAT WITH THE FAMILY OR TO HAVE A BATH. HER PARENTS ALSO HEAR HER WALKING ABOUT IN HER BEDROOM AT NIGHT WHILE THEY ARE IN BED. EVEN THOUGH THEY KNOW SHE IS ALONE, THEY HAVE HEARD HER SHOUTING AND ARGUING AS IF SOMEONE ELSE IS THERE. WHEN THEY TRY TO ENCOURAGE HER TO DO MORE THINGS, SHE WHISPERS THAT SHE WON'T LEAVE HOME BECAUSE SHE IS BEING SPIED UPON BY THE NEIGHBOUR. THEY REALISE SHE IS NOT TAKING DRUGS BECAUSE SHE NEVER SEES ANYONE OR GOES ANYWHERE.

—————→ Q.18

14. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE WHO ARE VERY LIKE HIM. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HIM, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: Hand Card 5

JOHN IS 30 YEARS OLD. HE HAS BEEN FEELING UNUSUALLY SAD AND MISERABLE FOR THE LAST FEW WEEKS. EVEN THOUGH HE IS TIRED ALL THE TIME, HE HAS TROUBLE SLEEPING NEARLY EVERY NIGHT. JOHN DOESN'T FEEL LIKE EATING AND HAS LOST WEIGHT. HE CAN'T KEEP HIS MIND ON HIS WORK AND PUTS OFF MAKING ANY DECISIONS. EVEN DAY-TO-DAY TASKS SEEM TOO MUCH FOR HIM. THIS HAS COME TO THE ATTENTION OF JOHN'S BOSS WHO IS CONCERNED ABOUT HIS LOWERED PRODUCTIVITY. JOHN FEELS HE WILL NEVER BE HAPPY AGAIN AND BELIEVES HIS FAMILY WOULD BE BETTER OFF WITHOUT HIM. JOHN HAS BEEN SO DESPERATE, HE HAS BEEN THINKING OF WAYS TO END HIS LIFE.

—————> **Q.18**

15. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE WHO ARE VERY LIKE HER. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HER, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: Hand Card 6

MARY IS 30 YEARS OLD. SHE HAS BEEN FEELING UNUSUALLY SAD AND MISERABLE FOR THE LAST FEW WEEKS. EVEN THOUGH SHE IS TIRED ALL THE TIME, SHE HAS TROUBLE SLEEPING NEARLY EVERY NIGHT. MARY DOESN'T FEEL LIKE EATING AND HAS LOST WEIGHT. SHE CAN'T KEEP HER MIND ON HER WORK AND PUTS OFF MAKING ANY DECISIONS. EVEN DAY-TO-DAY TASKS SEEM TOO MUCH FOR HER. THIS HAS COME TO THE ATTENTION OF MARY'S BOSS WHO IS CONCERNED ABOUT HER LOWERED PRODUCTIVITY. MARY FEELS SHE WILL NEVER BE HAPPY AGAIN AND BELIEVES HER FAMILY WOULD BE BETTER OFF WITHOUT HER. MARY HAS BEEN SO DESPERATE, SHE HAS BEEN THINKING OF WAYS TO END HER LIFE.

—————> Q.18

16. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE WHO ARE VERY LIKE HER. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HER, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: Hand Card 7

JOHN IS 44 YEARS OLD. HE IS LIVING IN A BOARDING HOUSE IN AN INDUSTRIAL AREA. HE HAS NOT WORKED FOR YEARS. HE WEARS THE SAME CLOTHES IN ALL WEATHERS AND HAS LEFT HIS HAIR TO GROW LONG AND UNTIDY. HE IS ALWAYS ON HIS OWN AND IS OFTEN SEEN SITTING IN THE PARK TALKING TO HIMSELF. AT TIMES HE STANDS AND MOVES HIS HANDS AS IF TO COMMUNICATE TO SOMEONE IN NEARBY TREES. HE RARELY DRINKS ALCOHOL. HE SPEAKS CAREFULLY USING UNCOMMON AND SOMETIMES MADE-UP WORDS. HE IS POLITE BUT AVOIDS TALKING WITH OTHER PEOPLE. AT TIMES HE ACCUSES SHOPKEEPERS OF GIVING INFORMATION ABOUT HIM TO OTHER PEOPLE. HE HAS ASKED HIS LANDLORD TO PUT EXTRA LOCKS ON HIS DOOR AND TO REMOVE THE TELEVISION SET FROM HIS ROOM. HE SAYS SPIES ARE TRYING TO KEEP HIM UNDER OBSERVATION BECAUSE HE HAS SECRET INFORMATION ABOUT INTERNATIONAL COMPUTER SYSTEMS WHICH CONTROL PEOPLE THROUGH TELEVISION TRANSMITTERS. HIS LANDLORD COMPLAINS THAT HE WILL NOT LET HIM CLEAN THE ROOM WHICH IS INCREASINGLY DIRTY AND FILLED WITH GLASS OBJECTS. JOHN SAYS HE IS USING THESE "TO RECEIVE MESSAGES FROM SPACE".

—————> Q.18

17. THE PERSON I WILL NOW DESCRIBE IS NOT A REAL PERSON, BUT THERE ARE PEOPLE WHO ARE VERY LIKE HER. IF YOU HAPPEN TO KNOW SOMEONE WHO IS EXACTLY LIKE HER, THEN THAT IS A TOTAL COINCIDENCE.

Interviewer: Hand Card 8

MARY IS 44 YEARS OLD. SHE IS LIVING IN A BOARDING HOUSE IN AN INDUSTRIAL AREA. SHE HAS NOT WORKED FOR YEARS. SHE WEARS THE SAME CLOTHES IN ALL WEATHERS AND HAS LEFT HER HAIR TO GROW LONG AND UNTIDY. SHE IS ALWAYS ON HER OWN AND IS OFTEN SEEN SITTING IN THE PARK TALKING TO HERSELF. AT TIMES SHE STANDS AND MOVES HER HANDS AS IF TO COMMUNICATE TO SOMEONE IN NEARBY TREES. SHE RARELY DRINKS ALCOHOL. SHE SPEAKS CAREFULLY USING UNCOMMON AND SOMETIMES MADE-UP WORDS. SHE IS POLITE BUT AVOIDS TALKING WITH OTHER PEOPLE. AT TIMES SHE ACCUSES SHOPKEEPERS OF GIVING INFORMATION ABOUT HER TO OTHER PEOPLE. SHE HAS ASKED HER LANDLORD TO PUT EXTRA LOCKS ON HER DOOR AND TO REMOVE THE TELEVISION SET FROM HER ROOM. SHE SAYS SPIES ARE TRYING TO KEEP HER UNDER OBSERVATION BECAUSE SHE HAS SECRET INFORMATION ABOUT INTERNATIONAL COMPUTER SYSTEMS WHICH CONTROL PEOPLE THROUGH TELEVISION TRANSMITTERS. HER LANDLORD COMPLAINS THAT SHE WILL NOT LET HIM CLEAN THE ROOM WHICH IS INCREASINGLY DIRTY AND FILLED WITH GLASS OBJECTS. MARY SAYS SHE IS USING THESE "TO RECEIVE MESSAGES FROM SPACE".

18. WHAT WOULD YOU SAY, IF ANYTHING, IS WRONG WITH JOHN (MARY)?

- Depression a ₁
- Nervous Breakdown..... b ₂
- Schizophrenia/ paranoid schizophrenia..... c ₃
- Mental illness..... d ₄
- Psychological/mental/emotional problems..... e ₅
- Stress..... f ₆
- Has a problem..... g ₇
- Cancer..... h ₈
- Other (*Specify*) i ₉

.....
..... Office Use Only
.....

- Nothing..... j ₁₀
- Don't know..... k ₉₉

19. HOW DO YOU THINK JOHN (MARY) COULD BEST BE HELPED?

- Talk over with friends/family..... a ₁
- See a doctor (GP) b ₂
- See a psychiatrist c ₃
- Take medication d ₄
- See a counsellor or have counselling..... e ₅
- John / Mary must first recognise the problem..... f ₆
- Other (*Specify*) g ₇

.....
..... Office Use Only
.....

- Don't know h ₈

20. IMAGINE JOHN (MARY) IS SOMEONE YOU HAVE KNOWN FOR A LONG TIME AND CARE ABOUT. YOU WANT TO HELP HIM (HER). WHAT WOULD YOU DO?

THERE ARE A NUMBER OF DIFFERENT PEOPLE, SOME PROFESSIONAL, SOME NOT WHO COULD POSSIBLY HELP JOHN (MARY).

FOR EACH OF THE FOLLOWING, ARE THE PEOPLE LIKELY TO BE HELPFUL, HARMFUL, OR NEITHER FOR JOHN (MARY)?

Interviewer: Show Card 9

21. A TYPICAL GP OR FAMILY DOCTOR?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

22. A TYPICAL CHEMIST (PHARMACIST)?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

23. A COUNSELLOR?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

24. WOULD A SOCIAL WORKER BE LIKELY TO BE HELPFUL, HARMFUL OR NEITHER?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

25. A TELEPHONE COUNSELLING SERVICE, SUCH AS LIFELINE?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

26. A PSYCHIATRIST?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

27. A PSYCHOLOGIST?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

28. WOULD HELP FROM HIS (HER) CLOSE FAMILY BE LIKELY TO BE HELPFUL, HARMFUL OR NEITHER?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

29. HELP FROM CLOSE FRIENDS?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

30. A NATUROPATH OR A HERBALIST?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

31. THE CLERGY, A MINISTER OR PRIEST?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

32. IS IT LIKELY TO BE HELPFUL, HARMFUL OR NEITHER IF JOHN (MARY) TRIED TO DEAL WITH HIS (HER) PROBLEMS ON HIS (HER) OWN?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

THERE ARE DIFFERENT KINDS OF HELP AND TREATMENT WHICH COULD BE OFFERED BY SOME OF THE PEOPLE JUST MENTIONED.

DO YOU THINK THE FOLLOWING DIFFERENT MEDICINES ARE LIKELY TO BE HELPFUL, HARMFUL OR NEITHER TO JOHN (MARY)?

Interviewer: Show Card 10

33. VITAMINS AND MINERALS, TONICS OR HERBAL MEDICINES?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

34. PAIN RELIEVERS, SUCH AS ASPIRIN, CODEINE OR PANADOL?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

35. ANTI-DEPRESSANTS?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

36. ANTIBIOTICS?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

37. SLEEPING PILLS?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

38. ANTI-PSYCHOTICS?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

39. TRANQUILLISERS SUCH AS VALIUM?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

40. DO YOU THINK THE FOLLOWING TREATMENTS ARE LIKELY TO BE HELPFUL, HARMFUL OR NEITHER FOR JOHN (MARY)?

Interviewer: Show Card 11

41. BECOMING MORE ACTIVE PHYSICALLY, SUCH AS PLAYING MORE SPORT, OR DOING A LOT MORE WALKING OR GARDENING?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

42. READING ABOUT PEOPLE WITH SIMILAR PROBLEMS AND HOW THEY HAVE DEALT WITH THEM?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

43. GETTING OUT AND ABOUT MORE?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

44. ATTENDING COURSES ON RELAXATION, STRESS MANAGEMENT, MEDITATION OR YOGA?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

45. CUTTING OUT ALCOHOL ALTOGETHER?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

46. PSYCHOTHERAPY?

Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

47. HYPNOSIS?
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉
48. BEING ADMITTED TO A PSYCHIATRIC WARD OF A HOSPITAL?
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉
49. UNDERGOING ELECTRO-CONVULSIVE THERAPY (ECT)?
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉
50. HAVING AN OCCASIONAL ALCOHOLIC DRINK TO RELAX?
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉
51. GOING ON A SPECIAL DIET OR AVOIDING CERTAIN FOODS?
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

DO YOU THINK THE FOLLOWING WOULD BE HELPFUL, HARMFUL OR NEITHER FOR JOHN (MARY)?

Interviewer: Show Card 12

52. CONSULTING A WEB SITE THAT GIVES INFORMATION ABOUT HIS (HER) PROBLEM.
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉
53. CONSULTING AN EXPERT USING EMAIL OR THE WEB ABOUT HIS (HER) PROBLEM.
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉
54. CONSULTING A BOOK THAT GIVES INFORMATION ABOUT HIS (HER) HEALTH PROBLEM.
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉
55. RECEIVING INFORMATION ABOUT HIS (HER) HEALTH PROBLEM FROM A HEALTH EDUCATOR.
Helpful ₁ Neither ₂ Harmful ₃ Depends ₄ Don't know ₉

THE NEXT FEW QUESTIONS ASK WHAT YOU THINK ARE JOHN'S (MARY'S) CHANCE OF RECOVERY.

Interviewer: Show Card 13

56. WHAT WOULD BE THE LIKELY RESULT IF JOHN (MARY) HAD THE SORT OF PROFESSIONAL HELP YOU THINK IS MOST APPROPRIATE?

- | | | | |
|----|--|--------------------------|---|
| 1. | Full recovery with no further problems | <input type="checkbox"/> | 1 |
| 2. | Full recovery, but problems would probably re-occur | <input type="checkbox"/> | 2 |
| 3. | Partial recovery | <input type="checkbox"/> | 3 |
| 4. | Partial recovery, but problems would probably re-occur | <input type="checkbox"/> | 4 |
| 5. | No improvement | <input type="checkbox"/> | 5 |
| 6. | Get worse | <input type="checkbox"/> | 6 |
| | Don't know | <input type="checkbox"/> | 9 |

57. *Interviewer: Show Card 13*

WHAT WOULD BE THE LIKELY RESULT IF JOHN (MARY) DID NOT HAVE ANY PROFESSIONAL HELP?

- | | | | |
|----|--|--------------------------|---|
| 1. | Full recovery with no further problems | <input type="checkbox"/> | 1 |
| 2. | Full recovery, but problems would probably re-occur | <input type="checkbox"/> | 2 |
| 3. | Partial recovery | <input type="checkbox"/> | 3 |
| 4. | Partial recovery, but problems would probably re-occur | <input type="checkbox"/> | 4 |
| 5. | No improvement | <input type="checkbox"/> | 5 |
| 6. | Get worse | <input type="checkbox"/> | 6 |
| | Don't know | <input type="checkbox"/> | 9 |

SUPPOSE THAT JOHN (MARY) HAD THE SORT OF HELP YOU THINK IS MOST APPROPRIATE FOR HIS (HER) PROBLEMS.

FOR EACH OF THE FOLLOWING HOW DO YOU THINK HE (SHE) WOULD BE IN THE LONG-TERM, COMPARED TO OTHER PEOPLE IN THE COMMUNITY?

Interviewer: Show Card 14

58. AFTER GETTING HELP, HOW LIKELY IS HE (SHE) TO BE VIOLENT?

- | | | | | | | | | | | | |
|-------------|--------------------------|---|----------------|--------------------------|---|-------------|--------------------------|---|---------|--------------------------|---|
| More likely | <input type="checkbox"/> | 1 | Just as likely | <input type="checkbox"/> | 2 | Less likely | <input type="checkbox"/> | 3 | Depends | <input type="checkbox"/> | 4 |
| Don't know | <input type="checkbox"/> | 9 | | | | | | | | | |

59. HOW LIKELY IS HE (SHE) TO DRINK TOO MUCH ALCOHOL?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

60. TO TAKE ILLEGAL DRUGS?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

61. AFTER GETTING HELP, HOW LIKELY IS HE (SHE) TO HAVE POOR FRIENDSHIPS?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

62. TO ATTEMPT SUICIDE?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

63. TO BE UNDERSTANDING OF OTHER PEOPLES' FEELINGS?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

64. AFTER GETTING HELP, HOW LIKELY IS HE (SHE) TO HAVE A GOOD MARRIAGE?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

65. TO BE A CARING PARENT?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

66. TO BE A PRODUCTIVE WORKER?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

67. TO BE CREATIVE OR ARTISTIC?

More likely ₁ Just as likely ₂ Less likely ₃ Depends ₄

Don't know ₉

68. DO YOU THINK THAT JOHN (MARY) WOULD BE DISCRIMINATED AGAINST, BY OTHERS IN THE COMMUNITY, IF THEY KNEW ABOUT THE PROBLEMS HE (SHE) HAS HAD?

Yes ₁

No ₂

Don't know ₉

THE NEXT FEW QUESTIONS CONTAIN STATEMENTS ABOUT JOHN'S (MARY'S) PROBLEM. PLEASE INDICATE HOW STRONGLY **YOU** PERSONALLY AGREE OR DISAGREE WITH EACH STATEMENT.

Interviewer: Show Card 15

69. PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) COULD SNAP OUT OF IT IF THEY WANTED.

Strongly agree ₁

Agree ₂

Neither agree nor disagree ₃

Disagree ₄

Strongly disagree ₅

70. A PROBLEM LIKE JOHN'S (MARY'S) IS A SIGN OF PERSONAL WEAKNESS.

Strongly agree ₁

Agree ₂

Neither agree nor disagree ₃

Disagree ₄

Strongly disagree ₅

71. JOHN'S (MARY'S) PROBLEM IS NOT A REAL MEDICAL ILLNESS.

Strongly agree ₁

Agree ₂

Neither agree nor disagree ₃

Disagree ₄

Strongly disagree ₅

72. PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) ARE DANGEROUS.

Interviewer: If the person is unsure of the meaning of 'dangerous' in this statement, inform them it means 'dangerous to others'.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

73. IT IS BEST TO AVOID PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) SO THAT YOU DON'T DEVELOP THIS PROBLEM.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

74. PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) ARE UNPREDICTABLE.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

75. IF I HAD A PROBLEM LIKE JOHN'S (MARY'S) I WOULD NOT TELL ANYONE.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

76. I WOULD NOT EMPLOY SOMEONE IF I KNEW THEY HAD A PROBLEM LIKE JOHN'S (MARY'S).

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

77. I WOULD NOT VOTE FOR A POLITICIAN IF I KNEW THEY HAD SUFFERED A PROBLEM LIKE JOHN'S (MARY'S).

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

NOW WE WOULD LIKE YOU TO TELL US WHAT YOU THINK **MOST OTHER PEOPLE** BELIEVE. PLEASE INDICATE HOW STRONGLY YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS.

Interviewer: Show Card 16

78. MOST OTHER PEOPLE BELIEVE THAT PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) COULD SNAP OUT OF IT IF THEY WANTED.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

79. MOST PEOPLE BELIEVE THAT A PROBLEM LIKE JOHN'S (MARY'S) IS A SIGN OF PERSONAL WEAKNESS.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

80. MOST PEOPLE BELIEVE THAT JOHN'S (MARY'S) PROBLEM IS NOT A REAL MEDICAL ILLNESS.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

81. MOST PEOPLE BELIEVE THAT PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) ARE DANGEROUS.

Interviewer: If the person is unsure of the meaning of 'dangerous' in this statement, inform them it means 'dangerous to others'.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

82. MOST PEOPLE BELIEVE THAT IT IS BEST TO AVOID PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) SO THAT YOU DON'T DEVELOP THIS PROBLEM.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

83. MOST PEOPLE BELIEVE THAT PEOPLE WITH A PROBLEM LIKE JOHN'S (MARY'S) ARE UNPREDICTABLE.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

84. IF THEY HAD A PROBLEM LIKE JOHN'S (MARY'S) MOST PEOPLE WOULD NOT TELL ANYONE.

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

85. MOST PEOPLE WOULD NOT EMPLOY SOMEONE THEY KNEW HAD SUFFERED A PROBLEM LIKE JOHN'S (MARY'S).

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

86. MOST PEOPLE WOULD NOT VOTE FOR A POLITICIAN THEY KNEW HAD SUFFERED A PROBLEM LIKE JOHN'S (MARY'S).

- Strongly agree 1
Agree 2
Neither agree nor disagree 3
Disagree 4
Strongly disagree 5

THE NEXT FEW QUESTIONS ASK ABOUT HOW WILLING YOU WOULD BE TO HAVE CONTACT WITH SOMEONE LIKE JOHN (MARY).

Interviewer: Show Card 17

87. HOW WILLING WOULD YOU BE TO MOVE NEXT DOOR TO JOHN (MARY)? WOULD YOU SAY: DEFINITELY WILLING, PROBABLY WILLING, PROBABLY UNWILLING, OR DEFINITELY UNWILLING?

- Definitely willing ₁
- Probably willing ₂
- Probably unwilling ₃
- Definitely unwilling ₄
- Don't know ₉

88. HOW WILLING WOULD YOU BE TO SPEND AN EVENING SOCIALISING WITH JOHN (MARY)? DEFINITELY WILLING, PROBABLY WILLING, PROBABLY UNWILLING, OR DEFINITELY UNWILLING?

- Definitely willing ₁
- Probably willing ₂
- Probably unwilling ₃
- Definitely unwilling ₄
- Don't know ₉

89. HOW WILLING WOULD YOU BE TO MAKE FRIENDS WITH JOHN (MARY)? DEFINITELY WILLING, PROBABLY WILLING, PROBABLY UNWILLING, OR DEFINITELY UNWILLING?

- Definitely willing ₁
- Probably willing ₂
- Probably unwilling ₃
- Definitely unwilling ₄
- Don't know ₉

90. HOW WILLING WOULD YOU BE TO HAVE JOHN (MARY) START WORKING CLOSELY WITH YOU ON A JOB. DEFINITELY WILLING, PROBABLY WILLING, PROBABLY UNWILLING, OR DEFINITELY UNWILLING?

- Definitely willing ₁
- Probably willing ₂
- Probably unwilling ₃
- Definitely unwilling ₄
- Don't know ₉

91. HOW WILLING WOULD YOU BE TO HAVE JOHN (MARY) MARRY INTO YOUR FAMILY? DEFINITELY WILLING, PROBABLY WILLING, PROBABLY UNWILLING, OR DEFINITELY UNWILLING?

- Definitely willing ₁
- Probably willing ₂
- Probably unwilling ₃
- Definitely unwilling ₄
- Don't know ₉

THERE ARE MANY PEOPLE IN THE COMMUNITY WHO SUFFER FROM PROBLEMS LIKE JOHN'S (MARY'S). THE NEXT FEW QUESTIONS ARE ABOUT POSSIBLE CAUSES OF THIS SORT OF PROBLEM DEVELOPING IN ANYBODY.

HOW LIKELY DO YOU THINK EACH OF THE FOLLOWING IS TO BE A REASON FOR SUCH PROBLEMS?

Interviewer: Show Card 18

92. COULD A VIRUS OR OTHER INFECTION, BE A REASON FOR THESE SORT OF PROBLEMS?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄
 Don't know ₉

93. HOW LIKELY IS AN ALLERGY OR REACTION TO BE A CAUSE?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄
 Don't know ₉

94. DAY-TO-DAY PROBLEMS SUCH AS STRESS, FAMILY ARGUMENTS, DIFFICULTIES AT WORK OR FINANCIAL DIFFICULTIES?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄
 Don't know ₉

95. THE RECENT DEATH OF A CLOSE FRIEND OR RELATIVE?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄
 Don't know ₉

96. SOME RECENT TRAUMATIC EVENT SUCH AS BUSHFIRES THREATENING YOUR HOME, A SEVERE TRAFFIC ACCIDENT OR BEING MUGGED?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄

Don't know ₉

97. PROBLEMS FROM CHILDHOOD SUCH AS BEING BADLY TREATED OR ABUSED, LOSING ONE OR BOTH PARENTS WHEN YOUNG OR COMING FROM A BROKEN HOME?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄

Don't know ₉

98. HOW LIKELY IS IT THAT THESE SORTS OF PROBLEMS ARE INHERITED OR GENETIC?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄

Don't know ₉

99. IS BEING A NERVOUS PERSON LIKELY TO BE A REASON?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄

Don't know ₉

100. HAVING WEAKNESS OF CHARACTER?

Very likely ₁ Likely ₂ Not likely ₃ Depends ₄

Don't know ₉

THE NEXT FEW QUESTIONS SEEK YOUR OPINION ABOUT WHETHER THERE ARE SOME PEOPLE IN THE COMMUNITY WHO ARE MORE LIKELY TO HAVE THESE PROBLEMS AND OTHERS WHO ARE PERHAPS LESS LIKELY.

Interviewer: Show Card 19

101. DO YOU THINK THAT WOMEN WOULD BE MORE LIKELY OR LESS LIKELY THAN MEN TO SUFFER THESE SORTS OF PROBLEMS?

More likely ₁ Less likely ₂ No difference ₃ Depends ₄

Don't know ₉

102. WOULD YOUNG PEOPLE, UNDER 25 YEARS OF AGE, BE MORE OR LESS LIKELY?

More likely ₁ Less likely ₂ No difference ₃ Depends ₄
Don't know ₉

103. WOULD OLDER PEOPLE, THOSE AGED OVER 65, BE MORE OR LESS LIKELY?

More likely ₁ Less likely ₂ No difference ₃ Depends ₄
Don't know ₉

104. WOULD POOR PEOPLE BE MORE OR LESS LIKELY TO SUFFER FROM THESE SORTS OF PROBLEMS?

More likely ₁ Less likely ₂ No difference ₃ Depends ₄
Don't know ₉

105. UNEMPLOYED PEOPLE?

More likely ₁ Less likely ₂ No difference ₃ Depends ₄
Don't know ₉

106. DIVORCED OR SEPARATED PEOPLE?

More likely ₁ Less likely ₂ No difference ₃ Depends ₄
Don't know ₉

107. WOULD SINGLE PEOPLE, WHO HAVE NEVER BEEN MARRIED OR IN A LONG-TERM RELATIONSHIP BE MORE OR LESS LIKELY?

More likely ₁ Less likely ₂ No difference ₃ Depends ₄
Don't know ₉

108. HAS ANYONE IN YOUR FAMILY OR CLOSE CIRCLE OF FRIENDS EVER HAD PROBLEMS SIMILAR TO JOHN'S (MARY'S)?

Yes ₁
No ₂ → Q.110
Refused to answer ₃ → Q.110
Don't know ₉ → Q.110

109. HAVE THEY RECEIVED ANY PROFESSIONAL HELP OR TREATMENT FOR THESE PROBLEMS?

- Yes ₁
No ₂
Don't know ₉

110. HAVE YOU EVER HAD PROBLEMS SIMILAR TO JOHN'S (MARY'S)

- Yes ₁
No ₂ → Q.112
Refused to answer ₃ → Q.112
Don't know ₉ → Q.112

111. HAVE YOU RECEIVED ANY PROFESSIONAL HELP OR TREATMENT FOR THESE PROBLEMS?

- Yes ₁
No ₂
Don't know ₉

112. HAVE YOU EVER HAD A JOB THAT INVOLVED PROVIDING TREATMENT OR SERVICES TO A PERSON WITH A PROBLEM LIKE JOHN'S (MARY'S)?

- Yes ₁
No ₂
Refused to answer ₃
Don't know ₉

THE NEXT FEW QUESTIONS ARE ABOUT YOUR OWN HEALTH.

113. IN GENERAL, WOULD YOU SAY THAT YOUR HEALTH IS EXCELLENT, GOOD, FAIR OR POOR?

- Excellent ₁
Good ₂
Fair ₃
Poor ₄
Don't know ₉

114. IN THE LAST MONTH HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING?

A) COLDS?

Yes ₁
No ₂
Don't know ₉

B) SORE THROATS?

Yes ₁
No ₂
Don't know ₉

C) HEADACHES?

Yes ₁
No ₂
Don't know ₉

D) DIZZINESS?

Yes ₁
No ₂
Don't know ₉

E) PALPITATIONS?

Yes ₁
No ₂
Don't know ₉

F) BREATHLESSNESS?

Yes ₁
No ₂
Don't know ₉

G) BACKACHE?

Yes ₁
No ₂
Don't know ₉

H) FLU?

Yes ₁
No ₂
Don't know ₉

I) ANXIETY?

Yes ₁

No ₂

Don't know ₉

J) DEPRESSION?

Yes ₁

No ₂

Don't know ₉

K) TIREDNESS?

Yes ₁

No ₂

Don't know ₉

L) IRRITABILITY?

Yes ₁

No ₂

Don't know ₉

M) NERVOUSNESS?

Yes ₁

No ₂

Don't know ₉

THE FOLLOWING QUESTIONS ARE ABOUT DEPRESSION.

115. HAVE YOU SEEN, READ OR HEARD ANYTHING IN THE MEDIA ABOUT DEPRESSION IN THE LAST 12 MONTHS?

Yes ₁

No ₂ → Q.117

Refused to answer ₃ → Q.117

Don't know ₉ → Q.117

116. CAN YOU TELL ME WHAT YOU RECALL?

Interviewer: Probe for up to five responses. For each response ask "Can you remember the name of the health professional or organisation associated with this media report?"

Probe question: And can you recall anything else in the media about depression?

Probe question: Can you remember the names of any other health professionals or organisations associated with this media report?

Information Recalled	Health Professional/Organisation
(i)	
(ii)	
(iii)	
(iv)	
(v)	

117. HAVE YOU HEARD OF ANY ORGANISATIONS RELATED TO DEPRESSION?

- Yes ₁
- No ₂ → Q.119
- Refused to answer ₃ → Q.119
- Don't know ₉ → Q.119

118. CAN YOU TELL ME/REMEMBER THE NAMES OF ANY OF THESE ORGANISATIONS?

Interviewer: Probe fully. If 'beyondblue' is not mentioned → Q.119
If 'beyondblue' is mentioned → Q.121

(i) Record first response:

(ii) Record other responses:

(iii) Record probed responses:

119. HAVE YOU HEARD OF THE ORGANISATION CALLED 'BEYONDBLUE: THE NATIONAL DEPRESSION INITIATIVE'?

- Yes ₁ → Q.121
No ₂
Refused to answer ₃
Don't know ₉

120. IT IS AN INITIATIVE ASSOCIATED WITH JEFF KENNETT. HAVE YOU HEARD OF IT?

- Yes ₁
No ₂ → Q.122
Refused to answer ₃ → Q.122
Don't know ₉ → Q.122

121. WHAT HAVE YOU SEEN, READ OR HEARD ABOUT 'BEYONDBLUE'?

Interviewer: Probe fully

(iv) Record first response:

(v) Record other responses:

(vi) Record probed responses:

122. AND FINALLY, HAVE YOU HEARD OF THE ORGANISATION
CALLED 'THE MELLOW YELLOW INSTITUTE'?

- Yes 1
- No 2
- Refused to answer 3
- Don't know 9

ATTACHMENT:

PROMPT CARDS

Prompt Card 1

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss who is concerned about his lowered productivity.

Prompt Card 2

Mary is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Mary doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Mary's boss who is concerned about her lowered productivity.

Prompt Card 3

John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realise he is not taking drugs because he never sees anyone or goes anywhere.

Prompt Card 4

Mary is 24 and lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last six months she has stopped seeing her friends and has begun locking herself in the bedroom and refusing to eat with the family or to have bath. Her parents also hear her walking about her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone else is there. When they try to encourage her to do more things, she whispers that she won't leave home because she is being spied upon by the neighbour. They realise she is not taking drugs because she never sees anyone or goes anywhere.

Prompt Card 5

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss who is concerned about his lowered productivity. John feels he will never be happy again and believes his family would be better off without him. John has been so desperate, he has been thinking of ways to end his life.

Prompt Card 6

Mary is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Mary doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Mary's boss who is concerned about her lowered productivity. Mary feels she will never be happy again and believes her family would be better off without her. Mary has been so desperate, she has been thinking of ways to end her life.

Prompt Card 7

John is 44 years old. He is living in a boarding house in an industrial area. He has not worked for years. He wears the same clothes in all weathers and has left his hair to grow long and untidy. He is always on his own and is often seen sitting in the park talking to himself. At times he stands and moves his hands as if to communicate to someone in nearby trees. He rarely drinks alcohol. He speaks carefully using uncommon and sometimes made-up words. He is polite but avoids talking with other people. At times he accuses shopkeepers of giving information about him to other people. He has asked his landlord to put extra locks on his door and to remove the television set from his room. He says spies are trying to keep him under observation because he has secret information about international computer systems which control people through television transmitters. His landlord complains that he will not let him clean the room which is increasingly dirty and filled with glass objects. John says he is using these “to receive messages from space”.

Prompt Card 8

Mary is 44 years old. She is living in a boarding house in an industrial area. She has not worked for years. She wears the same clothes in all weathers and has left her hair to grow long and untidy. She is always on her own and is often seen sitting in the park talking to herself. At times she stands and moves her hands as if to communicate to someone in nearby trees. She rarely drinks alcohol. She speaks carefully using uncommon and sometimes made-up words. She is polite but avoids talking with other people. At times she accuses shopkeepers of giving information about her to other people. She has asked her landlord to put extra locks on her door and to remove the television set from her room. She says spies are trying to keep her under observation because she has secret information about international computer systems which control people through television transmitters. Her landlord complains that she will not let him clean the room which is increasingly dirty and filled with glass objects. Mary says she is using these “to receive messages from space”.

Prompt Card 9

1.	2.	3.
HELPFUL	NEITHER HELPFUL NOR HARMFUL	HARMFUL

PEOPLE WHO COULD HELP

GP or family doctor

Chemist (Pharmacist)

Counsellor

Social Worker

Telephone counselling service (eg. Lifeline)

Psychiatrist

Psychologist

Family

Close Friends

Naturopath or Herbalist

The clergy, a minister or priest

Self

Prompt Card 10

1.

HELPFUL

2.

**NEITHER HELPFUL
NOR HARMFUL**

3.

HARMFUL

MEDICINES

Vitamins, minerals, tonics, herbal medicines

Pain relievers (eg. aspirin, codeine, panadol)

Anti-depressants

Antibiotics

Sleeping pills

Anti-psychotics

Tranquillisers (eg. valium)

Prompt Card 11

1.

HELPFUL

2.

**NEITHER HELPFUL
NOR HARMFUL**

3.

HARMFUL

OTHER TREATMENTS

Become more physically active

Read about people with similar problems

Get out and about more

Relaxation, stress management, meditation, yoga

No alcohol

Psychotherapy

Hypnosis

Be admitted to a psychiatric ward

ECT (Electro-convulsive therapy)

Have an occasional drink

Go on a special diet or avoid certain foods

Prompt Card 12

1.

HELPFUL

2.

**NEITHER HELPFUL
NOR HARMFUL**

3.

HARMFUL

OTHER TREATMENTS

Consulting a web site for information

Consulting an expert via email or the web

Consulting a book that gives information

Information from an educator

Prompt Card 13

1. **FULL RECOVERY WITH NO FURTHER PROBLEMS**
2. **FULL RECOVERY, BUT PROBLEMS WOULD PROBABLY RE-OCCUR.**
3. **PARTIAL RECOVERY**
4. **PARTIAL RECOVERY, BUT PROBLEMS WOULD PROBABLY RE-OCCUR**
5. **NO IMPROVEMENT**
6. **GET WORSE**

Prompt Card 14

- | | | |
|--|---|--|
| 1. | 2. | 3. |
| MORE LIKELY
THAN OTHER
PEOPLE | JUST AS LIKELY
AS OTHER
PEOPLE | LESS LIKELY
THAN OTHER
PEOPLE |

LONG-TERM OUTCOMES AFTER GETTING HELP

To be violent

To drink too much alcohol

To take illegal drugs

To have poor friendships

To attempt suicide

To be understanding of other peoples' feelings

To have a good marriage

To be a caring parent

To be a productive worker

To be creative or artistic

Prompt Card 15

1. STRONGLY AGREE 2. AGREE 3. NEITHER AGREE NOR DISAGREE 4. DISAGREE 5. STRONGLY DISAGREE

STATEMENTS ABOUT THEIR PROBLEM

People with a problem like this could snap out of it if they wanted

A problem like this is a sign of personal weakness

Their problem is not a real medical illness

People with a problem like this are dangerous

It is best to avoid people with a problem like this so that you don't develop this problem

People with a problem like this are unpredictable

If I had a problem like this I would not tell anyone

I would not employ someone if I knew they had this problem

I would not vote for a politician if I knew they had suffered a problem like this.

Prompt Card 16

- | | | | | |
|---------------------------|--------------|---|-----------------|------------------------------|
| 1. | 2. | 3. | 4. | 5. |
| STRONGLY
AGREE | AGREE | NEITHER
AGREE NOR
DISAGREE | DISAGREE | STRONGLY
DISAGREE |

STATEMENTS ABOUT THEIR PROBLEM

Most people believe that people with a problem like this could snap out of it if they wanted

Most people believe that a problem like this is a sign of personal weakness

Most people believe that their problem is not a real medical illness

Most people believe that people with a problem like this are dangerous

Most people believe it is best to avoid people with a problem like this so that you don't develop this problem

Most people believe that people with a problem like this are unpredictable

If they had a problem like this most people would not tell anyone

Most people would not employ someone they knew had suffered a problem like this

Most people would not vote for a politician they knew had suffered a problem like this

Prompt Card 17

1
DEFINITELY
WILLING

2
PROBABLY
WILLING

3
PROBABLY
UNWILLING

4
DEFINITELY
UNWILLING

WILLINGNESS FOR CONTACT

MOVE NEXT DOOR TO THEM

SPEND AN EVENING SOCIALISING WITH THEM

MAKE FRIENDS WITH THEM

**HAVE THEM START WORKING CLOSELY WITH
YOU ON A JOB**

HAVE THEM MARRY INTO YOUR FAMILY

Prompt Card 18

**1.
VERY LIKELY**

**2.
LIKELY**

**3.
NOT LIKELY**

POSSIBLE CAUSES

A virus or infection

An allergy or reaction

Day-to-day problems (eg. stress, family arguments, etc)

Recent death of a close friend or relative

Recent traumatic event

Problems from childhood

Inherited or genetic

Being a nervous person

Weakness of character

Prompt Card 19

**1.
MORE LIKELY
THAN OTHER
PEOPLE**

**2.
LESS LIKELY
THAN OTHER
PEOPLE**

**3.
NO DIFFERENCE**

WHO IS LIKELY TO HAVE THESE PROBLEMS

Women more or less likely than men

Young people (under 25)

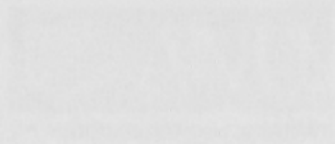
Older people (over 65)

Poor people

The unemployed

The divorced or separated

People who are single (never married)



THE AUSTRALIAN NATIONAL UNIVERSITY
HUMAN RESEARCH ETHICS COMMITTEE

Appendix 5

The Australian National University Human Research Ethics Committee Application Form –
Australia Japan survey

[Faint, illegible text of the application form, likely containing sections for project description, participant information, and ethical considerations.]

[Faint, illegible text at the bottom of the page, possibly containing contact information or additional instructions.]



THE AUSTRALIAN NATIONAL UNIVERSITY
HUMAN RESEARCH ETHICS COMMITTEE
APPLICATION FORM

Surname of Researcher: Jorm
First name/s: Anthony
Title (e.g. Ms., Mr., Dr. etc.): Prof
Position Held (staff, postgraduate, undergraduate, etc.): Staff
Student or Staff ID no. (if applicable): 8409322
Dept/School/Centre: Centre for Mental Health Research
Mailing address: Building 63, Eggleston Rd, ANU
Telephone: X58414
Fax: X50733
Email: Anthony.jorm@anu.edu.au

For students:

Name of ANU supervisor:
Email address of ANU supervisor:

PROJECT TITLE: Public beliefs and attitudes about mental health

Date of this application: August 2003
Anticipated start date for project: November 2003 **Anticipated end date:** June 2004

1. *The researcher/s*

Who are the investigators (including assistants) who will conduct the research and what are their qualification and experience? Please include their Department/School/Centre (or external institution for external researchers). Students should not include supervisors at this point unless they are actually participating in the research project as partner researchers.

The research is being directed by the following researchers at the Centre for Mental Health Research at ANU:

Prof. Tony Jorm, PhD, DSc, Director, Centre for Mental Health Research
Prof. Helen Christensen, PhD, Deputy Director, Centre for Mental Health Research
Dr. Kathy Griffiths, PhD, Director of Depression & Anxiety Consumer Research Unit, CMHR
Ms. Kelly Blewitt, BAppPsych, GradDipAppPsych, Research Assistant, CMHR

Jorm Christensen and Griffiths have all had extensive experience in conducting community surveys of mental health. Blewitt has been working as a Research Assistant on mental health research projects for the past one-and-a-half years.

The survey itself is being carried out by a survey company, Surveys Australia (also known as AC Nielsen). The people directing the survey in this company are:

Dr Phil Hughes, BA (Hons), BEc, MA (Stats) PhD (Soc Stats) Executive Director, Customised Measurement Sciences, Customised Research, Asia Pacific, ACNielsen.

Peter Blansjaar, National Account Manager, Surveys Australia (ACNielsen).

Gerard Culhane, Project Manager, Surveys Australia (ACNielsen).

P. Hughes has had extensive experience in designing and managing large scale public sector research and Blansjaar and Culhane have both had significant experience in managing projects of this nature.

2. *Understanding the national guidelines, the “National Statement on Ethical Conduct in Research Involving Humans” (1999)*

Can the proposer certify that the persons listed in the answer to Question 1 above have been fully briefed on appropriate procedures and in particular that they have read and are familiar with the national guidelines issued by the National Health and Medical Research Council (the *National Statement on Ethical Conduct in Research Involving Humans*) (cited below as the “National Statement”)? If there are guidelines from any relevant professional body with which the researcher/s are familiar they should also be listed below.

All have read the National Statement.

ACNielsen is a quality endorsed company and maintains a Quality Management System in accordance with AS/NZS/ISO9001:2000. The company acts in accordance with the Commonwealth Privacy Act 1988 and the Privacy Amendment (Private Sector) Act 2000. All company interviewers are trained according to the Market Research Society of Australia and IQCA (Interviewer Quality Control Australia) standards and ACNielsen (Surveys Australia) is an accredited member of the IQCA (2003).

3. *Purpose and design of the proposed research*

Purpose

(a) Briefly describe the basic purposes of the research proposed (in plain language intelligible to a non-specialist).

The research aims to see whether public beliefs and attitudes about mental health have changed over the past nine years. A national survey on this topic was carried out in 1995 by the Australian Bureau of Statistics using an interview provided by the Centre for Mental Health Research. We wish to repeat this survey to assess change in beliefs and attitudes. We also propose to add some additional questions not covered in the original survey. The purposes of these additional questions are:

1. To assess public beliefs and attitudes to chronic schizophrenia compared to acute schizophrenia.
2. To assess public beliefs and attitudes to depression when it is accompanied by suicidal thoughts.
3. To assess public exposure to the work of “beyondblue: the national depression initiative”.

A team of researchers in Japan intend doing a survey in their country using many of the same questions. This will allow a cross-country comparison. However, the Japanese survey is a separate study carried out by other researchers and is not the subject of this ethics application.

Design

(b) Outline the design of the project (in plain language intelligible to a non-specialist). (If interviewing people or administering a survey/questionnaire, please attach either a list of the broad questions you propose to ask, or a copy of the questionnaire.)

The project involves a household survey of 4000 Australian adults. This survey presents each participant with a description of a hypothetical person with a health problem. Respondents are presented with one of four types of description on a random basis. The four descriptions involve depression without suicidal thoughts, depression with suicidal thoughts, early schizophrenia, and chronic schizophrenia. Approximately 1000 persons will receive each type of case description. There are also male and female versions of each description, which refer to either "John" or "Mary". Respondents are then asked a series of questions about the hypothetical person. The questions cover the following topics:

1. What the respondent thinks is wrong with the person.
2. Beliefs about whether various treatments are likely to be helpful for the person.
3. Beliefs about the likely outcome for the person if they got professional help and if they did not.
4. General attitudes towards persons like the one described.
5. Beliefs about causes and risk factors for the person's health problem.
6. Personal contact with people like the person described.

Finally, there are questions about the respondent's own health in the past month and their exposure to media messages from "beyondblue".

A copy of the draft interview schedule is attached.

4. Sources of data involving humans

To ensure compliance with privacy legislation the committee needs to know your sources of information, i.e. where you are obtaining data involving humans. If you are using individual participants, tick at (a). If you are accessing personal records held by government departments or agencies, or by other bodies, e.g. private sector organisations, please tick and complete the relevant sections (b), (c) and/or (d) below.

- | | |
|---|---|
| (a) Individual subjects | <input checked="" type="checkbox"/> |
| (b) Commonwealth Department/s or agency (<i>specify</i>) | <input type="checkbox"/> |
| (c) State/Territory Department/s or agency (<i>specify</i>) | <input type="checkbox"/> |
| (d) Other sources (<i>specify</i>) | <input checked="" type="checkbox"/> ACNielsen is carrying out |

the household survey and will provide us with a de-identified data file

5. Personal identifiable data for medical/health research

Are you obtaining personal identifiable data specifically for medical/health research that is held by a government or private sector agency? (The committee needs this information to determine whether it needs to comply with relevant National Health and Medical Research Council guidelines relating to privacy legislation.)

NO (*delete whichever is not applicable*)

6. Recruitment

Describe how participants will be recruited for this project. Indicate how many participants are likely to be involved, how initial contact will be made, and how participants will be invited to take part in this project. A copy of any relevant

correspondence should be attached to this application. **Does the recruitment process raise any privacy issues, e.g. does the researcher plan to access personal information to identify potential participants without their knowledge or consent? Describe the steps to be taken to ensure that participation or refusal to participate will not impair any existing relationship between participants and researcher or institution involved.**

Households will be selected on a random basis. A survey interviewer will call at the household and say they are from AC Nielsen Market Research and doing a survey for the National Institute of Health and Human Sciences at ANU. They will ask to speak to the person with the most recent birthday (to get a random person within the household). This person will be given an information brochure (draft attached) and asked to read it. If they agree to participate, they will be asked to sign a consent form (draft also attached) before the interview commences.

7. *Arrangements for access to identifiable data held by another party*

In cases where participants are identified from information held by another party (e.g. government department, non-governmental organisation, private company, community association, doctor, hospital) describe the arrangement whereby you will gain access to this information. Attach any relevant correspondence.

At the end of the study, the survey company will send the consent forms to the Centre for Mental Health Research together with a de-identified data file.

8. *Vulnerable participants*

Will participants include students, children, the mentally ill or others in a dependent relationship? If so, provide details.

No.

9. *Payment*

Will payment be made to any participants? If so, give details of arrangements.

No.

10. *Consent*

Describe the consent issues involved in this proposal (see the National Statement, in particular Section 1.7-12, and other sections relevant to your research). Describe the procedures to be followed in obtaining the informed consent of participants and/or of others responsible. Attach any relevant documents such as a consent form, information sheet, letter of invitation etc. If you do not propose to obtain written consent (e.g. if working with non-literate people) give a detailed explanation of the reasons for seeking oral consent, describe the procedure you intend to adopt, and specify the information to be provided to participants. If you have answered YES to Question 8 above please address any issues of consent and the possibility of coercion.

A copy of the draft information sheet and consent form are attached.

Because the intention of this research is to see what the public believe about a hypothetical person with a mental health problem, it is necessary that they not be given any clues that the survey is about mental health specifically. In the previous survey carried out 9 years ago it was found that some respondents thought the person described had a physical health problem. We are interested in such responses because they show a lack of knowledge of the symptoms of common mental disorders. We will therefore not mention the Centre for Mental Health Research or the word “mental health” in the brochure and information sheet. The research is presented as coming from the National Institute of Health and Human Sciences at ANU. The staff involved in running the project are members of this Institute.

11. *Protection of privacy (confidentiality)*

Describe the confidentiality issues involving in this proposal. Give details of the measures that will be adopted to protect confidential information about participants, both in handling and storing raw research data and in any publications. Blanket guarantees of confidentiality are not helpful. If the term “confidential” is used in information provided to participants, a full description of what precisely confidentiality means in the context of this research should be given. You should be aware that, under Australian law, any data you collect can potentially be subpoenaed. Depending on the nature of your research, it may be helpful to qualify promises of confidentiality with terms such as “as far as possible” or “as far as the law allows”. [See the National Statement, in particular Sections 1.19, 18 and Appendix II]

ACNielsen (Surveys Australia) will send a de-identified data file to the researchers at ANU. The company will destroy the original paper copies of the survey three months after transfer to electronic format. The electronic file will be in a de-identified form. The consent forms will be detached from the original copies and sent to the ANU.

The data file will be stored on password protected computers within the Centre for Mental Health Research. The consent forms will be stored off-site in a locked data repository. There will be no linkage of names to survey responses once the data have been entered on computer.

12. *Cultural or social considerations*

Comment on any cultural or social considerations that may affect the design of the research. [See the National Statement, in particular Sections 1.2 and 1.19].

None.

13. *How the research might impact on participants*

Describe and discuss any possible impact of the proposed research on the participants or their communities that you can foresee. This might include psychological, health, social, economic or political changes or ramifications. Discuss how you will try to minimise any impact. [See the National Statement, in particular Sections 1.3 to 1.6 and Section 1.14]

No adverse affects are anticipated.

14. *Other ethical and any legal considerations*

Comment on any other ethical considerations that are involved in this proposal, including any potential for legal difficulties to arise for participants.

None are anticipated.

15. *Benefits versus risks*

Describe the possible benefit/s to be gained from the proposed research. Explain why these benefits outweigh or justify any possible discomforts and risks to participants. In framing your explanation make explicit reference to the ethical considerations mentioned in your answers to previous questions on this form. [See the National Statement, in particular Sections 1.3-6 and 1.13-14]

No discomforts or risks are anticipated. None were reported from the original survey carried out nine years ago.

The data will influence health promotion campaigns to improve public understanding of mental health.

16. *Handling possible problems arising from the research*

Describe the arrangements you have made to handle concerns and complaints by participants, or emergencies involving participants or researchers.

The information brochure contains names and phone numbers of two of the researchers who can be contacted if there are any questions or problems. The name and number of the ANU Ethics Officer are also given for any participant who has a complaint about ethical issues.

17. RESEARCH PROTOCOL CHECKLIST

There are some key ethical principles that need to be addressed in your protocol (as an ethics application is known). In particular the committee needs to see how you have addressed the issue of informed consent and the issue of confidentiality, i.e. how the identities of participants will be protected in the raw research data and in published material. The usual way to obtain informed consent is in writing, by use of a consent form that is signed by the participant and retained by you. Because you retain the consent form the same information needs to be included in an information sheet that participants retain. Both the consent form and the information sheet should include your name, contact details, title and brief description of the project, details on how the identities of participants will be protected (both when storing the raw research data and in its published form), a statement that participation is voluntary and participants can withdraw at any time, and contact details for the Human Research Ethics Committee in case of any ethical concerns. If you do not propose to seek written consent, you need to explain why oral consent will be sufficient and how you propose to obtain it.

Please tick the relevant boxes below to indicate what has been included in your protocol:

Outline of proposal and purpose	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Measures to be taken to protect confidentiality	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Explanation of how informed consent will be obtained	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

If written consent is not being sought, justification of a verbal consent procedure is included Yes

Full details on investigators (name, institution, etc.)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
All researchers on this project are familiar with the national guidelines (<i>National Statement</i>)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

Details re how participants will be recruited	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
---	---	-----------------------------

Is personal data from a Commonwealth department/agency or private sector organisation being used?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
---	---	-----------------------------

Details on how cultural and social sensitivities will be addressed	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
--	---	-----------------------------

Consideration of likely risk to participants (e.g. psychological stress; cultural, social, political or economic ramifications)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
---	---	-----------------------------

Do your research participants include:

Aboriginal or Torres Strait Islander peoples	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Children and young people (i.e. minors under the age of 18)	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
People with an intellectual or mental impairment	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
People highly dependent on medical case	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
People in dependent or unequal relationships	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Do you intend to pay participants?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
------------------------------------	------------------------------	--

Description of method and amount is included Yes

Description of clinical facilities (for medical research)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
---	---	-----------------------------

Period of research	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
--------------------	---	-----------------------------

SUPPORTING DOCUMENTATION: *The committee requires copies of all relevant documents*

Consent form to be signed by participants	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Information sheet for participants to retain	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

Dot point list of the points that will be made when seeking verbal consent Yes

List of interview questions	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Copy of questionnaire/s	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Invitation or introductory letter/s	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Publicity material (posters etc.)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Other (<i>specify</i>)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

18. SIGNATURES AND UNDERTAKINGS

PROPOSER OF THE RESEARCH

I certify that the above is as accurate a description of my research proposal as possible and that the research will be conducted in accordance with the *National Statement on Ethical Conduct in Research Involving Humans* (version current at time of application). I also agree to adhere to the conditions of approval stipulated by the ANU Human Research Ethics Committee (HREC) and will cooperate with HREC monitoring requirements. I agree to notify the Committee in writing immediately of any significant departures from this protocol and will not continue the research if ethical approval is withdrawn and will comply with any special conditions required by the HREC.

Name and title (please print): Anthony Jorm
(Proposer of research)

Signed:..... Date:.....

SUPERVISOR

Where the proposal is from a student, the Supervisor is asked to certify the accuracy of the above account.

I certify that I shall provide appropriate supervision to the student to ensure that the project is undertaken in accordance with the undertakings above:

Name and title (please print):
(Supervisor)

Department/School/Centre:

Signed:..... Date:.....

COMMENT ON PROJECT FROM HEAD OF DEPARTMENT/GROUP/CENTRE:

The Head of Department/School/Centre is asked to certify that this proposal has his/her support:

I certify that:

- I am familiar with this project and endorse its undertakings;
- the resources required to undertake this project are available; and
- the investigators have the skill and expertise to undertake this project appropriately.

Any additional comments (optional):

Name and title (please print):...Anthony Jorm.
(Head of Department/Group/Centre)

Department/School/Centre: ...Centre for Mental Health Research.

Signed:.....

Date:.....

Applications should be submitted as follows:

(a) 13 hard copies (one master copy with original signatures + 12 photocopies) and all supporting documentation

PLUS

(b) an identical email version emailed to Human.Ethics.Officer@anu.edu.au.

Hard copies of the completed protocol form, together with all supporting documents, should be sent to:

The Secretary
Human Research Ethics Committee
Research Services Office
Chancelry 10B
The Australian National University ACT 0200

Tel: 6125-2900
Fax: 6125-4807
Email: Human.Ethics.Officer@anu.edu.au

Q1. How many people recall of seeing a certain brand of... in the last twelve months?

Q2. How many people recall of seeing a certain brand of... in the last twelve months?

1. Brand name

2. Brand name

Appendix 6 Media recall coding sheet

3. Brand name

4. Brand name

5. Brand name

6. Brand name

7. Brand name

8. Brand name

9. Brand name

Qn 66. Have you seen, read or heard anything in the media about depression in the last twelve months?

Code up to three responses. If more than three responses have been given, code only the first three.

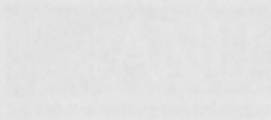
1. Individual's experience (stress related difficulties, a person's individual story – includes a person telling their own story or someone who is telling it about them)
2. Causes, symptoms and/or treatment of mental illness (risk, vulnerabilities, genetics, employment status, war, parental role, physical) Note: If the word treatment, causes, symptoms etc is used, then code for it. If treatment is discussed in the context of services, then code both 2 and 4.
3. Statistical overview (community attitudes, prevalence, prevalent, stats, statistics, age distribution, lack of awareness), stats stuff should be specific (ie about the stats for Australia or the community)
4. Mental health care and/or services (I want to get help, rehabilitation, complaining about hospitals, help lines) if treatment is discussed in the context of services, then code both 2 and 4.
5. Policy or program initiative (health warnings, inquiry being held)
6. Research Initiative
7. Opinion piece
8. Language (identified either positive or negative use of language)
9. Mental health/illness issues associated with the workplace (or school)
10. Mental health/illness issues associated with physical health
11. Mental health/illness mentioned in the context of suicide
12. Mental health/illness mentioned in the context of crime (gone off the deep end)
99. Other - can't remember, disagreed, didn't take much notice, none mentioned, missing

Pirkis, J., Blood, R. W., Francis, C., Putnis, P., Burgess, P., Morley, B., Stewart, A., & Payne, T. (2001). *The media monitoring project: a baseline description of how the Australian media report and portray suicide and mental health and illness*. Canberra: Commonwealth Department of Health and Aged Care.

Based on Table 25 p.47 – Item content for newspaper items on mental illness

HEALTH ATTITUDES OF MEDIA PROFESSIONALS IN AUSTRALIA

Appendix 7 HAMPA survey – suicidal depression version



HEALTH ATTITUDES OF MEDIA PROFESSIONALS IN AUSTRALIA



Please read the instructions before you begin.

Thank you for agreeing to take part in our survey. This survey is voluntary. As far as the law allows, all information you provide will be kept confidential. If you come to a question and you do not wish to answer it, please leave it blank.

1. Which age group do you belong to?

- | | | | | | |
|-------|--------------------------|---|-------|--------------------------|----|
| 18-19 | <input type="checkbox"/> | 1 | 50-54 | <input type="checkbox"/> | 8 |
| 20-24 | <input type="checkbox"/> | 2 | 55-59 | <input type="checkbox"/> | 9 |
| 25-29 | <input type="checkbox"/> | 3 | 60-64 | <input type="checkbox"/> | 10 |
| 30-34 | <input type="checkbox"/> | 4 | 65-69 | <input type="checkbox"/> | 11 |
| 35-39 | <input type="checkbox"/> | 5 | 70-74 | <input type="checkbox"/> | 12 |
| 40-44 | <input type="checkbox"/> | 6 | 75+ | <input type="checkbox"/> | 13 |
| 45-49 | <input type="checkbox"/> | 7 | | | |

2. What is your sex?

- Female 1 Male 2

3. What is the postcode of the place where you **usually work**?

4. What state or territory is this in?

- | | | | | | |
|-----------------|--------------------------|---|------------------------------|--------------------------|---|
| New South Wales | <input type="checkbox"/> | 1 | Western Australia | <input type="checkbox"/> | 5 |
| Victoria | <input type="checkbox"/> | 2 | Tasmania | <input type="checkbox"/> | 6 |
| Queensland | <input type="checkbox"/> | 3 | Northern Territory | <input type="checkbox"/> | 7 |
| South Australia | <input type="checkbox"/> | 4 | Australian Capital Territory | <input type="checkbox"/> | 8 |

5. What country were you born in?

- Australia 1
Outside Australia 2 (Please specify country _____)

6. What is the highest level of education you have completed?

- | | | |
|------------------------------------|--------------------------|---|
| Still attending school | <input type="checkbox"/> | 1 |
| Secondary school certificate | <input type="checkbox"/> | 2 |
| Trade certificate/apprenticeship | <input type="checkbox"/> | 3 |
| Other certificate | <input type="checkbox"/> | 4 |
| Associate or undergraduate diploma | <input type="checkbox"/> | 5 |
| Bachelor's degree | <input type="checkbox"/> | 6 |
| Higher degree (Masters, PhD) | <input type="checkbox"/> | 7 |
| Other | <input type="checkbox"/> | 8 |

7. Do you hold a Bachelor's degree or Higher degree (Masters, PhD)?

- | | | |
|--|--------------------------|---|
| Bachelor's degree in journalism only | <input type="checkbox"/> | 1 |
| Higher degree in journalism only | <input type="checkbox"/> | 2 |
| Both a Bachelor's and Higher degree in journalism | <input type="checkbox"/> | 3 |
| Other Bachelor's or Higher degree (not journalism) | <input type="checkbox"/> | 4 |
| Currently undertaking tertiary study | <input type="checkbox"/> | 5 |
| No tertiary training | <input type="checkbox"/> | 6 |

8. What is your current area of expertise? For example, journalist, features writer, health reporter, sports writer, editor, reporter etc. Please list.

9. What do you consider to be the major health problems in Australia at present?

10. Which of these is the most important health problem?

Please read the following story. The person in the story is not real, but there are people just like her. The subsequent questions are about things that might help the person described in this story.

Mary is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Mary doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Mary's boss who is concerned about her lowered productivity. Mary feels she will never be happy again and believes her family would be better off without her. To stop the pain, Mary has been thinking of ways to end her life.

11. What would you say, if anything, is wrong with Mary?

12. How do you think Mary could best be helped?

13. Imagine Mary is someone you have known for a long time and care about. You want to help her. What would you do?

There are a number of different people, some professional, some not, who could possibly help Mary.

Do you think the following people are likely to be helpful, harmful, or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
14. A typical GP or family doctor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15. A typical chemist or pharmacist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16. A counsellor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17. A social worker	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18. A telephone counselling service, such as lifeline	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19. A psychiatrist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20. A psychologist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
21. Help from Mary's family	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22. Help from close friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23. A naturopath or herbalist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24. A police officer	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25. The clergy, a minister or priest	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26. Mary dealing with it on her own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27. Other (please list) _____				

There are different kinds of help and treatment that could be offered by some of the people just mentioned. Do you think the following medicines are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
28. Vitamins and minerals, tonics or herbal medicines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29. Pain relievers, such as aspirin, codeine or panadol	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30. Anti-depressants	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31. Antibiotics	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32. Sleeping pills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33. Anti-psychotic medicines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34. Tranquillisers such as Valium	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35. Other (please list) _____				

Do you think the following treatments are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
36. Becoming more physically active, for example, playing more sport	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37. Reading about people with similar problems and how they have dealt with them	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38. Getting out and about more	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39. Attending courses on relaxation, stress management, meditation or yoga	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40. Cutting out alcohol altogether	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41. Psychotherapy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42. Hypnosis	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43. Being admitted to the psychiatric ward of a hospital	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
44. Undergoing electro-convulsive therapy (ECT)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45. Having an occasional alcoholic drink to relax	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46. Going on a special diet or avoiding certain foods	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Do you think the following are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
47. Consulting a website that gives information about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48. Consulting an expert using email or The Web about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49. Consulting a book that gives information about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50. Receiving information about her health problem from a health educator	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51. Other (please list) _____				

The next few questions ask what you think Mary's chances of recovery are.

52. What do you think the likely result would be if Mary had the professional help you think is most appropriate? (please tick the **one** box you feel is most true)

- Full recovery with no further problems ₁
- Full recovery, but problems would probably re-occur ₂
- Partial recovery ₃
- Partial recovery, but problems would probably re-occur ₄
- No improvement ₅
- Mary would get worse ₆
- Don't know/unsure ₇

53. What would be the likely result if Mary did **not** have any professional help?
*(please tick the **one** box you feel is most true.)*

- Full recovery with no further problems ₁
- Full recovery, but problems would probably re-occur ₂
- Partial recovery ₃
- Partial recovery, but problems would probably re-occur ₄
- No improvement ₅
- Mary would get worse ₆
- Don't know/unsure ₇

Suppose that Mary had the sort of help that you think is the most appropriate for her problems. In the long term, compared to other people in the community, how likely do you think Mary would be; *(tick one response for each line)*

	More Likely	Same	Less Likely	Don't Know
54. To be violent?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55. To drink too much alcohol?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56. To use illegal drugs?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57. To have poor friendships?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58. To attempt suicide?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59. To be understanding of other people's feelings?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60. In the future, to have a good marriage?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61. To be a caring parent?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62. To be a productive worker?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63. To be creative or artistic?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

64. Do you think that Mary would be discriminated against, by others in the community, if they knew about the problems she had?

- Yes ₁ Please go to question 65
- No ₂ Please go to question 66
- Don't know ₃ Please go to question 66

65. In what ways do you think she would be discriminated against?

The next few questions contain statements about Mary's problem. Please indicate how strongly you personally agree or disagree with each statement. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
66. People with a problem like Mary's could snap out of it if they wanted	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
67. A problem like Mary's is a sign of personal weakness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
68. Mary's problem is not a real medical illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
69. People with a problem like Mary's are dangerous (to others)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
70. It is best to avoid people with a problem like Mary's so that you don't develop this problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
71. People with a problem like Mary's are unpredictable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
72. If I had a problem like Mary's I would not tell anyone	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
73. I would not employ someone if I knew they had a problem like Mary's	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
74. I would not vote for a politician if I knew they had experienced a problem like Mary's	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
75. People with a problem like Mary's have difficulty fitting into social situations	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Now we would like you to tell us what you think most other people believe. Please indicate how strongly you agree or disagree with the following statements. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
76. Most people believe that people with a problem like Mary's could snap out of it if they wanted	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
77. Most people believe that a problem like Mary's is a sign of personal weakness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
78. Most people believe that Mary's problem is not a real medical illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
79. Most people believe that people with a problem like Mary's are dangerous (to others)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
80. Most people believe that it is best to avoid people with a problem like Mary's so that you don't develop this problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
81. Most people believe that people with a problem like Mary's are unpredictable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

- | | Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 82. If they had a problem like Mary's most people would not tell anyone | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 83. Most people would not employ someone if they knew they had experienced a problem like Mary's | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 84. Most people would not vote for a politician they knew had experienced a problem like Mary's | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 85. Most people believe that people with a problem like Mary's have difficulty fitting into social situations | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

The next few questions are about how willing you would be to have contact with someone like Mary. (tick one response for each line)

- | | Definitely Willing | Probably Willing | Probably Unwilling | Definitely Unwilling | Don't Know |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 86. How willing would you be to move next door to Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 87. How willing would you be to spend an evening socialising with Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 88. How willing would you be to make friends with Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 89. How willing would you be to have Mary start working closely with you on a job? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 90. How willing would you be to have Mary marry into your family? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 91. How willing would you be to stay with your current partner if they had a problem like Mary's? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

There are many people in the community who experience problems like Mary's. The next few questions are about possible causes of this sort of problem developing in anybody.

How likely do you think each of the following is to be the cause of such problems? (tick one response for each line)

- | | Very Likely | Likely | Not Likely | Don't know |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 92. A virus or other infection? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 93. An allergy or reaction to foods or drinks? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 94. Day-to-day problems such as stress, family arguments, problems at work, or financial difficulties? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 95. The recent death of a close friend or relative? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 96. A recent traumatic event, eg. bushfires threatening your home, a bad traffic accident or being mugged? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

- | | Very
Likely | Likely | Not
Likely | Don't
know |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 97. Problems from childhood, such as being badly treated or abused? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 98. Inherited or genetic factors? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 99. Is being a nervous person likely to be a reason? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 100. Having weakness of character? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

101. Anything else? Please tell us what it is.

The next few questions ask your opinion about whether there are some people in the community who are more likely to have these problems and others who are perhaps less likely. (tick one response for each line)

- | | More
Likely | Same | Less
Likely | Don't
Know |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 102. Are women, rather than men, more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 103. Would young people, under 25 years of age, be more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 104. Would older people, those aged over 65, be more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 105. People who come from poorer neighbourhoods? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 106. People who are unemployed? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 107. Divorced or separated people? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 108. Single people, who have never been married or in a long-term relationship be more or less likely? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

109. Has anyone in your family or close circle of friends ever had problems similar to Mary's?

- Yes ₁ Please go to question 110
- No ₂ Please go to question 111
- Don't know ₃ Please go to question 111

110. Have they received any professional help or treatment for these problems?

- Yes ₁
- No ₂
- Don't know ₃

111. Have you ever had problems similar to Mary's?

Yes ₁ Please go to question 112

No ₂ Please go to question 113

Don't know ₃ Please go to question 113

112. Have you received any professional help or treatment for these problems?

Yes ₁

No ₂

Don't know ₃

113. Have you ever cared for someone with a problem like Mary's?

Yes ₁

No ₂

Don't know ₃

114. Have you ever written a story about, or interviewed a person, with a problem like Mary's?

Yes ₁

No ₂

Don't know ₃

The following questions are about certain types of health problems and the usefulness of various health services.

115. What do you consider to be the main mental illnesses in Australia at present?

116. Which of these is the most important mental illness?

Guidelines, which encourage responsible approaches to the reporting of suicide and mental illness, have been developed in Australia. The next few questions ask your opinion about these guidelines.

117. Have you read *Reporting Suicide and Mental Illness* (August 2002), which is a resource for media professionals on reporting suicide and mental illness?

Yes ₁

No ₂

Don't know ₃

118. Have you read any other guidelines on the responsible reporting of suicide and mental illness?

- Yes (please list) ₁ _____
- No ₂
- Don't know ₃

119. Have you heard of any organisations that provide information about mental illness? If so, please list these. Asterisk any of the listed organisations you have acquired information from.

Please indicate how strongly you agree or disagree with the following statements. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
120. The Australian media plays an important role in influencing social attitudes about mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
121. The Australian media plays an important role in influencing social attitudes about suicide	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
122. Most media report suicide and mental illness appropriately	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
123. Negative reporting of mental illness impacts significantly on people experiencing a mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
124. I follow suggested media guidelines when reporting about suicide or mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
125. My colleagues follow suggested media guidelines when reporting about suicide or mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
126. The presentation of negative images of mental illness in both fiction and non-fiction media results in the development of more negative beliefs about mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
127. Responsible reporting about mental illness and suicide is a priority for the media	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
128. The current media guidelines for the reporting on suicide and mental illness are adequate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

- | | Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 129. The current media guidelines for the reporting on suicide and mental illness should be mandatory | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 130. I do not believe in censorship in relation to mental illness or suicide | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 131. Suicide risk may increase as a result of reading media reports about suicide | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

132. Any other comments you would like to add?

133. Would you be willing for the researcher to contact you by post in the future, to invite you to participate in further research?

- Yes ₁
- No ₂
- Don't know ₃

Thank you for completing this survey.
Please return this survey in the envelope provided.

If you have misplaced your envelope, or did not receive one, please send the survey to the following reply paid address:

Lara Bishop
CMHR – Building 63
Reply Paid 62656
AUSTRALIAN NATIONAL UNIVERSITY ACT 0200

At the completion of this project, in 2006, a report will be prepared outlining the findings. A press release will be sent to all journalists listed in the *Media Monitors Guide*. Alternatively, the results will be available online at the following website address:

<http://www.anu.edu.au/cmhr/> and click on the 'media' link.

HEALTH ATTITUDES OF MEDIA PROFESSIONALS IN AUSTRALIA

Appendix 8

HAMPA survey – early schizophrenia version



Please read the instructions before you begin.

HEALTH ATTITUDES OF MEDIA PROFESSIONALS IN AUSTRALIA



Please read the instructions before you begin.

Thank you for agreeing to take part in our survey. This survey is voluntary. As far as the law allows, all information you provide will be kept confidential. If you come to a question and you do not wish to answer it, please leave it blank.

1. Which age group do you belong to?

- | | | | | | |
|-------|--------------------------|---|-------|--------------------------|----|
| 18-19 | <input type="checkbox"/> | 1 | 50-54 | <input type="checkbox"/> | 8 |
| 20-24 | <input type="checkbox"/> | 2 | 55-59 | <input type="checkbox"/> | 9 |
| 25-29 | <input type="checkbox"/> | 3 | 60-64 | <input type="checkbox"/> | 10 |
| 30-34 | <input type="checkbox"/> | 4 | 65-69 | <input type="checkbox"/> | 11 |
| 35-39 | <input type="checkbox"/> | 5 | 70-74 | <input type="checkbox"/> | 12 |
| 40-44 | <input type="checkbox"/> | 6 | 75+ | <input type="checkbox"/> | 13 |
| 45-49 | <input type="checkbox"/> | 7 | | | |

2. What is your sex?

- Female 1 Male 2

3. What is the postcode of the place where you **usually work**?

4. What state or territory is this in?

- | | | | | | |
|-----------------|--------------------------|---|------------------------------|--------------------------|---|
| New South Wales | <input type="checkbox"/> | 1 | Western Australia | <input type="checkbox"/> | 5 |
| Victoria | <input type="checkbox"/> | 2 | Tasmania | <input type="checkbox"/> | 6 |
| Queensland | <input type="checkbox"/> | 3 | Northern Territory | <input type="checkbox"/> | 7 |
| South Australia | <input type="checkbox"/> | 4 | Australian Capital Territory | <input type="checkbox"/> | 8 |

5. What country were you born in?

- Australia 1
Outside Australia 2 (Please specify country _____)

6. What is the highest level of education you have completed?

- | | | |
|------------------------------------|--------------------------|---|
| Still attending school | <input type="checkbox"/> | 1 |
| Secondary school certificate | <input type="checkbox"/> | 2 |
| Trade certificate/apprenticeship | <input type="checkbox"/> | 3 |
| Other certificate | <input type="checkbox"/> | 4 |
| Associate or undergraduate diploma | <input type="checkbox"/> | 5 |
| Bachelor's degree | <input type="checkbox"/> | 6 |
| Higher degree (Masters, PhD) | <input type="checkbox"/> | 7 |
| Other | <input type="checkbox"/> | 8 |

7. Do you hold a Bachelor's degree or Higher degree (Masters, PhD)?

- | | | |
|--|--------------------------|---|
| Bachelor's degree in journalism only | <input type="checkbox"/> | 1 |
| Higher degree in journalism only | <input type="checkbox"/> | 2 |
| Both a Bachelor's and Higher degree in journalism | <input type="checkbox"/> | 3 |
| Other Bachelor's or Higher degree (not journalism) | <input type="checkbox"/> | 4 |
| Currently undertaking tertiary study | <input type="checkbox"/> | 5 |
| No tertiary training | <input type="checkbox"/> | 6 |

8. What is your current area of expertise? For example, journalist, features writer, health reporter, sports writer, editor, reporter etc. Please list.

9. What do you consider to be the major health problems in Australia at present?

10. Which of these is the most important health problem?

Please read the following story. The person in the story is not real, but there are people just like her. The subsequent questions are about things that might help the person described in this story.

Mary is 24 and lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last six months she has stopped seeing her friends and has begun locking herself in the bedroom and refusing to eat with the family or to have a bath. Her parents also hear her walking about her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone else is there. When they try to encourage her to do more things, she whispers that she won't leave home because she is being spied upon by the neighbour. They realise she is not taking drugs because she never sees anyone or goes anywhere.

11. What would you say, if anything, is wrong with Mary?

12. How do you think Mary could best be helped?

13. Imagine Mary is someone you have known for a long time and care about. You want to help her. What would you do?

There are a number of different people, some professional, some not, who could possibly help Mary.

Do you think the following people are likely to be helpful, harmful, or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
14. A typical GP or family doctor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15. A typical chemist or pharmacist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16. A counsellor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17. A social worker	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18. A telephone counselling service, such as lifeline	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19. A psychiatrist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20. A psychologist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
21. Help from Mary's family	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22. Help from close friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23. A naturopath or herbalist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24. A police officer	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25. The clergy, a minister or priest	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26. Mary dealing with it on her own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27. Other (please list) _____				

There are different kinds of help and treatment that could be offered by some of the people just mentioned. Do you think the following medicines are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
28. Vitamins and minerals, tonics or herbal medicines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29. Pain relievers, such as aspirin, codeine or panadol	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30. Anti-depressants	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31. Antibiotics	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32. Sleeping pills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33. Anti-psychotic medicines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34. Tranquillisers such as Valium	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35. Other (please list) _____				

Do you think the following treatments are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

		Helpful	Neither	Harmful	Don't Know
36.	Becoming more physically active, for example, playing more sport	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37.	Reading about people with similar problems and how they have dealt with them	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38.	Getting out and about more	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39.	Attending courses on relaxation, stress management, meditation or yoga	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40.	Cutting out alcohol altogether	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41.	Psychotherapy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42.	Hypnosis	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43.	Being admitted to the psychiatric ward of a hospital	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
44.	Undergoing electro-convulsive therapy (ECT)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45.	Having an occasional alcoholic drink to relax	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46.	Going on a special diet or avoiding certain foods	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Do you think the following are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

		Helpful	Neither	Harmful	Don't Know
47.	Consulting a website that gives information about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48.	Consulting an expert using email or The Web about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49.	Consulting a book that gives information about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50.	Receiving information about her health problem from a health educator	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51.	Other (please list) _____				

The next few questions ask what you think Mary's chances of recovery are.

52. What do you think the likely result would be if Mary had the professional help you think is most appropriate? (please tick the **one** box you feel is most true)

- Full recovery with no further problems ₁
- Full recovery, but problems would probably re-occur ₂
- Partial recovery ₃
- Partial recovery, but problems would probably re-occur ₄
- No improvement ₅
- Mary would get worse ₆
- Don't know/unsure ₇

53. What would be the likely result if Mary did **not** have any professional help?
 (please tick the **one** box you feel is most true.)

- Full recovery with no further problems ₁
- Full recovery, but problems would probably re-occur ₂
- Partial recovery ₃
- Partial recovery, but problems would probably re-occur ₄
- No improvement ₅
- Mary would get worse ₆
- Don't know/unsure ₇

Suppose that Mary had the sort of help that you think is the most appropriate for her problems. In the long term, compared to other people in the community, how likely do you think Mary would be; (tick one response for each line)

	More Likely	Same	Less Likely	Don't Know
54. To be violent?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55. To drink too much alcohol?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56. To use illegal drugs?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57. To have poor friendships?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58. To attempt suicide?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59. To be understanding of other people's feelings?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60. In the future, to have a good marriage?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61. To be a caring parent?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62. To be a productive worker?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63. To be creative or artistic?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

64. Do you think that Mary would be discriminated against, by others in the community, if they knew about the problems she had?

- Yes ₁ Please go to question 65
- No ₂ Please go to question 66
- Don't know ₃ Please go to question 66

65. In what ways do you think she would be discriminated against?

The next few questions contain statements about Mary's problem. Please indicate how strongly you personally agree or disagree with each statement. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
66. People with a problem like Mary's could snap out of it if they wanted	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
67. A problem like Mary's is a sign of personal weakness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
68. Mary's problem is not a real medical illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
69. People with a problem like Mary's are dangerous (to others)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
70. It is best to avoid people with a problem like Mary's so that you don't develop this problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
71. People with a problem like Mary's are unpredictable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
72. If I had a problem like Mary's I would not tell anyone	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
73. I would not employ someone if I knew they had a problem like Mary's	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
74. I would not vote for a politician if I knew they had experienced a problem like Mary's	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
75. People with a problem like Mary's have difficulty fitting into social situations	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Now we would like you to tell us what you think most other people believe. Please indicate how strongly you agree or disagree with the following statements. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
76. Most people believe that people with a problem like Mary's could snap out of it if they wanted	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
77. Most people believe that a problem like Mary's is a sign of personal weakness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
78. Most people believe that Mary's problem is not a real medical illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
79. Most people believe that people with a problem like Mary's are dangerous (to others)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
80. Most people believe that it is best to avoid people with a problem like Mary's so that you don't develop this problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
81. Most people believe that people with a problem like Mary's are unpredictable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

- | | Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 82. If they had a problem like Mary's most people would not tell anyone | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 83. Most people would not employ someone if they knew they had experienced a problem like Mary's | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 84. Most people would not vote for a politician they knew had experienced a problem like Mary's | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 85. Most people believe that people with a problem like Mary's have difficulty fitting into social situations | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

The next few questions are about how willing you would be to have contact with someone like Mary. (*tick one response for each line*)

- | | Definitely Willing | Probably Willing | Probably Unwilling | Definitely Unwilling | Don't Know |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 86. How willing would you be to move next door to Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 87. How willing would you be to spend an evening socialising with Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 88. How willing would you be to make friends with Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 89. How willing would you be to have Mary start working closely with you on a job? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 90. How willing would you be to have Mary marry into your family? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 91. How willing would you be to stay with your current partner if they had a problem like Mary's? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

There are many people in the community who experience problems like Mary's. The next few questions are about possible causes of this sort of problem developing in anybody.

How likely do you think each of the following is to be the cause of such problems? (*tick one response for each line*)

- | | Very Likely | Likely | Not Likely | Don't know |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 92. A virus or other infection? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 93. An allergy or reaction to foods or drinks? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 94. Day-to-day problems such as stress, family arguments, problems at work, or financial difficulties? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 95. The recent death of a close friend or relative? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 96. A recent traumatic event, eg. bushfires threatening your home, a bad traffic accident or being mugged? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

- | | Very
Likely | Likely | Not
Likely | Don't
know |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 97. Problems from childhood, such as being badly treated or abused? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 98. Inherited or genetic factors? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 99. Is being a nervous person likely to be a reason? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 100. Having weakness of character? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

101. Anything else? Please tell us what it is.

The next few questions ask your opinion about whether there are some people in the community who are more likely to have these problems and others who are perhaps less likely. (tick one response for each line)

- | | More
Likely | Same | Less
Likely | Don't
Know |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 102. Are women, rather than men, more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 103. Would young people, under 25 years of age, be more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 104. Would older people, those aged over 65, be more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 105. People who come from poorer neighbourhoods? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 106. People who are unemployed? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 107. Divorced or separated people? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 108. Single people, who have never been married or in a long-term relationship be more or less likely? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

109. Has anyone in your family or close circle of friends ever had problems similar to Mary's?

- Yes ₁ Please go to question 110
- No ₂ Please go to question 111
- Don't know ₃ Please go to question 111

110. Have they received any professional help or treatment for these problems?

- Yes ₁
- No ₂
- Don't know ₃

111. Have you ever had problems similar to Mary's?

Yes ₁ Please go to question 112

No ₂ Please go to question 113

Don't know ₃ Please go to question 113

112. Have you received any professional help or treatment for these problems?

Yes ₁

No ₂

Don't know ₃

113. Have you ever cared for someone with a problem like Mary's?

Yes ₁

No ₂

Don't know ₃

114. Have you ever written a story about, or interviewed a person, with a problem like Mary's?

Yes ₁

No ₂

Don't know ₃

The following questions are about certain types of health problems and the usefulness of various health services.

115. What do you consider to be the main mental illnesses in Australia at present?

116. Which of these is the most important mental illness?

Guidelines, which encourage responsible approaches to the reporting of suicide and mental illness, have been developed in Australia. The next few questions ask your opinion about these guidelines.

117. Have you read *Reporting Suicide and Mental Illness* (August 2002), which is a resource for media professionals on reporting suicide and mental illness?

Yes ₁

No ₂

Don't know ₃

118. Have you read any other guidelines on the responsible reporting of suicide and mental illness?

Yes (please list) ₁ _____

No ₂

Don't know ₃

119. Have you heard of any organisations that provide information about mental illness? If so, please list these. Asterisk any of the listed organisations you have acquired information from.

Please indicate how strongly you agree or disagree with the following statements. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
120. The Australian media plays an important role in influencing social attitudes about mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
121. The Australian media plays an important role in influencing social attitudes about suicide	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
122. Most media report suicide and mental illness appropriately	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
123. Negative reporting of mental illness impacts significantly on people experiencing a mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
124. I follow suggested media guidelines when reporting about suicide or mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
125. My colleagues follow suggested media guidelines when reporting about suicide or mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
126. The presentation of negative images of mental illness in both fiction and non-fiction media results in the development of more negative beliefs about mental illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
127. Responsible reporting about mental illness and suicide is a priority for the media	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
128. The current media guidelines for the reporting on suicide and mental illness are adequate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

129. The current media guidelines for the reporting on suicide and mental illness should be mandatory

Strongly Agree ₁ Agree ₂ Neither Agree nor Disagree ₃ Disagree ₄ Strongly Disagree ₅

130. I do not believe in censorship in relation to mental illness or suicide

₁ ₂ ₃ ₄ ₅

131. Suicide risk may increase as a result of reading media reports about suicide

₁ ₂ ₃ ₄ ₅

132. Any other comments you would like to add?

133. Would you be willing for the researcher to contact you by post in the future, to invite you to participate in further research?

Yes ₁
No ₂
Don't know ₃

Thank you for completing this survey.
Please return this survey in the envelope provided.

If you have misplaced your envelope, or did not receive one, please send the survey to the following reply paid address:

Lara Bishop
CMHR – Building 63
Reply Paid 62656
AUSTRALIAN NATIONAL UNIVERSITY ACT 0200

At the completion of this project, in 2006, a report will be prepared outlining the findings. A press release will be sent to all journalists listed in the *Media Monitors Guide*. Alternatively, the results will be available online at the following website address:

<http://www.anu.edu.au/cmhr/> and click on the 'media' link.

HEALTH ATTITUDES OF MEDIA PROFESSIONALS IN AUSTRALIA

Appendix 9

HAMPA survey – postnatal depression version



Prepared for the Department of Health and Ageing

HEALTH ATTITUDES OF MEDIA PROFESSIONALS IN AUSTRALIA



Please read the instructions before you begin.

Thank you for agreeing to take part in our survey. This survey is voluntary. As far as the law allows, all information you provide will be kept confidential. If you come to a question and you do not wish to answer it, please leave it blank.

1. Which age group do you belong to?

- | | | | | | |
|-------|--------------------------|---|-------|--------------------------|----|
| 18-19 | <input type="checkbox"/> | 1 | 50-54 | <input type="checkbox"/> | 8 |
| 20-24 | <input type="checkbox"/> | 2 | 55-59 | <input type="checkbox"/> | 9 |
| 25-29 | <input type="checkbox"/> | 3 | 60-64 | <input type="checkbox"/> | 10 |
| 30-34 | <input type="checkbox"/> | 4 | 65-69 | <input type="checkbox"/> | 11 |
| 35-39 | <input type="checkbox"/> | 5 | 70-74 | <input type="checkbox"/> | 12 |
| 40-44 | <input type="checkbox"/> | 6 | 75+ | <input type="checkbox"/> | 13 |
| 45-49 | <input type="checkbox"/> | 7 | | | |

2. What is your sex?

- Female ₁ Male ₂

3. What is the postcode of the place where you **usually work**?

4. What state or territory is this in?

- | | | | | | |
|-----------------|--------------------------|---|------------------------------|--------------------------|---|
| New South Wales | <input type="checkbox"/> | 1 | Western Australia | <input type="checkbox"/> | 5 |
| Victoria | <input type="checkbox"/> | 2 | Tasmania | <input type="checkbox"/> | 6 |
| Queensland | <input type="checkbox"/> | 3 | Northern Territory | <input type="checkbox"/> | 7 |
| South Australia | <input type="checkbox"/> | 4 | Australian Capital Territory | <input type="checkbox"/> | 8 |

5. What country were you born in?

- Australia ₁
Outside Australia ₂ (Please specify country _____)

6. What is the highest level of education you have completed?

- | | | |
|------------------------------------|--------------------------|---|
| Still attending school | <input type="checkbox"/> | 1 |
| Secondary school certificate | <input type="checkbox"/> | 2 |
| Trade certificate/apprenticeship | <input type="checkbox"/> | 3 |
| Other certificate | <input type="checkbox"/> | 4 |
| Associate or undergraduate diploma | <input type="checkbox"/> | 5 |
| Bachelor's degree | <input type="checkbox"/> | 6 |
| Higher degree (Masters, PhD) | <input type="checkbox"/> | 7 |
| Other | <input type="checkbox"/> | 8 |

7. Do you hold a Bachelor's degree or Higher degree (Masters, PhD)?

- | | | |
|--|--------------------------|---|
| Bachelor's degree in journalism only | <input type="checkbox"/> | 1 |
| Higher degree in journalism only | <input type="checkbox"/> | 2 |
| Both a Bachelor's and Higher degree in journalism | <input type="checkbox"/> | 3 |
| Other Bachelor's or Higher degree (not journalism) | <input type="checkbox"/> | 4 |
| Currently undertaking tertiary study | <input type="checkbox"/> | 5 |
| No tertiary training | <input type="checkbox"/> | 6 |

8. What is your current area of expertise? For example, journalist, features writer, health reporter, sports writer, editor, reporter etc. Please list.

9. What do you consider to be the major health problems in Australia at present?

10. Which of these is the most important health problem?

Please read the following story. The person in the story is not real, but there are people just like her. The subsequent questions are about things that might help the person described in this story.

Six weeks after having her child, Mary is crying most days and is unable to sleep even when her child sleeps through. She is worrying constantly about her baby and thinks there is something wrong. She believes she is a bad mother and shouldn't have had a baby. Most days when she wakes she wishes she were dead. James, her husband, finds there is nothing he can say to Mary that makes her feel better.

11. What would you say, if anything, is wrong with Mary?

12. How do you think Mary could best be helped?

13. Imagine Mary is someone you have known for a long time and care about. You want to help her. What would you do?

There are a number of different people, some professional, some not, who could possibly help Mary.

Do you think the following people are likely to be helpful, harmful, or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
14. A typical GP or family doctor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15. A typical chemist or pharmacist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16. A counsellor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17. A social worker	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18. A telephone counselling service, such as lifeline	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19. A psychiatrist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20. A psychologist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
21. Help from Mary's family	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22. Help from close friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23. A naturopath or herbalist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24. A police officer	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25. The clergy, a minister or priest	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26. Mary dealing with it on her own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27. Other (please list) _____				

There are different kinds of help and treatment that could be offered by some of the people just mentioned. Do you think the following medicines are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
28. Vitamins and minerals, tonics or herbal medicines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29. Pain relievers, such as aspirin, codeine or panadol	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30. Anti-depressants	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31. Antibiotics	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32. Sleeping pills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33. Anti-psychotic medicines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34. Tranquillisers such as Valium	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35. Other (please list) _____				

Do you think the following treatments are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
36. Becoming more physically active, for example, playing more sport	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37. Reading about people with similar problems and how they have dealt with them	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38. Getting out and about more	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39. Attending courses on relaxation, stress management, meditation or yoga	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40. Cutting out alcohol altogether	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41. Psychotherapy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42. Hypnosis	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43. Being admitted to the psychiatric ward of a hospital	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
44. Undergoing electro-convulsive therapy (ECT)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45. Having an occasional alcoholic drink to relax	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46. Going on a special diet or avoiding certain foods	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Do you think the following are likely to be helpful, harmful or neither helpful nor harmful for Mary? (tick one response for each line)

	Helpful	Neither	Harmful	Don't Know
47. Consulting a website that gives information about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48. Consulting an expert using email or The Web about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49. Consulting a book that gives information about her problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50. Receiving information about her health problem from a health educator	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51. Other (please list) _____				

The next few questions ask what you think Mary's chances of recovery are.

52. What do you think the likely result would be if Mary had the professional help you think is most appropriate? (please tick the **one** box you feel is most true)

- Full recovery with no further problems ₁
- Full recovery, but problems would probably re-occur ₂
- Partial recovery ₃
- Partial recovery, but problems would probably re-occur ₄
- No improvement ₅
- Mary would get worse ₆
- Don't know/unsure ₇

53. What would be the likely result if Mary did **not** have any professional help?
 (please tick the **one** box you feel is most true.)

- Full recovery with no further problems ₁
- Full recovery, but problems would probably re-occur ₂
- Partial recovery ₃
- Partial recovery, but problems would probably re-occur ₄
- No improvement ₅
- Mary would get worse ₆
- Don't know/unsure ₇

Suppose that Mary had the sort of help that you think is the most appropriate for her problems. In the long term, compared to other people in the community, how likely do you think Mary would be; (tick one response for each line)

	More Likely	Same	Less Likely	Don't Know
54. To be violent?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55. To drink too much alcohol?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56. To use illegal drugs?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57. To have poor friendships?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58. To attempt suicide?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59. To be understanding of other people's feelings?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60. In the future, to have a good marriage?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61. To be a caring parent?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62. To be a productive worker?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63. To be creative or artistic?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

64. Do you think that Mary would be discriminated against, by others in the community, if they knew about the problems she had?

- Yes ₁ Please go to question 65
- No ₂ Please go to question 66
- Don't know ₃ Please go to question 66

65. In what ways do you think she would be discriminated against?

The next few questions contain statements about Mary's problem. Please indicate how strongly you personally agree or disagree with each statement. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
66. People with a problem like Mary's could snap out of it if they wanted	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
67. A problem like Mary's is a sign of personal weakness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
68. Mary's problem is not a real medical illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
69. People with a problem like Mary's are dangerous (to others)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
70. It is best to avoid people with a problem like Mary's so that you don't develop this problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
71. People with a problem like Mary's are unpredictable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
72. If I had a problem like Mary's I would not tell anyone	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
73. I would not employ someone if I knew they had a problem like Mary's	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
74. I would not vote for a politician if I knew they had experienced a problem like Mary's	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
75. People with a problem like Mary's have difficulty fitting into social situations	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Now we would like you to tell us what you think most other people believe. Please indicate how strongly you agree or disagree with the following statements. (tick one response for each line)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
76. Most people believe that people with a problem like Mary's could snap out of it if they wanted	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
77. Most people believe that a problem like Mary's is a sign of personal weakness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
78. Most people believe that Mary's problem is not a real medical illness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
79. Most people believe that people with a problem like Mary's are dangerous (to others)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
80. Most people believe that it is best to avoid people with a problem like Mary's so that you don't develop this problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
81. Most people believe that people with a problem like Mary's are unpredictable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

- | | Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 82. If they had a problem like Mary's most people would not tell anyone | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 83. Most people would not employ someone if they knew they had experienced a problem like Mary's | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 84. Most people would not vote for a politician they knew had experienced a problem like Mary's | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 85. Most people believe that people with a problem like Mary's have difficulty fitting into social situations | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

The next few questions are about how willing you would be to have contact with someone like Mary. (tick one response for each line)

- | | Definitely Willing | Probably Willing | Probably Unwilling | Definitely Unwilling | Don't Know |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 86. How willing would you be to move next door to Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 87. How willing would you be to spend an evening socialising with Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 88. How willing would you be to make friends with Mary? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 89. How willing would you be to have Mary babysit your children? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 90. How willing would you be to have Mary marry into your family? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 91. How willing would you be to stay with your current partner if they had a problem like Mary's? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

There are many people in the community who experience problems like Mary's. The next few questions are about possible causes of this sort of problem developing in anybody.

How likely do you think each of the following is to be the cause of such problems? (tick one response for each line)

- | | Very Likely | Likely | Not Likely | Don't know |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 92. A virus or other infection? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 93. An allergy or reaction to foods or drinks? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 94. Day-to-day problems such as stress, family arguments, problems at work, or financial difficulties? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 95. The recent death of a close friend or relative? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 96. A recent traumatic event, eg. bushfires threatening your home, a bad traffic accident or being mugged? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

- | | Very Likely | Likely | Not Likely | Don't know |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 97. Problems from childhood, such as being badly treated or abused? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 98. Inherited or genetic factors? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 99. Is being a nervous person likely to be a reason? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 100. Having weakness of character? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

101. Anything else? Please tell us what it is.

The next few questions ask your opinion about whether there are some people in the community who are more likely to have these problems and others who are perhaps less likely. (tick one response for each line)

- | | More Likely | Same | Less Likely | Don't Know |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 102. Are women, rather than men, more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 103. Would young people, under 25 years of age, be more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 104. Would older people, those aged over 65, be more or less likely to have these problems? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 105. People who come from poorer neighbourhoods? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 106. People who are unemployed? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 107. Divorced or separated people? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |
| 108. Single people, who have never been married or in a long-term relationship be more or less likely? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

109. Has anyone in your family or close circle of friends ever had problems similar to Mary's?

- Yes ₁ Please go to question 110
- No ₂ Please go to question 111
- Don't know ₃ Please go to question 111

110. Have they received any professional help or treatment for these problems?

- Yes ₁
- No ₂
- Don't know ₃

111. Have you ever had problems similar to Mary's?

- Yes ₁ Please go to question 112
No ₂ Please go to question 113
Don't know ₃ Please go to question 113

112. Have you received any professional help or treatment for these problems?

- Yes ₁
No ₂
Don't know ₃

113. Have you ever cared for someone with a problem like Mary's?

- Yes ₁
No ₂
Don't know ₃

114. Have you ever written a story about, or interviewed a person, with a problem like Mary's?

- Yes ₁
No ₂
Don't know ₃

The following questions are about certain types of health problems and the usefulness of various health services.

115. What do you consider to be the main mental illnesses in Australia at present?

116. Which of these is the most important mental illness?

Guidelines, which encourage responsible approaches to the reporting of suicide and mental illness, have been developed in Australia. The next few questions ask your opinion about these guidelines.

117. Have you read *Reporting Suicide and Mental Illness* (August 2002), which is a resource for media professionals on reporting suicide and mental illness?

- Yes ₁
No ₂
Don't know ₃

118. Have you read any other guidelines on the responsible reporting of suicide and mental illness?

- Yes (please list) ₁ _____
- No ₂
- Don't know ₃

119. Have you heard of any organisations that provide information about mental illness? If so, please list these. Asterisk any of the listed organisations you have acquired information from.

Please indicate how strongly you agree or disagree with the following statements. (tick one response for each line)

- | | Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 120. The Australian media plays an important role in influencing social attitudes about mental illness | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 121. The Australian media plays an important role in influencing social attitudes about suicide | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 122. Most media report suicide and mental illness appropriately | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 123. Negative reporting of mental illness impacts significantly on people experiencing a mental illness | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 124. I follow suggested media guidelines when reporting about suicide or mental illness | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 125. My colleagues follow suggested media guidelines when reporting about suicide or mental illness | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 126. The presentation of negative images of mental illness in both fiction and non-fiction media results in the development of more negative beliefs about mental illness | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 127. Responsible reporting about mental illness and suicide is a priority for the media | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 128. The current media guidelines for the reporting on suicide and mental illness are adequate | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
129. The current media guidelines for the reporting on suicide and mental illness should be mandatory	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

130. I do not believe in censorship in relation to mental illness or suicide	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
--	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

131. Suicide risk may increase as a result of reading media reports about suicide	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
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132. Any other comments you would like to add?

133. Would you be willing for the researcher to contact you by post in the future, to invite you to participate in further research?

Yes ₁
No ₂
Don't know ₃

Thank you for completing this survey.
Please return this survey in the envelope provided.

If you have misplaced your envelope, or did not receive one, please send the survey to the following reply paid address:

Lara Bishop
CMHR – Building 63
Reply Paid 62656
AUSTRALIAN NATIONAL UNIVERSITY ACT 0200

At the completion of this project, in 2006, a report will be prepared outlining the findings. A press release will be sent to all journalists listed in the *Media Monitors Guide*. Alternatively, the results will be available online at the following website address:

<http://www.anu.edu.au/cmhr/> and click on the 'media' link.



THE AUSTRALIAN NATIONAL UNIVERSITY
RESEARCH ETHICS COMMITTEE

Appendix 10

The Australian National University Human Research Ethics Committee application form – HAMP survey

[The content of this form is extremely faint and illegible. It appears to be a standard ethics application form with various sections for project details, researcher information, and ethical considerations.]



THE AUSTRALIAN NATIONAL UNIVERSITY
HUMAN RESEARCH ETHICS COMMITTEE
APPLICATION FORM

Surname of Researcher: Bishop
First name/s: Lara
Title (e.g. Ms., Mr., Dr. etc.): Ms

Position Held (staff, postgraduate, undergraduate, etc.): Postgraduate

Student or Staff ID no. (if applicable): u3493145

Dept/School/Centre: Centre for Mental health Research

Mailing address: Bldg 63, ANU, Acton, ACT 0200

Telephone: (02) 6125 8699

Fax: (02) 6125 0733

Email: lara.bishop@anu.edu.au

For students:

Name of ANU supervisor: Professor Helen Christensen,
Dr Kathy Griffiths and
Professor Tony Jorm

Email address of ANU supervisor: Helen.Christensen@anu.edu.au;
Kathy.Griffiths@anu.edu.au; Anthony.Jorm@anu.edu.au

PROJECT TITLE: Health Attitudes of Media Professionals in Australia

Date of this application: 31 July, 2003

Anticipated start date for project: September 2003 **Anticipated end date:**
February 2006

1. *The researcher/s*

Who are the investigators (including assistants) who will conduct the research and what are their qualification and experience? Please include their Department/School/Centre (or external institution for external researchers). Students should not include supervisors at this point unless they are actually participating in the research project as partner researchers.

Lara Bishop, BA, BAppSci (Honours), current PhD student, Centre for Mental Health Research, ANU.

I have had extensive experience working on community projects to develop information about mental health literacy (Currently, Chair of beyondbabyblues subcommittee of beyondblue). I conducted a large survey of Australian Councils, for my honours thesis. I have compiled material about depression from individuals, I am a member of a larger consumer organisation and have written a book for a lay audience on postnatal depression.

2. *Understanding the national guidelines, the “National Statement on Ethical Conduct in Research Involving Humans” (1999)*

Can the proposer certify that the persons listed in the answer to Question 1 above have been fully briefed on appropriate procedures and in particular that they have read and are familiar with the national guidelines issued by the National Health and Medical Research Council (the *National Statement on Ethical Conduct in Research Involving Humans*) (cited below as the “National Statement”)? If there are guidelines from any relevant professional body with which the researcher/s are familiar they should also be listed below.

I have read, and am familiar with the NHMRC’s National Statement on Ethical Conduct in Research Involving Humans and believe this research is within these guidelines.

3. *Purpose and design of the proposed research*

(a) Briefly describe the basic purposes of the research proposed (*in plain language intelligible to a non-specialist*).

The PhD project has two stages. In the first stage, I aim to compare the mental health literacy (attitudes and beliefs about mental health problems and their management) of Australian newspaper journalists with 3rd year journalism students in Australia using survey methodology. Later, at a second stage of the project, I intend to develop and then evaluate interventions aimed at increasing the mental health literacy of media groups. Overseas research has shown that around 30 – 40% of people obtain mental health information from media sources, yet this information is often inaccurate, stereotypical and stigmatising. It is hoped that this research will aid in increasing mental health knowledge amongst journalist participants, so that stories reported by the Australian print media more accurately represent mental illnesses and the people who have them. Current journalism students in Australian Universities are required to complete a mandatory unit in mental health as part of their course requirements, so they have been chosen for this project to see if they have higher rates of mental health literacy than established journalists. This research will provide an overview of the accuracy of mental health knowledge in journalists and methods that are likely to improve this knowledge.

(b) Outline the design of the project (in plain language intelligible to a non-specialist). (If interviewing people or administering a survey/questionnaire, please attach either a list of the broad questions you propose to ask, or a copy of the questionnaire.)

The project will be conducted in two phases. **The first phase, which is covered in this ethics application,** involves sampling all Australian print media journalists who work for a metropolitan or regional newspaper, and asking those sampled to complete a questionnaire that assesses their mental health literacy (see attached draft questionnaires and introductory letter). There are three versions of the questionnaire, each with a different vignette and journalists will be randomly assigned to receive one of the three questionnaires. The contact details for all Australian journalists will be obtained from the publicly available guide "*Media Monitors*". Each questionnaire contains a description of an individual with a mental health problem, and participants answer questions about this person plus a number of other questions assessing stigma and attitudes to health issues. These questionnaires (or very similar variants) have been used repeatedly by the CMHR and other research groups since 1996.

4. Sources of data involving humans

To ensure compliance with privacy legislation the committee needs to know your sources of information, i.e. where you are obtaining data involving humans. If you are using individual participants, tick at (a). If you are accessing personal records held by government departments or agencies, or by other bodies, e.g. private sector organisations, please tick and complete the relevant sections (b), (c) and/or (d) below.

- (a) Individual subjects ()
- (b) Commonwealth Department/s or agency (*specify*) (
).....
- (c) State/Territory Department/s or agency (*specify*) (
).....
- (d) Other sources (*specify*) (✓) *Media Monitors*
 Guide for journalists and university course co-ordinators for 3rd year journalism students
 (see qns 5 & 6).

5. Personal identifiable data for medical/health research

Are you obtaining personal identifiable data specifically for medical/health research that is held by a government or private sector agency? (The committee needs this information to determine whether it needs to comply with relevant National Health and Medical Research Council guidelines relating to privacy legislation.)

YES

Information will be obtained from the *Media Monitors* Guide, which is freely available to the public. This guide lists all journalists by name, the paper they work for, their job title and contact details. I will link the names of journalists to the questionnaire using an ID number. This linking will be treated confidentially. Files linking ID numbers and names will be held separately. Questionnaires will never be linked back to names.

Questionnaires going to 3rd year journalism students will have no identifying number. The only identifying feature will be an "s" in the top right hand corner of the questionnaire which will identify that it is a student questionnaire.

6. *Recruitment*

Describe how participants will be recruited for this project. Indicate how many participants are likely to be involved, how initial contact will be made, and how participants will be invited to take part in this project. A copy of any relevant correspondence should be attached to this application. Does the recruitment process raise any privacy issues, e.g. does the researcher plan to access personal information to identify potential participants without their knowledge or consent? Describe the steps to be taken to ensure that participation or refusal to participate will not impair any existing relationship between participants and researcher or institution involved.

Participants will include journalists and third year journalism students from Australian Universities.

All Australian Newspaper journalists (approximately 5000) who are permanently on staff and attached to a "metropolitan" or "regional" newspaper and who are named and identified in the latest *Media Monitors* guide –will receive a mental health literacy questionnaire. Questionnaires will be sent by conventional post. One reminder will be sent.

About 1000 students from approximately 20 universities will be recruited. Course co-ordinators at each university will be approached and asked to distribute the questionnaire to third year journalism students. Participation will be voluntary. No credit will be given to students for the completion of this questionnaire. Course co-ordinators will be asked to provide students with the questionnaire and an individual reply paid envelope. Students will then be able to complete the questionnaire at their leisure and return it upon completion. This will ensure that individual students responses are confidential. In addition, no class lists will be provided to the researcher, so students will retain total anonymity.

On the first page of the questionnaire, all participants are advised that the questionnaire is totally voluntary.

7. *Arrangements for access to identifiable data held by another party*

In cases where participants are identified from information held by another party (e.g. government department, non-governmental organisation, private company, community association, doctor, hospital) describe the arrangement whereby you will gain access to this information. Attach any relevant correspondence.

As stated previously, information will be obtained from the publication, *Media Monitors* Guide. This guide is freely available to the general public at the National Library and other libraries or can be purchased from the Media Monitors Agency. Journalism students will never be identified

to the researcher as the questionnaires will be distributed only by the relevant course co-ordinators and will be returned by individual students.

8. *Vulnerable participants*

Will participants include students, children, the mentally ill or others in a dependent relationship? If so, provide details.

No.

9. *Payment*

Will payment be made to any participants? If so, give details of arrangements.

No payments will be made.

10. *Consent*

Describe the consent issues involved in this proposal (see the National Statement, in particular Section 1.7-12, and other sections relevant to your research). Describe the procedures to be followed in obtaining the informed consent of participants and/or of others responsible. Attach any relevant documents such as a consent form, information sheet, letter of invitation etc. If you do not propose to obtain written consent (e.g. if working with non-literate people) give a detailed explanation of the reasons for seeking oral consent, describe the procedure you intend to adopt, and specify the information to be provided to participants. If you have answered YES to Question 8 above please address any issues of consent and the possibility of coercion.

Both the introductory letter and the questionnaire clearly explain that participation in the project is voluntary. Filling out and return of the questionnaire will imply consent.

11. *Protection of privacy (confidentiality)*

Describe the confidentiality issues involving in this proposal. Give details of the measures that will be adopted to protect confidential information about participants, both in handling and storing raw research data and in any publications. Blanket guarantees of confidentiality are not helpful. If the term “confidential” is used in information provided to participants, a full description of what precisely confidentiality means in the context of this research should be given. You should be aware that, under Australian law, any data you collect can potentially be subpoenaed. Depending on the nature of your research, it may be helpful to qualify promises of confidentiality with terms such as “as far as possible” or “as far as the law allows”. [See the National Statement, in particular Sections 1.19, 18 and Appendix II]

On return all questionnaires will be kept in a locked filing cabinet in a locked room in a security protected building (the CMHR). Names will not be kept with these records. The list linking names and Ids will be stored in the fireproof chubb safe located in the older wing of CMHR.

(Names of journalists are required to allow reminders to be sent, to link to the specialist areas of the journalist, and to allow me to re contact participants for phase 2 of the study). Published material will never include the names of participants. Aggregate data only will be published, and individuals will not be able to be identified (small cell numbers will be carefully scrutinised for this risk).

12. Cultural or social considerations

Comment on any cultural or social considerations that may affect the design of the research. [*See the National Statement, in particular Sections 1.2 and 1.19*].

Prior to sending out the questionnaire, it will be piloted on a small number of journalists who will be asked to provide and asked to give feedback on the relevance of the questions and any minor alterations that need to be made. In this way, it is hoped that the research will be especially relevant to all journalists. We include demographic questions pertinent to journalists from culturally diverse backgrounds in order to determine if there is significant variation in mental health literacy according to cultural background, although this is not a focus of this study.

13. How the research might impact on participants

Describe and discuss any possible impact of the proposed research on the participants or their communities that you can foresee. This might include psychological, health, social, economic or political changes or ramifications.

Discuss how you will try to minimise any impact. [*See the National Statement, in particular Sections 1.3 to 1.6 and Section 1.14*]

A large component of the questionnaire requires answers to a series of simple questions about mental health literacy and is unlikely to affect the participants at all. There are a small number of questions relating specifically to emotional states and concerns. With any research in mental health, there is a small risk of distress in particularly sensitive participants. The introductory letter clearly invites participants to contact the researcher or her supervisor if they have any concerns. If necessary, participants will be advised of support services. Participants are provided with the phone number of lifeline in the introductory letter. Lifeline will refer to an appropriate mental health service if necessary.

The feedback we have had when piloting the questionnaire amongst colleagues has been very positive. No person has become distressed by the questions. Overall the experience has been enjoyable and of interest to participants.

14. Other ethical and any legal considerations

Comment on any other ethical considerations that are involved in this proposal, including any potential for legal difficulties to arise for participants.

No legal difficulties are anticipated.

15. *Benefits versus risks*

Describe the possible benefit/s to be gained from the proposed research. Explain why these benefits outweigh or justify any possible discomforts and risks to participants. In framing your explanation make explicit reference to the ethical considerations mentioned in your answers to previous questions on this form. [See the National Statement, in particular Sections 1.3-6 and 1.13-14]

It is hoped that this research will aid in increasing mental health knowledge amongst participants, so that stories reported by the Australian print media more accurately represent mental illnesses. We anticipate that this in turn will have a positive effect on people with mental illnesses.

A report of findings will be disseminated through the CMHR website in 2006. A press release of the findings will be sent to all participating and non-participating journalists. The findings are also planned to be published in peer review articles.

The potential benefits therefore far outweigh the very minimal risks involved.

16. *Handling possible problems arising from the research*

Describe the arrangements you have made to handle concerns and complaints by participants, or emergencies involving participants or researchers.

No problems are expected to arise with this research.

Participants who have any concerns or complaints can access either the researcher (Lara Bishop) or her supervisor (Professor Helen Christensen) as both telephone and email contact details are provided for both parties in an introductory letter. In addition, the introductory letter provides the contact details for the Human Ethics Officer at ANU (Ms Sylvia Deutsch).

17. RESEARCH PROTOCOL CHECKLIST

There are some key ethical principles that need to be addressed in your protocol (as an ethics application is known). In particular the committee needs to see how you have addressed the issue of informed consent and the issue of confidentiality, i.e. how the identities of participants will be protected in the raw research data and in published material. The usual way to obtain informed consent is in writing, by use of a consent form that is signed by the participant and retained by you. Because you retain the consent form the same information needs to be included in an information sheet that participants retain. Both the consent form and the information sheet should include your name, contact details, title and brief description of the project, details on how the identities of participants will be protected (both when storing the raw research data and in its published form), a statement that participation is voluntary and participants can withdraw at any time, and contact details for the Human Research Ethics Committee in case of any ethical concerns. If you do not propose to seek written consent, you need to explain why oral consent will be sufficient and how you propose to obtain it.

Please tick the relevant boxes below to indicate what has been included in your protocol:

- Outline of proposal and purpose Yes
 No
- Measures to be taken to protect confidentiality Yes
 No
- Explanation of how informed consent will be obtained Yes
 No

If written consent is not being sought, justification of a verbal consent procedure is included Yes

- Full details on investigators (name, institution, etc.) Yes
 No
- All researchers on this project are familiar with the national guidelines (*National Statement*) Yes
 No
- Details re how participants will be recruited Yes
 No

- Is personal data from a Commonwealth department/agency or private sector organisation being used?
 Yes No

- Details on how cultural and social sensitivities will be addressed Yes
 No

- Consideration of likely risk to participants (e.g. psychological stress; cultural, social, political or economic ramifications) Yes
 No

Do your research participants include:

- | | | |
|---|------------------------------|--|
| Aboriginal or Torres Strait Islander peoples | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Children and young people (i.e. minors under the age of 18) | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| People with an intellectual or mental impairment | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| People highly dependent on medical case | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| People in dependent or unequal relationships | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

- Do you intend to pay participants? Yes No

Description of method and amount is included Yes

- Description of clinical facilities (for medical research) Yes No

Period of research

Yes

No

SUPPORTING DOCUMENTATION: *The committee requires copies of all relevant documents*

Consent form to be signed by participants

Yes

No

Information sheet for participants to retain

Yes

No

Dot point list of the points that will be made when seeking verbal consent

Yes

List of interview questions

Yes

No

Copy of questionnaire/s

Yes

No

Invitation or introductory letter/s

Yes

No

Publicity material (posters etc.)

Yes

No

Other (*specify*)

Yes

No

18. SIGNATURES AND UNDERTAKINGS

PROPOSER OF THE RESEARCH

I certify that the above is as accurate a description of my research proposal as possible and that the research will be conducted in accordance with the *National Statement on Ethical Conduct in Research Involving Humans* (version current at time of application). I also agree to adhere to the conditions of approval stipulated by the ANU Human Research Ethics Committee (HREC) and will cooperate with HREC monitoring requirements. I agree to notify the Committee in writing immediately of any significant departures from this protocol and will not continue the research if ethical approval is withdrawn and will comply with any special conditions required by the HREC.

Name and title (please print):
(Proposer of research)

Signed:..... Date:.....

SUPERVISOR

Where the proposal is from a student, the Supervisor is asked to certify the accuracy of the above account.

I certify that I shall provide appropriate supervision to the student to ensure that the project is undertaken in accordance with the undertakings above:

Name and title (please print):
(Supervisor)

Department/School/Centre:

Signed:.....

Date:.....



COMMENT ON PROJECT FROM HEAD OF DEPARTMENT/GROUP/CENTRE:

The Head of Department/School/Centre is asked to certify that this proposal has his/her support:

I certify that:

- I am familiar with this project and endorse its undertakings;
- the resources required to undertake this project are available; and
- the investigators have the skill and expertise to undertake this project appropriately.

Any additional comments (optional):

Name and title (please print):.....
(Head of Department/Group/Centre)

Department/School/Centre:

Signed:.....

Date:.....

Applications should be submitted as follows:

(a) 13 hard copies (one master copy with original signatures + 12 photocopies) and all supporting documentation

PLUS

(b) an identical email version emailed to
Human.Ethics.Officer@anu.edu.au.

Hard copies of the completed protocol form, together with all supporting documents, should be sent to:

The Secretary
Human Research Ethics Committee
Research Services Office
Chancelry 10B
The Australian National University ACT 0200

Tel: 6125-2900
Fax: 6125-4807
Email: Human.Ethics.Officer@anu.edu.au



Appendix 11 Information Sheet – HAMP survey

The proposed health consultation by EPA to HHS is a voluntary activity. The HHS will be invited to participate in the health consultation if the Agency has received a request for a health consultation regarding the project.

The health consultation will be conducted in a confidential and non-proprietary manner. The HHS will be invited to participate in the health consultation if the Agency has received a request for a health consultation regarding the project.

All information that you provide will be kept confidential. The information that you provide will be used to determine if there is a need for a health consultation. The information that you provide will be used to determine if there is a need for a health consultation.

To be invited, you must first be invited by EPA. EPA will invite you to participate in the health consultation if the Agency has received a request for a health consultation regarding the project.

If the need for a health consultation is determined, EPA will invite you to participate in the health consultation. The information that you provide will be used to determine if there is a need for a health consultation.

The information that you provide will be kept confidential. The information that you provide will be used to determine if there is a need for a health consultation.

The information that you provide will be kept confidential. The information that you provide will be used to determine if there is a need for a health consultation.

The information that you provide will be kept confidential. The information that you provide will be used to determine if there is a need for a health consultation.



HEALTH ATTITUDES OF MEDIA PROFESSIONALS IN AUSTRALIA

INFORMATION SHEET

Principal Researcher: Ms Lara Bishop Australian National University Ph: (02) 6125 8699 Email: Lara.Bishop@anu.edu.au	Research Supervisor: Professor Helen Christensen Australian National University Ph: (02) 6125 2741 Email: Helen.Christensen@anu.edu.au
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“Health Attitudes of Media Professionals in Australia” is a large study designed to find out what Australian print media journalists and Australian journalism students think about health issues affecting Australians.

The project is being conducted by Lara Bishop, a PhD student in the National Institute for Health and Human Sciences at the Australian National University in Canberra. Professor Helen Christensen is overseeing the project.

The enclosed survey has been sent to all Australian print media journalists who are listed in the Media Monitors guide and who are employed by an Australian newspaper and about 300 journalism students. We would be grateful if you could fill in this survey and return it to us.

All information that you provide will be treated confidentially. Every aspect of the research in the “Health Attitudes of Media Professionals in Australia” project is carried out strictly in accordance with the ethical guidelines set out by the National Health and Medical Research Council. This means that your survey will only be identified by an ID number and that files linking ID numbers and names are held separately. Surveys are never linked back to names¹.

To be involved, you simply need to complete the enclosed survey and return it in the reply paid envelope. It will take about 20 minutes for you to complete this survey. All responses are helpful. The more people that complete this survey, the more meaningful our study results will be. Participation in this research is totally voluntary and participants may withdraw at any time.

At the end of the survey, you will be asked if we may contact you again at some time in the future to invite you to participate in further research. Even if you do not wish to be contacted by us in the future, we would appreciate it if you could fill in this initial survey.

We value your interest in our project and look forward to your responses.

If you have any queries about this project please contact either Lara Bishop or Professor Christensen.

Yours sincerely,

Lara Bishop

¹This study has been approved by the Australian National University Human Research Ethics Committee. If you have any questions about this ethics approval, please contact Ms Sylvia Deutsch – Human Ethics Officer, The Australian National University, ACT 0200, Tel: 6125 2900; Fax 6125 4807; email: Human.Ethics.Officer@anu.edu.au



Dr. [Name]
[Address]
[City, State, Zip]

12 January 2004

Appendix 12 Information Sheet – HAMP survey

I am writing to follow up on a letter that I sent to describe the attached survey which seeks your opinion about local business using American products. I appreciate your response to my letter and the fact that you have responded to my request. I am sure that you will find the survey interesting and helpful. I would like to see the results of the survey. I would like to see the results of the survey. I would like to see the results of the survey.

Very truly,

Dr. [Name]
PhD Candidate

CMHR
Canberra ACT 0200 Australia
Building 63
Telephone: +61 2 6125 8699
Facsimile: +61 2 6125 0733

Email: lara.bishop@anu.edu.au

13th January 2004

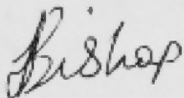
Dear (Journalist's Name)

I am writing to follow up on a previous request for you to complete the attached survey which seeks your opinion about health issues affecting Australians.

I appreciate your high work demands and the large number of similar requests received by journalists, however this questionnaire should take no longer than 20 minutes and will have important research outcomes for strategies addressing the health of Australians.

Thankyou for taking the time to consider this request – your input is important to the overall success of this project.

Yours faithfully,



Lara Bishop
PhD Candidate