



**I See a Psychologist:
Reducing Stigma through Normalizing Mental Health Care in Australia**



An Interactive Qualifying Project to be submitted to the faculty of Worcester Polytechnic Institute in partial fulfillment of the requirements for the Degree of Bachelor of Science

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ABSTRACT

The goal of this project was to create a web-based campaign to normalize mental health care in Australia. We surveyed university students in Melbourne and interviewed mental health professionals to inform our campaign's content and approach. The project resulted in an extensive mental health website which strengthens VCPS's web platform and centers on our campaign, named 'I See A Psychologist,' with videos, quizzes, and other resources to encourage people to seek mental health care as part of their regular routine.

EXECUTIVE SUMMARY

Almost half of Australians have or will experience a mental illness in their life; about 20% of Australians are experiencing a 12-month mental illness at any given time and only 35% of these people will seek help (Australian Bureau of Statistics, 2007). According to the National Survey on Emotional and Mental Health, young adults, ages 16 to 24, are the group of people who have the greatest prevalence of mental health disorders, and are the group that use mental health services the least (Australian Bureau of Statistics, 2007). The Australian government has tried to combat issues that are preventing people from seeking mental health care with Medicare, the universal health care system, and the National Mental Health Strategy. However, stigmatization of mental health is still present. This consists of public stigma, which is prejudice derived from media and social standards, and institutional discrimination, which is the systematic discrimination by corporations against those with mental illnesses. These lead to self-stigma and shame which inhibit individuals from seeking mental health care.

Through the years, organizations like Mental Health Australia, beyondblue, Headspace, SANE Australia, Lifeline, and Australian Psychological Society (APS) have emerged to offer resources and guidance to people who could benefit from mental health care. All of these promote mental health care, and several of them have campaigns to promote the use of mental health care. For example, the “Man Therapy” campaign by beyondblue was very successful in reaching its audience, which was the middle-age Caucasian population, by creating a fictional character that used humor to educate them. Lifeline specifically targets suicide prevention and intervention, and Headspace focuses primarily on young adults. The issue with these campaigns is that they all focus on some specific mental health illness or condition, like depression, anxiety, or suicide, and they target specific people or groups, like young adults, aboriginals, pregnant women, and others. There is a need for a campaign that is centered around normalizing mental health care, which means promoting the regular and common use of mental health care as a form of preventative care.

Project Goals

The goal of this project was to develop a web-based campaign with Victorian Counselling and Psychological Services (VCPS) that emphasizes normalizing mental health care. The campaign, called ‘I See a Psychologist’ includes a website with a series of videos, self-assessment quizzes, connections to mental health practitioners, and general information on mental health. The project assessed public perceptions of mental health and mental health care among different cultural groups in Victoria through public surveys. Additionally, the project

evaluated mental health outreach strategies by interviewing other health-related organizations in Melbourne to inspire the campaign. The campaign makes it easier for Australians to receive necessary care to recognize early symptoms of mental illness, thus reducing the severity of those illnesses, while providing educational resources to maintain a good well-being.

Learning from Key Stakeholders

Victorian Counselling and Psychological Services

To understand the role of the web-based campaign in VCPS's broader goal of normalizing mental health care, we built relationships with several of the staff at VCPS to learn about the practice and the methods they have been using to attract clients. In a focus group with VCPS staff, psychologists suggested that people from lower socioeconomic classes were less likely to seek care because they could not access mental health services; even among those who started treatment, the limit of 10 sessions imposed by Medicare meant that they could not complete necessary treatments. White collar workers were also found to be not very willing to seek mental health care, which is probably due to their time commitments. We found that most people thought that mental health care was only useful to directly prevent or treat a serious mental disorder. Respondents did not think of mental health care as a way to maintain one's general well-being. Some practitioners commented that the issue of few people seeking mental health care is related to not having a sense of community approach to emotional struggles. Historically, mental health care was dealt with by religious leaders, family or other trusted individuals; however, it has become more of an individual problem. It was suggested that it is necessary to "re-normalize" mental health care so that people feel comfortable seeking help as preventative care.

Public Perceptions

We assessed public perceptions of mental health and mental health care among different demographics in Melbourne. Research suggests the utilization of mental health care is particularly lower in some minority cultural groups (Minas et al, 2013), and in young adults, from 16 to 25 years of age (Australian Bureau of Statistics, 2007). To understand the perceptions of these groups and to better target our campaign, we had conversations with some stakeholders in the mental health industry that could give us insight on the use of mental health care by different cultural groups. Mr. Yonas Mihtsuntu, a social worker in Victoria, gave a general overview of the social worker practice and how he tries to engage with people as efficiently as possible to be able to offer mental health services. He discussed how difficult it can be

interacting with different cultural groups because of their hesitation to discuss mental health. Additionally, he discussed how the differences between perception are vastly different among different cultural groups and even individuals within the cultural groups that there are no “one size fits all” solutions.

We also performed a survey of 55 students at Melbourne University to understand the views on mental health care of the young adult demographic. Responses suggest that very few people have a diagnosed mental disorder, even if the Australian Bureau of Statistics has previously shown that in a 12-month period about one fourth of the population will experience a mental health disorder. The number of people seeking mental health care significantly improved from the National Mental Health Survey of 2007, which suggests that there might be better access and promotion of mental health care now, a decade later. The survey also suggests that people mostly consider mental health care during difficult moments in life, and that even if they identify that it is important to maintain mental well-being, people are not willing to go to a mental health practitioner for preventative care.

Mental Health Organizations

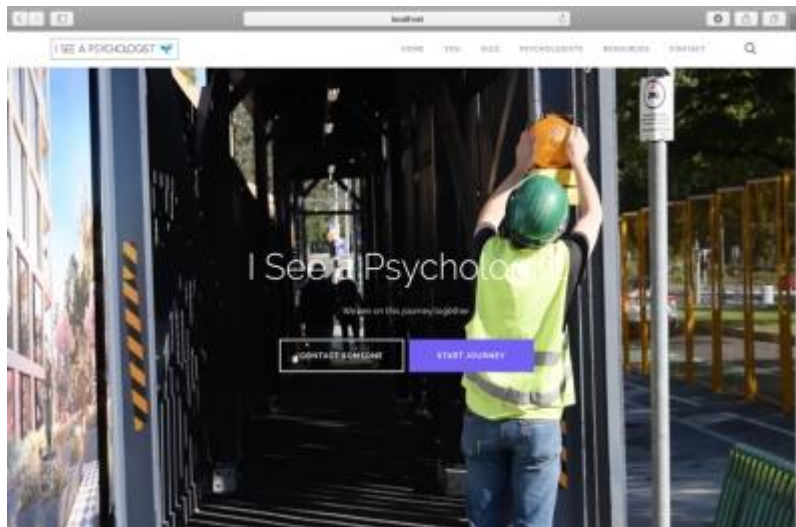
To gain unique insight into the design process of mental health campaigns, we interviewed experts who have worked closely with other campaigns. With the help of our project liaison at VCPS, we fostered relationships with beyondblue, one of the major mental health organizations in Australia. Through the snowball sampling method, we were able to connect with a representative from a mental health and disability support non-profit organization. Through phone and email we were able to contact several of the other mental health organizations. Most of the organizations could not share information on their campaigns, except for SANE Australia and beyondblue. In these interviews, we learned about the importance of target audience, relatability to the campaign, word choice and phrasing of the message and the importance of ensuring that our campaign is not offensive to any potential users.

The Campaign

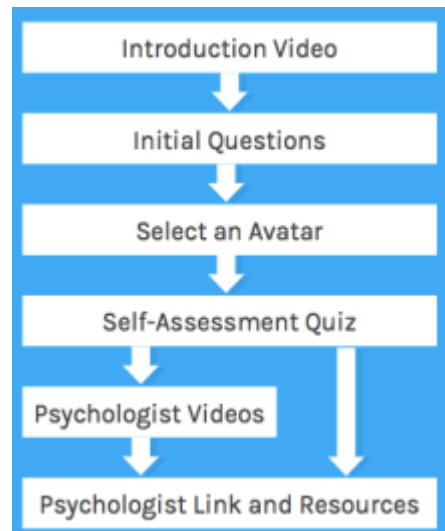
With a more informed understanding of issues surrounding mental health and the communication challenges with such a sensitive topic, we developed the ‘I See a Psychologist’ campaign. The campaign is centered on a website with a series of videos, self-assessment quizzes, connection to mental health practitioners, and general information on mental health. It is aimed at the general public, to encourage all people to utilize the available mental health care

resources for preventative care. This focus complements the goal of VCPS to provide care to all people who could benefit from it.

We designed the campaign website as an interactive journey that visitors will complete. The site begins with an introductory video that is engaging and interests the user in continuing in the campaign while conveying the concept of the overwhelming aspects of life and how we are able to manage those overwhelming aspects by looking after our mental health. The campaign then prompts the user to enter some information about themselves to begin their journey and to provide information to VCPS that will allow them to improve the campaign. The user can select an avatar to follow their daily journey and learn about how they integrate mental health care into their lives. There are three avatar videos that were created for the campaign: a student, a blue-collar worker, and a businesswoman. Each of the videos is approximately 90 seconds long and details the daily routine of one of the avatars, including how he or she incorporates seeing a psychologist into their lifestyle.



Homepage of Campaign Website



Flowchart of the Campaign Website

After watching one of the avatar videos, the user is led through a modified Kessler 10 emotional distress questionnaire which will assess the emotional distress levels of the user. Based on the result of the questionnaire, different recommendations may be displayed for the user. The users also see videos of psychologists explaining what seeing a psychologist is like, what they should expect, and what they will get out of the experience. These educational videos answer any questions the users may have about seeing a psychologist so that they can make an informed decision on whether to seek care. The combination of many different health professionals all reinforcing the same point shows the diversity of mental health care available while reinforcing the point of using care

preventatively. Finally, users will get routed to a resources page that will contain resources such as explaining Medicare coverage or specific mental illnesses. It will also contain information how to maintain their mental well-being. The website also has a link to connect a person directly to a member of the VCPS team. After visiting the website, visitors will have an understanding of the benefits of using mental health care as a preventative measure, knowledge on what to expect from the experience and what they can expect to get out of the experience as well as knowledge on a variety of mental health related topics they might find helpful.

In the future, this campaign can be grown or improved upon to attain a greater influence. The integration of the campaign into the wider network of VCPS's other resources will increase traffic to the campaign and make all resources among all platforms available to all visitors, increasing the knowledge base available. The expansion of the campaign will also be important. This can include additional avatar videos that individuals can relate to, as well as potentially adding videos of real people telling their real stories with mental well-being. In addition to this, additional focus testing will be vital to ensuring the effectiveness of the campaign. preliminary focus groups have suggested areas of improvement already, but, larger and more diverse focus groups will only help further refine the campaign. VCPS can also improve their social outreach using their presence to reach more individuals with the campaign and learn more about other cultures to incorporate them into the campaign. Finally, the expansion of the campaign through social media will be useful for reaching a broader audience and more efficiently maintaining a constant reminder of the campaign for those who see it.

Conclusion

The 'I See A Psychologist' campaign will cause more people to seek mental health care for minor concerns and as preventative care against developing mental illness, which can potentially reduce the number and severity of mental illnesses in Victoria. More generally, the campaign could either stand alone or serve as the foundation for future projects to further normalize mental health care and extend the reach to other parts of Australia or even other countries. Just by elevating the position of mental health in the public view, the existence of this campaign invites more work on this important subject in the future, which can have wide-reaching implications beyond Victoria or even Australia.

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Nicolas Vayas Tobar contributed to the writing of the executive summary, background and results section, the planning for the websites and the videos, and the development of the website.

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1. INTRODUCTION

Mental health is an issue of global importance that most people rarely consider when thinking about health in general. According to the World Health Organization (WHO, 2014), about one fifth of the world's children have a mental illness, and over 800,000 people commit suicide each year. Mental illnesses are among the leading causes of disability (WHO, 2014). Several international efforts have been conducted to address this issue, making mental health a priority in documents like the United Nations Sustainable Development Goals and the WHO Mental Health Action Plan. These efforts are bolstered by The Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, which mention that access to health care is a fundamental right (WHO, 2015). However, government spending does not reflect this commitment, with only 3% of government health spending going towards mental health (WHO, 2016). Furthermore, many people do not take advantage of the available resources to treat mental illnesses, with many not seeking care until a serious illness develops.

Australians have an average life expectancy of 80.3 years, which is the fourth highest in the world (Australian Institute of Health and Welfare, n.d.). As a part of its successful national health care system, Australia provides many resources for those struggling with mental illness, and a full recovery is very common for people who utilize those resources (Fava et al, 2014). However, the country still struggles with addressing mental health, not because the resources are not available, but because people do not seek them out. About 45% of Australians will experience some sort of mental illness at some point in their lifetimes; two thirds of those cases go untreated (Australian Bureau of Statistics, 2010). Every year, mental illness costs Australia around \$20 billion in lost labor and productivity (Australian Bureau of Statistics, 2010). This illustrates that while Australia's health care system is better than health care systems of other countries, there is still work to be done for everyone in the country to experience those benefits.

Research has shown that stigma associated with mental health care can have adverse effects on the individuals who receive such care (Corrigan, Markowitz & Watson, 2004). The public discourse on mental health often includes "stereotypical,

negative, or wrong” ideas on mental illness, affecting individuals who want to seek help by providing them with harmful misconceptions of themselves and of the care they need (Fawcett, 2015). Both public perceptions and institutional discrimination are forms of stigma that affect people seeking mental health care. People may avoid seeking care because they are worried about what others will think, or they are worried that they may be penalized professionally or financially. An understanding of both types of stigma is useful in order to properly address the barriers that prevent people from seeking care.

The World Health Organization (2004) recognizes that “to reduce the health, social and economic burdens of mental [illness] it is essential that countries and regions pay greater attention to prevention and promotion in mental health” (pg. 15). Even if psychologists (see [Section 4.1](#)) agree with seeking mental health care as preventative care or for early detection of mental health illness, campaigns in Australia are not geared towards this. Mental health organizations, like beyondblue, Headspace, SANE Australia, or Lifeline, all focus on some type of mental health illness or condition, like depression, anxiety, or suicide. Furthermore, campaigns done by these organizations are targeted to specific people or groups, like young adults, aboriginals, pregnant women, and others. Due to the great diversity of Australia, the whole population is not benefiting from these campaigns that promote the use of mental health care for mental challenges. For this reason, there is a need for a campaign that is centered on normalizing mental health and mental health care, which means promoting the regular and common use of mental health care as a form of preventative care.

The goal of this project is to develop a web-based campaign with Victorian Counselling and Psychological Services (VCPS) that normalizes mental health and mental health care. The campaign, called ‘I See a Psychologist’ will include a website with a series of videos, self-assessment quizzes, connection to mental health practitioners, and general information on mental health. The project assesses public perceptions of mental health and mental health care among different cultural groups in Victoria through public surveys. Additionally, the project evaluates mental health outreach strategies by interviewing other health-related organizations in Melbourne to inspire the campaign. The campaign will make it easier for Australians to receive necessary care to recognize early symptoms of mental illness, thus reducing the

severity of those illnesses. In improving mental health in Victoria, this project could serve as a reference to improve mental health care in other parts of Australia, and even in other parts of the world.

2. BACKGROUND

Mental health is a complex, multifaceted issue that affects every aspect of one's life and well-being. Specifically, the stigma which surrounds mental illness and the seeking of mental health care makes it difficult for individuals in Australia and around the world to receive beneficial treatments or discourages individuals from seeking such treatment. To combat this stigma, we researched mental health and the stigma that surrounds mental illness in order to create a campaign which can combat this stigma. As part of this research, we discuss mental health policy in Australia and the work that has been done in recent years. We also study the forms and potential causes of stigma in depth in order to better understand the concepts that our campaign needs to directly address. We then look at the various demographics that make up the state of Victoria. By understanding the factors that can affect certain segments of the population differently, we can better target our campaign to address the concerns of those demographics. Finally, we examine general outreach strategies and existing mental health campaigns to set the campaign's foundation and to ensure that the message is delivered to the public as effectively as possible.

2.1. Important Definitions

The following definitions will be vital to understanding the context of this work:

Mental health: one's emotional state, specifically a positive emotional state that allows a person to easily adapt and thrive in his or her daily life.

Mental illness: specific diagnosable ailments that negatively impact an individual's mental health.

Mental health care: the system in place to aid people in improving their mental health and may include visiting a psychologist, psychiatrist or other mental health care professional.

Emotional distress: less serious symptoms that are not necessary emblematic of a mental illness but result in reduced mental health.

2.2. Mental Health

People go to the gym, eat a balanced diet, and even brush their teeth twice a day, all to maintain good physical health and hygiene. However, taking care of mental health is also fundamental to a healthy lifestyle. According to the World Health Organization (WHO, 2016), exceptional mental health allows an individual to cope with the stresses of everyday life. This section will give an overview of mental health, mental health policy in Australia, and indicators of mental illness. It will then highlight different treatment options while calling attention to stigma and exploring the importance of maintaining mental health.

2.2.1. Indicators of Mental Health Conditions

Early treatment and intervention results in a more favorable outcome for patients, however, individuals often defer or avoid treatment of mental health conditions until more serious issues develop. It can sometimes be difficult to determine when mental health care should be sought if one does not know the symptoms. Some indicators of mental illness may include withdrawal from social interactions, a decrease in productivity and function, problems concentrating, hypersensitivity, apathy, illogical thinking, nervousness, unusual behavior, sleep changes, eating changes, and mood changes (Parekh, 2015). One or two of these do not definitively indicate any mental health issues, but experiencing several of these at a given time is a good indication that the help of a mental health care professional could be beneficial (Parekh, 2015).

2.2.2. Treatment of Mental Health Conditions

Treatment options are available to help individuals cope with and overcome struggles with mental health. Without treatment, these struggles can become issues that alter thinking, mood, or behavior (Mental health basics, 2013). There are many different ways to seek treatment for emotional distress. One of the most common early stages of seeking treatment is consulting with a general practitioner, who is able to conduct a mental health assessment and can help prepare a mental health plan. While a general practitioner may be able to begin treatment, he or she may also refer a patient to a psychiatrist, psychologist or another mental health professional (see [Appendix B](#) for a list of mental health professionals). Psychologists are the most common option when

one is seeking treatment. Psychologists provide therapy to individuals for mental health conditions that range from mild to severe. While the treatment differs from patient to patient depending on the medical condition, three of the most common forms of therapy are cognitive behavior therapy, behavior therapy and psychoanalytic psychotherapy.

Cognitive behavior therapy (CBT) looks to understand how the way people think and act affects how they feel. Working with a therapist, an individual will determine thoughts and behaviors that lead to their negative symptoms. Using this knowledge, the patient can begin to make changes that will replace these behaviors and thoughts with others that prevent symptoms. Some examples of this kind of treatment include teaching breathing techniques, and muscle relaxation (American Psychological Association, n.d.). Behavior therapy is different from cognitive behavior therapy in that it does not try to change beliefs and attitudes, but rather encourages rewarding activities to boost mental health (American Psychological Association, n.d.).

Psychoanalytic psychotherapy is another common treatment for mental challenges. This longer-term solution is dependent on the relationship between the psychologist and the patient. In this form of therapy, the two work together to understand the patient's difficulties and help the patient overcome them. Often, patients gain a deeper understanding of themselves as they more openly communicate with a counsellor. They begin to view their difficulties in a different light and can replace negative behavior with more constructive behavior. In particular, this form of therapy helps individuals learn to trust and rely on one another, so that they can depend on others to support them in the future (VCPS, N.D.). [Appendix C](#) lists brief descriptions of several other forms of mental health treatments.

2.2.3. Stigmatization of Mental Health

As previously indicated, the number of people who experience mental health problems is high while the number of people who actually seek help is low. Stigma can be identified as one of the major obstacles when seeking mental health care; some perceive that people who seek mental health care or have mental illnesses are dangerous or unable to lead normal lives. This tends to make people seek counseling as a last resort, as they prefer to avoid stereotypes, prejudice, and discrimination that

might come with it. This tendency to avoid seeking care is concerning, as the majority of people could benefit from counseling services or treatment. Corrigan (2004) identifies three types of stigma: self, public, and structural. The last two types greatly contribute to self-stigma, which is then related to the avoidance of seeking mental health care, as seen in *Figure 1*. The diagram shows the impact of stigma based on its sources, in both personal and public levels, referred to as micro levels of stigma, and structural levels, referred to as macro levels of stigma. This is used to emphasize how different types of stigma lead to the loss of opportunity of individuals, by pointing out that public and structural discrimination are directly related to self-stigmatization attitudes. In the following paragraphs, these types of stigma will be discussed in depth to easily identify how they affect people’s decisions to not seek help.

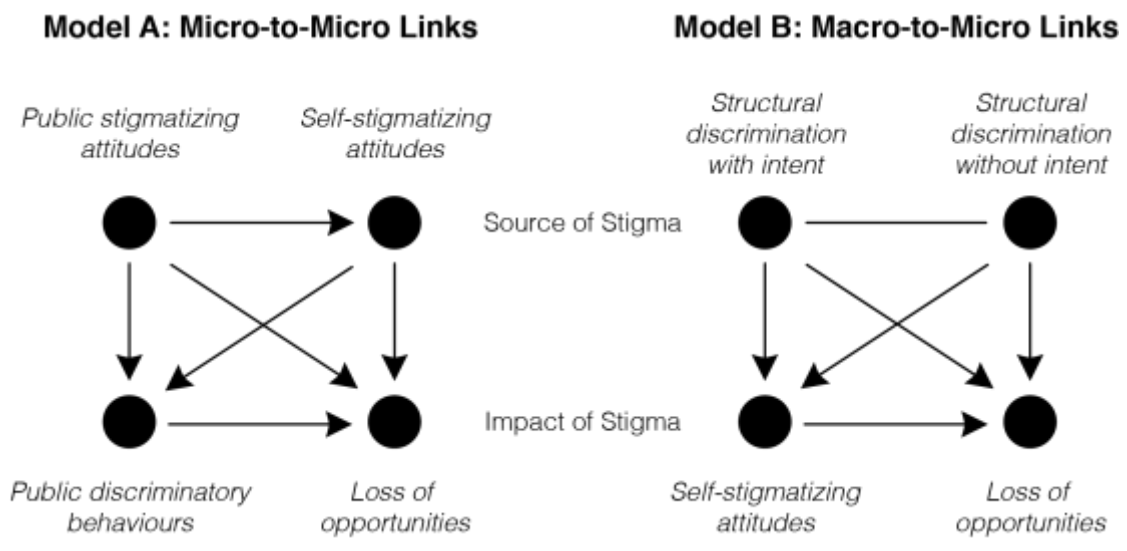


Figure 1: Macro and micro levels of analysis in mental health stigma and discrimination. Adapted from Corrigan and colleagues (2004).

2.2.3.1. Self-Stigma

Literature has often discussed how mental health stigma can be internalized, causing individuals to avoid seeking help for minor life advice or emotional distress (see Corrigan, 2004, Watson et al, 2007, Vogel et al, 2013). As research shows, people avoid seeking help of a friend for minor problems to avoid feeling incapable of dealing

with problems themselves (Vogel et al, 2007). If people avoid seeking help for minor issues, it is likely that they will not seek help for more serious issues such as a developing mental illness. Authors, like Corrigan (2004) and Watson and colleagues (2007), have presented self-stigma as a “harm to self-esteem,” which comes with diminished views of the person itself or self-prejudice. Several papers discuss the effects that self-stigmatization can have on people. Vogel (2007), for example, showed that self-stigma can be used to predict help-seeking behaviors and willingness to continue counseling.

There are several different views on how to address self-stigma. Vogel (2007) suggests that practitioners should be addressing the negative perception that people might have of themselves before trying to address a greater crowd to reduce stigmatizing ideas. Furthermore, Schreiber & Hartrick (2002) discuss how normalizing mental health illness symptoms can help reduce self-stigma. An effective way of addressing self-stigma is for people to acknowledge their own self-stigma when it comes to mental health, to understand how this might be stopping them from seeking help or from continuing seeking help.

2.2.3.2. Public Stigma

Public stigma refers to “the stigmatizing perception, endorsed by the general population, that a person who seeks mental health services is undesirable or socially unacceptable” (Vogel et. al, 2013, p. 311). This means that the help-seeking attitudes of people are affected by the perceptions of mental health in society. It can be difficult to determine how people form these perceptions of mental health; however, explanations of why those views prevail can be ascertained from discriminatory statements of people.

Mental health issues are often negatively presented, whether in public perception or through media representation, making individuals feel embarrassed, ashamed, or even afraid. Generally, the bulk of information that people receive about mental health comes from the newspapers they read, the television shows they watch and the movies they see. Studies indicate that mass media is one of the public’s primary sources of information about mental health (Fawcett, 2015). Research also suggests that most media portrayals of mental illness are stereotypical, negative or wrong (Fawcett, 2015).

This means that many people gain an unfavorable or inaccurate view of those with mental health concerns simply by skimming a few sentences in the newspapers or watching a few minutes of television. News and entertainment media portray mental illness with violence and stigmatize the characters with symptoms of psychological distress. The media dehumanizes the people who might have mental illness by calling them names such as “psycho,” “lunatic,” or “maniac” that isolate them or represent them as abnormal. The media, together with other sources of information, has been known to give the public narrowly focused stories based on stereotypes. These negative attitudes portrayed through media manifest into prejudice and the persistence of negative public attitudes about mental illnesses.

2.2.3.3. Structural and Institutional Discrimination

In addition to individualistic aspects of stigmatization, a systematic view of stigma needs to be explored, as stigma is also present in organizations, institutions, and health systems. This idea, often called structural, systemic, or institutional discrimination, “includes the policies of private and governmental institutions that intentionally restrict the opportunities of people with mental illnesses” (Corrigan, Markowitz & Watson, 2004, p. 481). The existence of such discrimination is challenged by the fact that sometimes institutions, like banks or insurance companies, discriminate against specific demographics in the interest of risk management (Block, 2008). However, a few examples from the Australian context show that institutions tend to exhibit these types of discrimination even if they are not banks or insurance companies. Addressing structural discrimination becomes important as an indicator of institutionalized stigma that might be inherently connected to policy of the public and private sectors.

Insurance companies are good examples of organizations that demonstrate structural discrimination. One specific instance of structural discrimination is the case of Ella Ingram, a woman who filed a claim for a flight refund through QBE insurance after having to cancel a flight due to severe depression (Medhora, 2015). Her claim was denied twice, but with legal support from the Australian beyondblue foundation, she was able to win the case in court against the insurance company. In this case, the insurance company refusing services to someone on the basis of mental illness is an example of

structural discrimination. In an article in the Sydney Morning Herald, advocates of mental health blame this type of discrimination on the lack of governmental policy to limit institutions from refusing services based on the mental health conditions of people (Wilkins, 2017). By viewing mental illnesses as separate from physical illnesses, this exemplifies how companies can further discriminatory ideas even when they do not intend to do so.

Another example is Matthew Attwater, who was helped by his employer to seek psychiatric help for post-traumatic stress disorder. His treatment required him to leave the workforce due to his disorder. This put him in a position in which he was eligible to apply for paid leave from his employer. Ironically, the psychiatrist statement was used by the employer to remove him from the company and leave him in a state of financial distress, where he could not work to afford his living expenses, or pay for a lawyer to fight for his benefits. As seen in this case, structural discrimination is present here as the company intentionally uses the mental health condition of the employee to undermine the employee's standing. As shown in both examples, structural discrimination places individuals with mental illnesses at a disadvantage both personally and professionally. It could therefore be in someone's best interest to decline to seek treatment for a mental illness since the potential diagnosis may make that person a victim of structural discrimination.

2.3. Mental Health in Australia

About 45% of Australians will experience some sort of mental illness at some point in their lifetimes, and two thirds of those cases will go untreated (Australian Bureau of Statistics, 2010). To better understand how to address the issue of untreated mental illness and promote health reforms across the country, the Australian government began a five-year report on mental health in 1993, which was then renewed four more times in five-year periods. Also, there are certain goals the Department of Health and Ageing has set to improve mental health care in Australia. The main areas of improvement are social inclusion, recovery, prevention, early intervention, service access, coordination of care, continuity of care, quality improvement, and innovation (Department of Health and Ageing, 2013). These goals attempt to address mental

health issues in the country allowing more people to utilize care and not just those who have a severe illness. The following paragraphs will give an overview of mental health in Australia and the current efforts being done by the government to address it, such as policy reforms, and discuss about the use of mental health care in its population.

2.3.1. National Mental Health Strategy

The Australian National Mental Health Strategy began in 1992 as a “framework to guide mental health reform” in the country (National Mental Health Strategy, 2014). According to the Australian Department of Health, the strategy looks to promote mental health, to decrease the effects of mental illnesses, and to guarantee the rights of people to mental health care. Since 1993, the total expenditure on mental health care has increased by 178% (Department of Health and Ageing, 2013). Each of the updated and renewed versions of the strategy provides different objectives and establishes new ways of promoting mental health and wellness. The changes from one version to the next can be compared by looking at the following system-level indicators present in them: expenditure in mental health, workforce trends, expansion of mental health services, trends in the public and private sector mental health services, and utilization of mental health care (National Mental Health Report, 2013).

In the National Mental Health Report (2013), the progress and outcomes of the National Mental Health Plan are evaluated in the following areas: social inclusion and recovery, prevention, early intervention, service access, coordination and continuity of care, quality improvement, and innovation. Comparing the results of the strategy to previous years shows that there has been a significant improvement in all areas over the time the strategy has been in effect. Nonetheless, several results of the report suggest various areas are in need of improvement. For example, the report suggests that Australians, in social situations, remained barely willing to interact with people with a mental illness. This means that there is still a great amount of stigmatization towards people with a mental illness. An analysis of the mental health reform up to 2012 showed that the successes of the strategy have been “overshadowed” by the failure to fully implement the strategy (Grace, 2015).

In addition, the Fifth National Mental Health Plan (2016) has identified some more critical objectives: to increase accessibility to mental health care, to improve treatments for mental illness, to make sure people have good physical health, to have fewer people suffering from mental illnesses, to have less discrimination and stigma, and to have a more responsive and effective system. To do this, the first priority discusses “integrated regional planning and service delivery” in which local governments will work with health institutions to provide mental health services to the consumers (*ibid*, pg. 4). Another priority discusses the “coordinated treatment” for people with severe mental illness, where hospitals and health networks will work with the social service agencies to support these individuals (*ibid*, pg. 5). Suicide prevention will take place through effective awareness strategies. Additionally, another priority is to promote physical health through guidelines provided through public and private health organizations, and to monitor progress in physical health for people with mental illness. In this current strategy, the government does a better job of providing methods to implement the policy, but there exists a need for mental health organizations to help take local action with the government.

2.3.2. Medicare: Australia’s Universal Health Care System

Medicare, a government-funded universal health care system in Australia, provides coverage for general practitioners, hospital costs, and pharmaceuticals (Australian Government Department of Health, n.d.). Coverage offered by Medicare makes mental health treatment accessible for all Australians but offers a limited number of treatment sessions per year (Australian Bureau of Statistics, 2010). For further benefits, individuals have the opportunity to purchase private insurance, which serves as an alternative to Medicare, and 30% of it is subsidized by the government (Australian Government Department of Health, n.d.). Australia’s Medicare plan offers rebates for up to 10 individual and 10 group allied mental health services per year provided by psychiatrists, psychologists and therapists. Individuals may access these benefits if they have a diagnosed mental illness and have been referred by a general practitioner or a psychiatrist (Australian Government Department of Health and Ageing, n.d.).

While there are ways to receive coverage from Medicare for mental health, there is inadequate use of Medicare for psychological services. The awareness that Medicare provides coverage for psychological services is also a concern as few people are aware that you can use Medicare for mental health related services. However, these services are limited by the requirement that a patient receive a specific diagnosis. Patients are restricted in the amount of support they can seek before paying for mental health care themselves. Many people see this limited scope of support from Medicare as an issue. Programs like the Better Access Initiative, which the Australian government has created to supplement Medicare, have increased the use of mental health services by 27.6% in the first four years of their implementation, up through November 2006 (Whiteford et al, 2014). Additionally, there is an increase in providers of mental health care who are subsidized by the Medicare system, which has seen a spike in utilization since the Better Access Program was implemented (Department of Health and Ageing, 2013). However, more substantial progress is still needed. There is still a significant financial impact of mental health on the community. Every year, mental health related problems cost Australia around \$20 billion (Australian Bureau of Statistics, 2010).

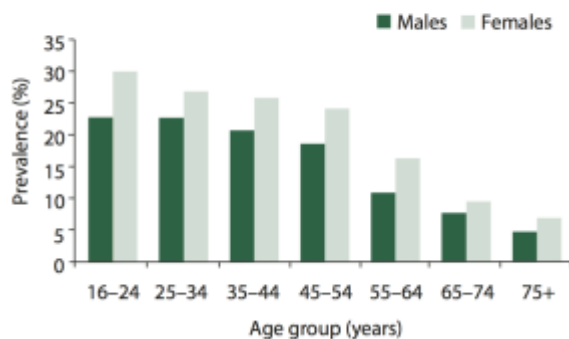
2.3.3. Prevalence and Use of Mental Health Care in Australia

International and Australian organizations have recognized that mental health is an issue of global importance; however, there is still a high number of people that experience mental illness and emotional distress. As stated before, almost half of Australians are or will be experiencing mental health illness in their life, about 20% of Australians are experiencing a 12-month mental illness and only 35% of these people will seek help (Australian Bureau of Statistics, 2007). This data includes people that are or will specifically experience anxiety disorder, affective disorders or substance use disorders. However, emotional distress, which cannot be classified as a diagnosable disorder or mental illness, is being experienced in everyday life by individuals. This means that mental health should be more relevant as it is greatly present in the Australian population in different ways.

To better understand the prevalence of mental health in Australia, Figure 2(a) shows the prevalence of mental health illness among different ages and sexes. As seen

in the figure, the prevalence of mental illness declines with the age of people, meaning that teenagers and young adults are more likely to experience a mental illness. Figure 2(b) shows that the use of mental health services follows an opposite pattern. The fact that this data is not proportional suggests that more resources or education should be offered to teenagers and young adults to promote mental health care as they are the group that experiences mental illness the most. Additionally, 11.9% of the population used mental health services in a twelve-month period (Australian Bureau of Statistics, 2007), which is a small number compared to the average number of people who experience a mental illness or who can benefit from the services to improve their well-being. In this way, even if both the National Mental Health Strategy and Medicare have made efforts to improve the mental health care of the population, the numbers show there is still a lot of improvement to be made.

(a) Prevalence of mental disorders in the previous 12 months by age and sex



(b) Service use among people with 12-month mental disorders by sex and age

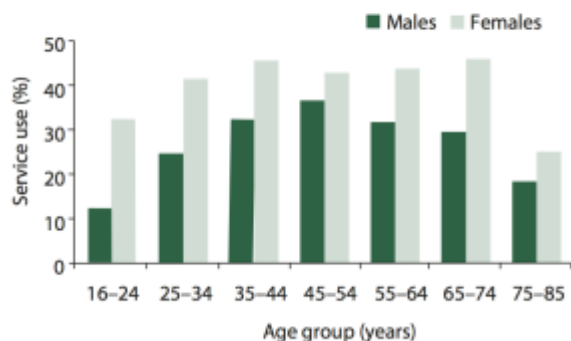


Figure 2: Prevalence of mental illness (a) and service use (b) of different age groups in the Australian population. Adapted from the 2007 National Survey on Mental Health and Wellbeing.

2.3.4. Demographics and Mental Health Care

Victoria is a diverse state that is home to a large number of cultural groups, for which mental health can have different meanings. Each of these groups has a different predisposition regarding seeking help for mental health (Fava et al, 2014). A summary

of these predispositions can be seen in [Appendix F](#). Similarly, individuals living in poverty and with low levels of education are at a higher risk of mental health issues compared to the general population (Parekh, 2015). Poor mental health also can come as a result of social change, stressors, discrimination, exclusion, violence, lack of physical health, and violations of basic human rights (WHO, 2016).

Socioeconomic status can also influence one's susceptibility to mental illness. Important determinants of mental health include age, marital status, languages spoken, cultural and ethnic background, education, employment, and housing, among other less significant factors (Enticott et al, 2016). The amount of psychological distress in socioeconomically advantaged portions of Australia, which make up about one fifth of the country, was found to be significantly lower than that in less socioeconomically advantaged regions (Enticott et al, 2016). There was an unsurprising positive correlation between disadvantage and mental challenges. This points to especially vulnerable demographics that should be targeted in the campaign.

Victoria hosts many different cultures; about 28% of people living in Victoria were born outside Australia (Australian Bureau of Statistics, 2011). Some of the most common cultural groups are English, Irish, Scottish, Italian, Indian, Chinese, Greek and Vietnamese (Australian Bureau of Statistics, 2016). Figure 3 represents the different cultural groups making up the 28% of residents born outside Australia.

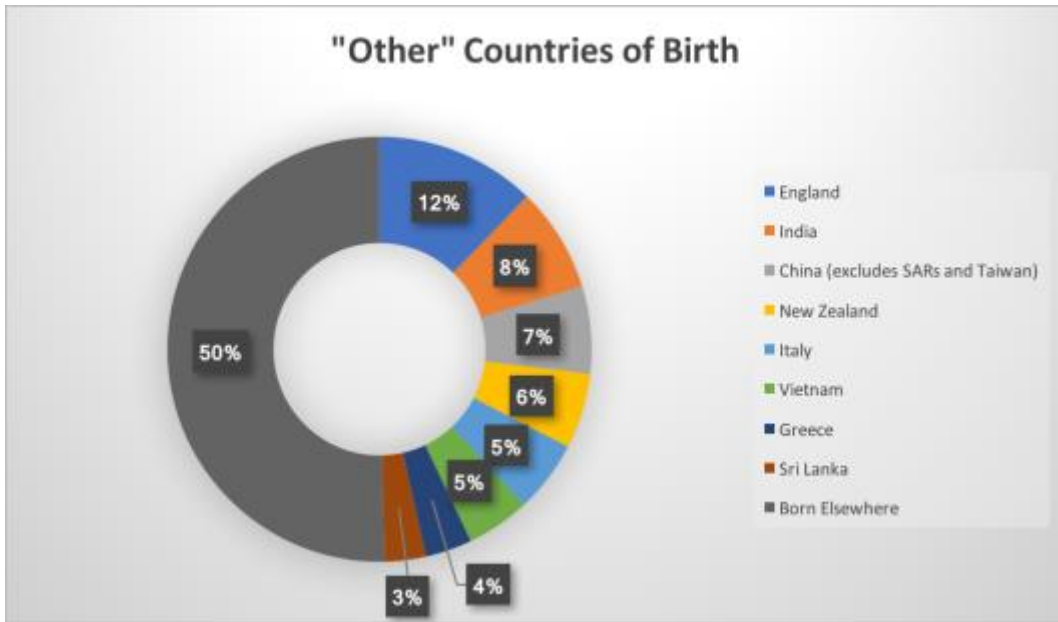


Figure 3: The country of birth of residents of Victoria. Adapted from The Australian Bureau of Statistics, 2011.

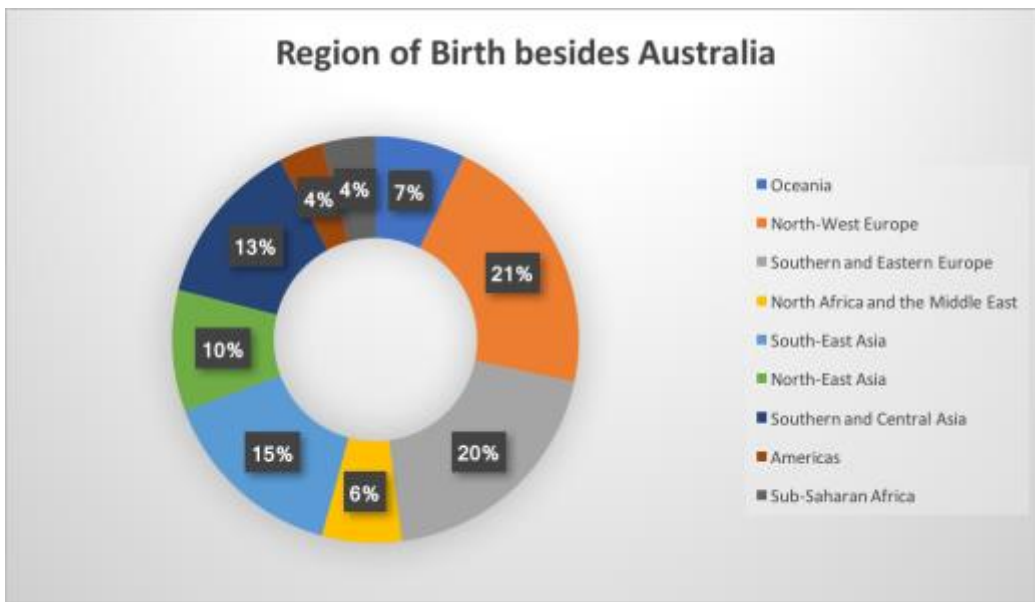


Figure 4: The region of birth of residents of Victoria. Adapted from The Australian Bureau of Statistics, 2011.

As seen in Figure 3, Victoria's population comes from various countries of origin with no overwhelming majority. The "Born Elsewhere" group in the graph represents

more than forty other countries that their population does not reach two percent of the population under this sample. Clearly, there is a wide diversity of cultural backgrounds, which may be more appropriate to divide into geographic regions. Figure 4 represents the various geographical regions of origin. Similar to the chart in Figure 3, there is no clear geographic majority that foreign-born Australian residents are born in.

A concern with minorities is that they are often more likely to experience emotional distress resulting from discrimination. For example, Aboriginal Australians are more likely to experience anxiety and depression because of racism (Wilson, 2014). Additionally, in Australia, non-native English speakers are about twice as likely to experience discrimination as English speakers (Markus, 2015). This is a concerning statistic because data from the 2011 Census shows that about 24% of individuals speak a language other than English at home (Australian Bureau of Statistics, 2011). In spite of it being a diverse country, about fifteen percent of Australians reported discrimination because of skin color, ethnic origin or religion, making them more likely to suffer from mental health concerns (Fava et al, 2014). In fact, over fifty percent of aboriginal Australians demonstrated a “high” or “very high” level of psychological distress, and the level increased as instances of racism occurred (Ferdinand et al, 2013).

Another concern with minorities in regards to mental health is that they are often unable to find a professional who can relate to their cultural background. When seeking mental health care, there is a consensus among the aboriginal community that it is more important to find a medical professional who understands a patient's needs rather than focusing on cultural aspects (Hart et al, 2009). The significance of this consensus is that while culture is a factor in selecting a mental health professional, at least one minority is willing to overcome these differences to get the care they need, and other cultural groups may agree with these beliefs. Among immigrants and refugees in Australia, the rates of utilization of mental health resources are very low and minorities are often underrepresented in medical health research studies (Minas et al, 2013). It is important to determine the cause of the low utilization rates of mental health care for minorities groups to ensure these are addressed.

2.4. Outreach Strategies for Mental Health Campaigns

For a public awareness campaign about mental health to be successful, an understanding of communication is equally as important as an understanding of mental health. Without effective communication, outreach or marketing campaigns are likely to fail, regardless of the merit of the ideas or product involved. This section explores the concepts of successful communication and awareness campaigns, both in general, and as they relate to mental health specifically, analyzing how mental health literacy, or self-awareness as it pertains to mental health, is essential for the success of awareness campaigns. The conclusions drawn from analysis of the literature on this subject will serve as the basis for the future awareness campaign's methodology.

The most important prerequisite of any communication campaign is to identify the audience and target the message accordingly. Sometimes, this may even require the construction of several forms of the message to target different segments of the audience. According to Charles Atkin and Ronald Rice in their 2012 book on public communication campaigns, there are two main benefits of subdividing a campaign's audience: efficiency and effectiveness (Atkin and Rice, 2012). By giving priority to subsets of the audience that are more crucial to the campaign's objectives and more willing to receive the message, less effort must be expended than if the campaign tried to reach everyone. In addition to saving effort, by tailoring the message and its delivery to the groups being prioritized, the message will be more successful with that group than if the message tried to appeal to everyone.

Atkin and Rice also address the way messages should be framed as part of campaigns. In particular, they draw a clear distinction between prevention and promotion campaigns. Prevention campaigns try to discourage specific behaviors by warning about the negative outcomes of the undesirable behavior. In contrast, promotion campaigns encourage positive behaviors, focusing on the benefits of those behaviors. Depending on the context of the societal issue being addressed, one type of campaign will likely be more effective than the other. A prevention campaign, for example, "is most potent in cases where harmful outcomes are genuinely threatening or positive products are insufficiently compelling" (Atkin and Rice, 2012, p. 8).

In addition to the difference between prevention and promotion campaigns, there is also a difference between informational and persuasive campaigns. Informational campaigns involve simpler messages that are easier for the audience to understand and actions that the audience would be inclined to pursue. Persuasive campaigns, however, provide more specific information to convince the audience that a change in their action is necessary, especially if the audience would not otherwise be inclined to accept that message. Even for audiences that already support the campaign's message, "the campaign has the easier persuasive task of reinforcing existing predispositions" (Atkin and Rice, 2012, p. 9).

On the topic of making a message appealing, Everett Rogers and Arvind Singhal (2001) analyzed a strategy that specifically aims to make a campaign entertaining and educational simultaneously. One of the elements that they mention as being essential to an entertainment-education campaign is a moral framework or what they call a value grid. Creating a moral framework in this context is the process of determining in precise terms whether certain actions are desirable or undesirable as they relate to the campaign's objectives. Creating a moral framework in advance gives the campaign focus and clarity that make it easier to focus on spreading the message.

In evaluating the effectiveness of entertainment-education campaigns, Rogers and Singhal (2001) studied a South African HIV awareness campaign called "Soul City," which involved a television program as part of the campaign to promote health practices which could prevent HIV and AIDS. The Soul City campaign reached millions of people through the television program and other forms of media such as written pamphlets and meetings. For entertainment-education campaigns to be successful, Rogers and Singhal recommend utilizing multiple forms of media in a similar way.

One detriment of an entertainment-education strategy is that the message must become even more targeted than in other campaigns. Often, this extreme audience segmentation can lead to important target demographics being left out. "For example, media messages about family planning in developing countries are usually targeted to fertile-aged couples. Such segmentation, however, may alienate other important audience segments, such as adolescents, sexually active singles, and others who

believe they too could benefit from contraceptive messages” (Rogers and Singhal, p. 353).

A campaign about mental health seeks to utilize these general communication strategies to establish public mental health literacy, a more specific form of general health literacy. Don Nutbeam, who wrote an article for *Health Promotion International*, compares health literacy to linguistic literacy, analyzing the three forms of literacy in the context of health and what each form of literacy allows people to do in their daily lives (2000). The first form of literacy is functional literacy, which encompasses basic reading and writing skills, allowing people to function effectively. The health equivalent of functional literacy is simply being able to survive from day to day independently. The second form of literacy is interactive literacy, which allows people to gain and share information through direct communication with others. In the health context, this would mean being able to effectively talk to doctors and to follow instructions to improve one’s health. The third and most useful form of literacy is critical literacy. Critical literacy involves analyzing information and using that information to exert control over one’s life. In terms of health, this would mean recognizing changes in one’s body and understanding the cause, allowing one to adapt and improve one’s own health before seeing a doctor becomes necessary. The focus of a typical mental health campaign is for the public to achieve critical mental health literacy.

A mental health awareness campaign in particular must be careful in its language to avoid negative connotations that can cause the public to become disengaged with the message. A team from King’s College in the United Kingdom (Clement et al, 2010) conducted a study in which they asked participants to judge the desirability of certain types of messages in the context of an anti-stigma mental health campaign. Their study concluded by highly recommending messages which focus on the whole person instead of the diagnosis of the person. Messages which emphasize successful recovery were also highly recommended by the group. Messages which focus on social inclusion of individuals with mental illness or the high prevalence of mental illness was also recommended, but not as strongly. The group cautioned that other kinds of messages which focus on topics such as the serious consequences of mental illness should only be used in certain situations and with caveats. The study concluded that messages

needed to be phrased and targeted very carefully in order to not isolate any portion of the potential audience (ibid, p. 78).

2.4.1. Mental Health Awareness Campaigns in Australia

Since the implementation of the National Mental Health Strategy in Australia, several groups have advocated for the creation of entities to promote mental health. Through the years, organizations like Mental Health Australia, *beyondblue*, Headspace, SANE Australia, Lifeline, and Australian Psychological Society have emerged to offer resources and guidance to people who could benefit from mental health care. The following paragraphs offer an overview of the purpose of mental health organizations, campaigns and initiatives.

2.4.1.1. *Mental Health Australia*

Mental Health Australia is a non-government organization that was established in 1997 to represent the full range of mental health stakeholders in Australia. As stated in their constitution (2014), their objectives are to promote and facilitate improvements in mental health and wellness, to increase the effect of institutions and organizations in mental health, and raise awareness of mental health to all Australians. To achieve this, the organization is promoting mentally healthy communities, providing a voice for mental health reform and policy, influencing decisions on federal funding on mental health, contributing to mental health research, liaising with different mental health institutions, and targeting programs to educate and change behavior of people regarding mental health (Constitution of Mental Health Australia Ltd, 2014). Their website points out that they focus on “policy, advocacy and the reform of mental health service delivery,” which are commonly done through the interaction with state departments and national and regional governments. Mental Health Australia provides links to most of the campaigns present in this section to address specific mental health conditions that are prevalent in Australia.

2.4.1.2. *beyondblue*

beyondblue, a non-profit organization, focuses in raising awareness about depression, anxiety and suicide. Through several types of campaigns, they have been

able to promote mental health to individuals in different contexts or with different mental conditions. Using advertising, social awareness campaigns, and educational strategies, they have been able to tackle anxiety, depression and discrimination of youths, adults, and minority groups like indigenous Australians or people from the LGBT community (Independent Evaluation of beyondblue, 2014). In a study performed in 2005, in which the recognition of depression was compared from 1995 to that in 2004 in different regions of Australia, researchers found that the awareness of depression almost doubled in the states where beyondblue was present (Jorm, 2005). From their first campaigns on depression, beyondblue has expanded in various important areas to reach people. These areas include the Man Therapy campaign aimed at men who may suffer from depression or anxiety, the National Workplace Program (NWP) aimed at employees to promote their well-being, and blueVoices that lets people who had experienced depression, anxiety or suicidal thoughts share their experiences with other people. In this way, beyondblue seeks to help all people across their lifespan including perinatal, childhood, youths, adults, and older adults (beyondblue).

2.4.1.3. Man Therapy

Like the other beyondblue campaigns, Man Therapy addresses depression, anxiety and suicide prevention, particularly targeting men from 18 to 54 years of age, greatly impacting its targeted audience. In the rationale for the campaign (2015), beyondblue presents the following Australian statistics that demonstrate the importance of an awareness campaign geared to men: “one in eight men are likely to experience depression in their lifetime, one in five men are likely to experience anxiety,” and thirty-three men commit suicide weekly. According to the document “Independent evaluation of beyondblue” by Nous Group (2014), about a third of the targeted audience was successfully reached as part of beyondblue’s goal to raise awareness about depression and anxiety (p. 19). The campaign, which includes self-help quizzes, videos, educational material of the known signs of the conditions and treatments, and the resulting action plan, has helped to change the public discourse of men seeking help for mental health. This was particularly seen by a change in stigmatization attitudes in the communities, where men subject to the campaign became more likely to make lifestyle changes and seek professional help (Independent evaluation of beyondblue, 2014).

2.4.1.4. Headspace

The National Youth Mental Health Foundation, Headspace, provides mental health intervention and promotes well-being to young people (ages 12-25) in Australia by focusing on mental health, physical health, work and study, and alcohol and drugs. According to Patrick McGorry (2007), a psychiatrist and advocate for mental health reforms in Australia, the prevalence of mental health problems in youths under 25 years of age in Australia can go as high as 27%, which is the highest incidence across the lifespan of individuals. The developmental importance of this stage in life makes it a priority to intervene early on a mental health condition. The Headspace campaigns include reaching out to isolated communities, like aboriginals, to promote awareness on mental health problems. For example, in 2014, Headspace started a campaign to improve mental health literacy among children of the aboriginal and Torres Strait Islander communities. Currently, the foundation provides online counseling services at Headspace and has centers for young people to have access to health workers, including general practitioners, psychologists, social workers, and counsellors, for a small or no cost. According to their website, as of March 2016 they have provided 1.5 million services to help around 250,000 young people.

2.4.1.5. SANE Australia

SANE Australia is a national charity that helps Australians with more severe mental illness diagnoses have a better quality of living, by providing information on mental health, having a support center online or by phone, working with employers to respond appropriately to mental health in the workplace, and advocating for policy change on mental health. In contrast to the other initiatives, the website particularly focuses on providing resources to have a better lifestyle. This wellness promotion includes how to increase one's happiness, how to get back to work, how to have a successful intimate life, how to stay physically healthy, and other resources to better approach a mental health condition. They run community awareness programs like the Mindful Employer, Stigma Watch, SANE Speakers, and Peer health coaching to help individuals with mental conditions live a better life. SANE Australia also has made a

series of videos called “Living Stories” in which people with mental health illness tell their experience with mental health and how seeking help made them be better.

2.4.1.6. Lifeline

Lifeline is an organization that focuses on crisis management and suicide prevention through direct contact with support through online chat or call. In contrast to the other campaigns that promote mental health awareness and prevention of illness or suicide, Lifeline is geared toward providing immediate support in times of need. According to their website, the crisis line receives calls from people who need help with suicidal thoughts or attempts, anxiety, depression, loneliness, abuse, trauma and stress. The outreach is done mainly through videos to promote their services in case of need. Combatting the high rate of suicide, which is the leading cause of death for young adults in the country, the goal of the organization is to have a suicide free country. Currently, the support network has 97% recognition in the country and 94% trust, which makes it the most effective direct support for mental health (About Lifeline, 2016). Many of the mental health initiatives include Lifeline as one of the support networks in their portals.

2.4.1.7. Believe in Change

Believe in Change is a campaign designed by the Australian Psychological Society (APS), which, according to Pat Freeland-Small, aims to make “the public understand the benefits psychologists can bring to everyone's lives” (as cited in Ricki, 2017, pg. 1). The main advertising tool for the campaign is a one-minute video about how people are always walking into and out of experiences and situations in their lives, presenting walking as a symbol of change. According to the video, people are always trying to get from where they are to where they want to be. These transitions in life can be difficult, but psychologists can help people do them. Furthermore, the campaign also includes a series of videos that explain the different types of psychologists and their roles for different people from various contexts, backgrounds, and ages. The campaign is entirely under the APS, appearing to have “Believe in Change” as a slogan that goes with the name of the organization. Due to this, Believe in Change appears to not only

promote psychologists as a tool to make life transitions, but to specifically promote the use of APS psychologists.

2.4.2 Social and Video Campaigns

In order to create a web-based campaign with videos of individuals' journey's, we studied past social campaigns and projects that used video which would be shared publicly. We wanted to see which strategies for public communication are most successful. Specifically, we examined the Humans of New York social media pages and an Interactive Qualifying Project completed by WPI students in Cape Town, South Africa. Both of these examples provided us with information about how to properly execute a campaign that would rely on social media and other outreach.

2.4.2.1 *Humans of New York*

Humans of New York is a blog and family of social media pages started by Brandon Stanton in 2010. His initial reason for starting the project was to photograph 10,000 New Yorkers to create a catalogue of New York City's inhabitants. After a while, Stanton decided to interview the subjects of his photography to include stories and quotes from the people featured on the blog. The blog usually updates with two new photos per day, each with an associated story. Some stories are split into multiple posts with different photographs of the same subject. Even though Humans of New York does not usually utilize video, we chose to study it because of its well-known online presence. As of 2017, the Humans of New York project has become widely known on social media for its candid views of people's lives without any external bias, as the captions are always direct quotations from the subjects. The project's largest social media page is on Facebook, with over 18 million "likes." Brandon Stanton has even published several books with series of photos and stories that were featured on the blog.

A 2016 study by students at Penn State University (Wang et al, 2016) analyzed the success of posts made on the Humans of New York social media pages to determine whether there was a correlation between certain kinds of stories and increased social media engagement. They specifically focused on the topic, tone, and length of the posts to the Humans of New York Facebook page during the first half of 2015 (ibid, p. 150). The group found that approximately half of the narratives shared by

Humans of New York dealt with subjects' families, careers, or romantic lives. However, the posts that received the most likes were those that involved the subjects' dreams, careers, or friendships, (ibid, p. 152). This information could be useful in promoting mental health, particularly when focusing on topics that will help a potential campaign to reach more people. In that light, the Penn State study also found that the Humans of New York Facebook posts that were shared the most times involved the subjects' education or pro-social issues. Additionally, longer posts were shared more often than shorter posts, (ibid, p. 153). These considerations of tone, topic, and length can be further analyzed to determine the best way to structure social media posts in the Humans of New York style to spread to the greatest possible number of people.

2.4.2.2 *The Big Issue IQP*

In 2014, a team of students from WPI completed their Interactive Qualifying Project in Cape Town, South Africa. Their project was to help a nonprofit organization called *The Big Issue* to introduce a digital version of their print street paper that was sold by independent vendors in the city. Throughout their project, they produced videos with the vendors that sold the paper in order to make the marketing for *The Big Issue* more personal. They also documented their experiences meeting and working with all of the vendors to be able to include themselves as part of the project's narrative. A web-based mental health campaign could work similarly if we form relationships with individuals related to our project that would be willing to work with us, and it would make it easier to create videos with some of the people who would be closely affected by the project's outcome.

2.5. Victorian Counselling and Psychological Services (VCPS)

Victorian Counselling & Psychological Services is an organization that provides various treatment and counselling services across the state of Victoria. VCPS is equipped with well experienced practitioners who help individuals facing challenges with their mental health. Their team includes highly experienced specialists in the fields of psychology, psychiatry, general practice and psychotherapy. According to Ms. Ace, the operations manager at VCPS, the organization has two main components: what the community sees, and how the business is run. First, people see an institution that can

provide qualified mental health practitioners, who can be accessed with a full fee payment of practice. This means that the clients pay an additional cost to that subsidized by Medicare (AUD 124.50), to access their services. The second component involves the structure of the organization, which has multiple private practitioners that offer their services making use of VCPS's portal and offices; this is further achieved by client referrals. Regarding their clients, many are students that use the service through their universities or people who have been referred to the organization. VCPS acknowledges that because mental health often carries a stigma, many people fail to get help and wait until a moment of crisis to seek it. With the vision to normalize seeking mental health care, VCPS is seeking to develop a web-based campaign and set of resources that encourage the users to educate themselves and understand their needs regarding their well-being, as they pursue a normalization of mental health.

3. METHODOLOGY

The goal of this project is to support Victorian Counseling and Psychological Services (VCPS) in promoting mental health and normalizing mental health care by developing a web-based campaign aimed at encouraging the use of mental health care as a preventative measure. The campaign includes general information on mental health and well-being, self-assessment quizzes, and narrative videos to promote routine and preventative mental health care, and to encourage self-monitoring of mental health conditions. This goal was achieved by fulfilling the following objectives:

1. Engage with VCPS to establish the scope of the project and understand the role of the web-based campaign in VCPS's broader goal of normalizing mental health care.
2. Assess public perceptions of mental health and mental health care among different demographics in Melbourne.
3. Evaluate mental health outreach strategies utilized by other health-related organizations in Victoria.
4. Design a web-based campaign, 'I See A Psychologist,' connected to EasyHealth, that is centered around normalizing mental health care.

The study did not concern itself with specific mental illnesses or crises but instead adopted a broad approach to mental health care needs across a range of symptoms or emotional distress. We centered the campaign on less serious situations that are present in a large proportion of the population. This study will focus on breaking down stigmas, both internal and external, that prevent people from seeking mental health care.

3.1. Objective 1: Engage with VCPS to establish the scope of the project and understand the role of the web-based campaign in VCPS's broader goal of normalizing mental health care

The expectations that VCPS had for this project and the outcomes they sought to achieve were the first things that our group explored. We engaged with VCPS to better understand their organization and to establish effective communication channels that would ensure our project kept in line with their expectations. We introduced ourselves to

most of the staff members in the office, and we began to establish relationships with management and administrative staff, particularly Mr. Robert Luzza and Mr. Harry Bryce, the director and the general manager of VCPS, respectively. We set up initial meetings during the first week with Mr. Bryce and Ms. Natasha Ace, our liaison with VCPS through the preparation term, in order to clarify all of our views regarding the project before work began.

The vision of a web-based campaign to address normalizing mental health originated with Ms. Natasha Ace, our project liaison, who saw an opportunity to reach a wide variety of people and address the topic of normalization of mental health care. Throughout the project term, Ms. Ace offered valuable insights into the campaign and mental health in Australia. She largely provided the vision that our project should meet. It was through her that we understood the boundaries of the project and the nuances of how to communicate with the public regarding mental health. She was able to provide us with many forms or resources and support, including web development software, access to existing VCPS media useful to the campaign and access to a web development professional. Overall, our interactions with her proved invaluable for the project's success.

In order to understand the scope of our project, we conducted a focus group with VCPS staff designed to better understand VCPS employees' perspectives on the campaign. We used the opportunity to hear from mental health practitioners and professionals directly about the challenges that come with trying to normalize mental health care. The focus group consisted of 7 participants, which included a variety of VCPS employees, including psychologists, general practitioners, and administrative workers. We were able to utilize both written notes and recorded audio during the focus group, which made it easier for us to extract all of the useful information from the conversations that we may have otherwise missed or forgotten. The focus group allowed us to hear the perspectives of people who play several different roles in the process of providing mental health care. Interestingly, the focus group revealed the many different opinions on mental health and how normalization should occur. It opened our eyes to the many different factors that influence whether a person seeks mental health care, some of which we could address in our campaign and some of which are

out of the scope of this project. Information gathered from the focus group allowed us to refocus and adjust our project in a manner that yields the most successful and effective result for both our team and VCPS.

3.2. Objective 2: Assess public perceptions of mental health and mental health care among different demographics in Melbourne

VCPS has expressed a concern that there is underutilization of mental health care services. Research suggests the utilization of mental health care is particularly lower in some minority cultural groups, which makes up a significant portion of the population of Victoria (Minas et al, 2013). Similarly, research shows that young adults (people ages 16-25) are the age group with greater prevalence of emotional distress and are the once who seek mental health care the least. We have focused our research on these groups to create a campaign that engages the majority demographic as well as demographics that have been underrepresented previously. This information allowed us to target our campaign at those who underutilize mental health care, not necessarily just the demographics with lower socioeconomic statuses. Our research aims to answers the following research questions:

- What are the different demographic groups in Victoria?
- What is the utilization of mental health care by these groups?
- What are the common perceptions and misconceptions that exist among these different groups about mental health and mental health care?

For the first part of this research we had conversations with some stakeholders in the mental health practice that could give us insight on the use of mental health care by different cultural groups. Through initial conversations with the General Manager at VCPS, Mr. Harry Bryce, we were able to get an overview of how mental health care works on Australia. His insight paralleled the research we have completed on mental health in Australia. Implementing the snowball method, we were able to get in contact with with Godefa G'her, a community advisor for the western suburbs of Melbourne. Through his years of work, Mr. G'her has encouraged communication with different cultural groups, which has made him aware of particular challenges these groups face in Australia. Through him, we were able to contact Yonas Mihtsuntu, a social worker

and program coordinator at Wellways, who was able to give us some insight on different perceptions of mental health among minority groups. These conversations were helpful to draw some conclusions about what is limiting people to seek mental health care, especially those from different backgrounds. We were able to compile our notes from these various conversations in order to code and identify the common concepts.

For the second part of this research, we develop a survey tool that allowed us to determine the perceptions on mental health and mental health care of young adults, as we had determined to be necessary in our background research. The questions we asked pertained to general mental health and well-being and did not explore serious mental illnesses. We conducted surveys at a university in the city, Melbourne University, to understand the perceptions of young adults. We used simple random sampling (SRS) to get an accurate pool of people within the university demographic to answer our survey. We were able to gather responses from over 40 students from a variety of backgrounds to provide some context as we develop our campaign. The data was later analyzed to get an understanding on the perceptions of mental health and mental health care among the young adult demographic.

3.3. Objective 3: Evaluate mental health outreach strategies utilized by other health-related organizations in Victoria

Evaluating existing mental health outreach strategies was important for learning how to effectively reach our target audience. To do this, we developed a set of interview questions aimed at mental health organizations' supervisors that focused on how organizations reached out to people using mental health campaigns. We identified the successes and failures of a few mental health campaigns to understand the common outcomes and mistakes that resulted in failure, in an effort to address them in our campaign. In the case of more general campaigns that do not deal with specific health concerns, we found several helpful strategies that were used to reach people more effectively, but we did not focus on content delivery, since mental health topics are more sensitive, and the methods of those campaigns were not necessarily relevant to our project.

We interviewed experts who have worked closely with other campaigns, since they were able to offer unique insight into the design process of mental health campaigns. Initially, the identification of the organizations and the individuals was done by referrals from VCPS. With the help of our project liaison at VCPS, we fostered relationships with beyondblue, one of the major mental health organizations in Australia. Through the snowball sampling method mentioned in the previous objective, we were able to connect with a representative from a mental health and disability support non-profit organization. Through phone and email we were able to contact several of the other mental health organizations, which we had identified during our background research as having important campaigns in Australia. Most of the organizations could not share information on their campaigns, except for SANE Australia and beyondblue. We worked with all of the successfully contacted organizations to ensure that we learned as much from them as possible. In these interviews, we explored the most effective ways to market and reach out to the public as well as some of the challenges to expect from a campaign.

Once we established contact with the various mental health organizations and scheduled times to interview representatives from the organizations, we refined our set of drafted interview questions to specifically relate to each organization. We also received an oral statement of consent from all interviewees which covered whether they preferred to remain anonymous, and whether they were providing their own personal views, or the official views of their organizations. The interviews were not recorded, but we took thorough notes from each interview, which were later coded and analyzed to accentuate the common themes between interviews. This data helped us in creating the campaign, since we could better understand the previous successes and shortcomings of other organizations.

3.4. Objective 4: Develop a web-based campaign, I See A Psychologist, connected to EasyHealth, that is centered around normalizing mental health care

The goal of this project is to develop a web-based campaign that normalizes mental health care. The campaign is centered on a website with a series of videos, self-assessment quizzes, connection to mental health practitioners, and general information

on mental health. The campaign is aimed at the general public, to encourage all people to utilize the available mental health care resources. This focus complements the goal of VCPS to provide care to all people who could benefit from it. In order to create the campaign, we carried out three main phases: plan, build and implement. Each of these phases was crucial in creating the best possible campaign for VCPS that serves as the culmination of all of our previous research.

First, we carried out a planning process in which we synthesized the findings of our first three objectives; this was carried out in the following stages: determine the needs, establish the content, identify resources, and set tasks. We further identified the needs of this campaign by engaging with Ms. Ace and others members of VCPS, as established in the first objective. We also identified the main messages that we needed to convey in our campaign, as well as the best means to communicate these messages. The messages themselves were derived from the analysis of the perception of mental health among the general public, specifically the different cultural groups that we surveyed for the second objective. This helped us assess the common doubts that people have regarding mental health which needed to be addressed.

In the planning phase, we also identified the resources that will be necessary to create the web-based campaign. These resources included web development software, web domains, video editing software, graphic design software, stock photos, royalty free audio and others. As VCPS looks to have a reliable and modifiable campaign platform, we have chosen to use WordPress as the web design platform. Additionally, the adaptability of WordPress to Google Analytics and to search engine optimization tools (SEO) will be beneficial to promote the campaign through different types of media in the future. Additionally, we will consider using one or more social media platforms to promote our campaign, similar in approach to Humans of New York, except, in this case, the social media pages will serve primarily to direct visitors to the campaign's main webpage, rather than standing on their own. Different mediums of communications, such as Facebook, YouTube, and Instagram, can help us promote our campaign in this manner. Furthermore, information gathered in the third objective from other mental health organizations will be helpful to understand the most effective strategies and means of communication for our campaign.

The main platform for the campaign is a website that will offer a journey through mental health care practice and its benefits to everyday life, which mimics the flow of the survey used in the second objective. The interactive website, which walks the participant through an educational experience on mental health care, looks to destigmatize mental health care through education and show its benefits for an individual's life. The video portion of the campaign includes three types of videos, the introductory video mentioned earlier, the people stories videos, and the psychologists' experiences videos. We worked with individuals associated with our team and the Melbourne Project Center to record the footage for the character videos over the course of one week.

The 'I See A Psychologist' campaign is structured as one part of the EasyHealth platform VCPS wants to create. This platform will host present and future VCPS resources and initiatives. The ultimate motivation behind the creation of EasyHealth is to be able to separate initiatives such as the 'I See A Psychologist' campaign from the VCPS brand and to make it easier for the public to access these resources, hence the EasyHealth name. At its creation, EasyHealth only contains our campaign, with a plan for a separate VCPS initiative called Early Care; however, in future years, it can grow to include many more projects.

The final phase of developing the campaign was testing. The campaign design process will be periodically evaluated by people at VCPS through meetings with our liaison and potentially one or two focus groups at key developmental milestones. This will allow us to confirm that our campaign follows the vision that VCPS provided us at the beginning of the project term. After producing all of the established content, we will seek approval of our sponsor to finalize the development process and proceed to releasing the campaign to the public. Before the campaign is open to the general people of Victoria, we will try to collect a sample of people who are willing to test the effectiveness of the content in normalizing mental health care. Based on feedback from these repeated rounds of testing, we will make modifications to the campaign to either keep more with the vision of VCPS, or to be more effective among certain population demographics. Once the project is approved and is demonstrated to be effective, we will release the website with all the content to the general public. Once we depart from

Melbourne, VCPS can use our recommendations and plans to maintain and continue the campaign.

4. RESULTS AND DISCUSSION

Through the completion of our methods, we are able to learn more about the website that we will be building and come to certain conclusions about what should or should not be included. Through our interactions with VCPS, surveying, and engaging with other organizations we are able to come to conclusions about our campaign that will ensure that it is the most effective it can be.

4.1 VCPS Insights

VCPS played a major role in this project in that they offered many different resources that helped complete the project. Having access to a mental health practice allowed for the understanding of many different mental health professionals, all who have different perspectives on mental health. In addition to the many different people who offered insights, we also had access to many resources, such as media and website building software, which was beneficial to the development of the campaign. We also had access to the website designer for VCPS who was a valuable resource for completing the final website.

4.1.1 Focus Group

We held a focus group with seven members of the VCPS staff to gain their insight into the nuances surrounding the issue of normalizing mental health care. One of our main topics of discussion revolved around the demographics that do or do not seek mental health care, and why that may be the case. One psychologist found among her clients that members of lower socioeconomic classes were less likely to seek care because they could not access mental health services. Even among those who started treatment, the limit of 10 sessions imposed by Medicare meant that they could not complete necessary treatments. Another psychologist suggested that white male professionals also underutilize mental health resources, but for vastly different reasons. White collar workers tend to be busier, and they are used to being able to solve problems on their own, so they lack both the time and the inclination to seek out mental

health care, even if they need it. Older generations are also seen less. One successful strategy the general practitioner used with these demographics was to focus on the physical consequences of mental illnesses, such as high blood pressure. Framing mental health care as an aspect of physical health made the clients much more receptive of the message.

We then asked the psychologists what they thought it meant to normalize mental health care. One of the practitioners stated that to normalize mental health care is to “not having [mental health] connected to an idea or pathology,” meaning that we “move towards a preventative model.” Most of the participants agreed with this; the general consensus was the notion that all people could benefit from mental health care. Following the conversation, the general practitioner in the focus group mentioned that in the past, people would go to a priest or community leader for open conversations like those that one would have with a psychologist today. She suggested that mental health care needed to be reintroduced as the modern equivalent of this community approach. A psychologist mentioned that this shifted the idea of normalizing mental health care to renormalizing emotional care in a community context. Another psychologist suggested that people could afford mental health care if they reprioritized some of their spending habits, either for themselves or for their children. Coming out of the focus group, we had a better idea of the demographics that our campaign needs to target and the way we should structure our message.

4.1.2 EasyHealth

After a discussion with Ms. Ace, the project liaison, we discovered the importance of integrating ‘I See A Psychologist’ with EasyHealth, a website VCPS is creating that will host the campaign and offer a platform to house future projects and initiatives. Ensuring that the ‘I See A Psychologist’ project is not a standalone campaign will enable us to design a campaign with an impact that will last beyond the duration of the project term.

EasyHealth is the website that is being developed for VCPS and will act as a platform for multiple resources regarding mental health. By hosting ‘I See A Psychologist’ on the EasyHealth website, VCPS will be able to market both websites

together to increase traffic and flow to both. Additionally, since EasyHealth would host other resources, it would be a great platform to include our resources where they can be valuable to visitors even beyond the life of the 'I See A Psychologist' campaign. Likewise, visitors will also have access to all of the resources that are offered on the EasyHealth website that are not directly related to the campaign. This site also has the potential to provide a foundation for future IQP teams from WPI. As a result, we have the opportunity to leave behind a basis for initiatives that could benefit the Australian public for years to come. The existence of EasyHealth allows our project to be more robust than it would otherwise be, and it can have a wider reach than we could achieve on our own. Since EasyHealth will be based around 'I See A Psychologist', we will be building the website in conjunction with the 'I See A Psychologist' campaign.

4.2 Survey of Students at Melbourne University

We visited the Melbourne University campus to learn about the students' perceptions of mental health care. Approximately one third of respondents had consulted with a mental health care practitioner, with about three quarters of those only consulting with a practitioner for less than three months. About three fifths of those who had consulted with a practitioner had done so within the last year, with only one respondent having done so more than 10 times in the past year. About one third of those respondents were unlikely to consult with a practitioner again (of those, most did not find their experience very helpful), while the remaining two thirds were at least somewhat likely to do so again. The respondents were fairly evenly split over whether they would be likely to tell someone else that they consulted with a mental health care practitioner, perhaps indicative of the internal stigma associated with seeking mental health care.

We focused on the data collected of the students between 18 and 25 years of age to compare it with the 16 to 25-year-old demographic that showed the highest prevalence of mental health illness and the lowest use of mental health care services. As shown in Figure 5 (a), we found out that about 10.5% of males and 7.1% of females were people diagnosed with mental health disorders. These statistics do not match with the data in Figure 2, showing the prevalence of mental health disorders among various

age groups in 2007. The data of the Australian Bureau of Statistics used the diagnostic algorithms of the World Health Organization using information on life experiences and symptoms (see Australian Bureau of Statistics, 2007, pg. 7, 65). In this way, it can be predicted that a higher number of respondents have mental health disorder symptoms that can lead to diagnosis than the ones that identified that they were diagnosed with a mental health disorder. In the case of people who actually consulted with a mental health practitioner, it can be seen that female young adults had consulted with mental health practitioners much more than male young adults. This trend is also found in the National Survey of Mental Health and Well-being, where about 32% of females in the ages 16-25 used a mental health care services, and about 12% of males in the same age range did too. The difference in the percentage of the use of mental health care in this demographic might be due to better access and promotion of mental health care, or to a difference in the surveying group which included a lower age range and was not limited to the university demographic. However, data still shows that there must be a significant improvement in access and use of mental health care services.



Figure 5: College students in the 18-25 age group who have (a) been diagnosed with a mental health disorder, and (b) consulted with a mental health practitioner.



Figure 6: Survey response on the (a) willingness to consult with a mental health practitioner for life struggles and (b) willingness to consult with a mental health practitioner for well-being purposes.

The views that people had on maintaining mental well-being were explored using several questions with a rating scale response. We found that people consider mental health care when they are having difficult moments in life. As seen in Figure 6 (a) all the people agreed to a certain extent that a mental health practitioner can help in difficult moments in life. However, as seen in Figure 6 (b), most people do not believe that a mental health practitioner can help for general well-being purposes. This is troubling because, as established by the practitioners in the focus group, maintaining mental well-being using psychologists is important as preventative care. Interestingly, this seems to be contradictory to people's' responses, who cite mental well-being as highly important. As seen in Figure 7, the majority of surveyed students believe that maintaining emotional health is as or more important than maintaining physical health; however, they do not reflect this in their actions. This trend is likely a result of the personal stigma that young adults have surrounding the seeking of mental health care. While people are aware of the importance of maintaining mental well-being, there is room for improvement in raising awareness of the importance of using mental health care to improve or maintain their emotional health.

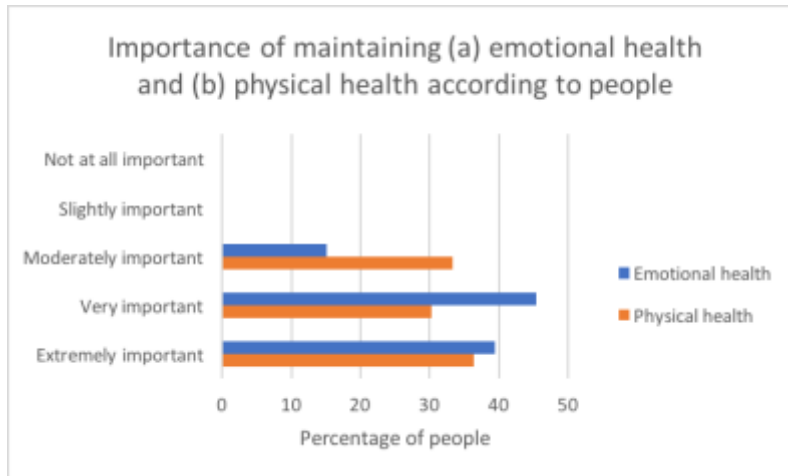


Figure 7: Survey responses of the importance of maintaining emotional and physical health.

Several other conclusions can be drawn from the survey; over 90% of the respondents felt that seeing a mental health care practitioner would be at least moderately helpful, with a majority of respondents saying it would be “very” or “extremely” helpful. Most respondents at least somewhat agreed that people are generally caring toward people with mental illnesses. About 80% of respondents either thought that Medicare did not cover mental health care, or were unsure if it did. This is an important statistic, as people may be more likely to seek care if they know there is Medicare coverage. An important element of our campaign will also be effectively informing people of their benefits under Medicare. This will be included as a resource.

We found that surveying people outside the university was much more difficult. People were unwilling to take time to participate, especially the business demographic. We also had difficulty forming a relationship with cultural organizations. Some of the organizations were not as well defined as we expected, and some of the groups were very hesitant to work with people outside their cultural group, let alone people from outside Australia. We later found during our interview with Yonas, mentioned below, that those difficulties were to be expected, as it took him years to form some of the relationships he has with cultural organizations.

4.3 Engagement with Other Organizations

After a few weeks of contacting organizations using different methods, we successfully engaged with three mental health service organizations. Two of the three organizations were contacted through VCPS contacts and snowballing method, which we found was a very effective way to get in contact with people. In the case of SANE Australia, we contacted them by calling and emailing the media department. This method of contact was not very effective since we used it with other five organizations and we either did not hear back from them or were told they could not provide the information we required. However, the organizations we interviewed make up a diverse array of the mental health sector.

4.3.1. SANE Australia

The first organization we interfaced with was SANE Australia through a 30-minute phone interview. SANE does much of its work through its own website as opposed to other separate campaigns. In our interview with the Director of Media, we were able to discuss some of the most effective tactics that they found. A very effective tactic for SANE's outreach was the use of people telling personal stories. The organization has an extensive network of speakers they have built up over time who they use for publicizing real stories of people's experiences with mental health care. While the information was interesting to learn about, speaking to this organization we were able to tell that their view on mental health campaigns was very idealized. There was no mention of any real difficulties or challenges that the organization faces. Some of this can be attributed to the individual we interviewed being with the organization for only 6 months. The organization also struggles with achieving a representative demographic. Often, they do not have representation from some minorities in their campaigns and in research they conduct.

4.3.2. Social Worker

We also engaged with Yonas Mihtsuntu, a manager at Wellways, a social service organization specifically focused on mental health. He focuses on community outreach and strives to change perceptions among different minority groups through education. The advantage of speaking with Yonas is that he has spent a lot of time working with

different cultural groups and understands some of the challenges of working with mental health in such a diverse city. When working with different minority groups Yonas mentioned how there is no “one size fits all” solution. Some tactics that work for one group or one person might not work for another. Additionally, there is also complexity in that each individual person also has their own, different perceptions. While we are able to build a campaign that will target a lot of people, it is important to understand that it cannot target everyone. Yonas has many connections with different cultural groups and also discussed the difficulty of working with different cultural groups. Often, it can be difficult to interact with different cultural groups because of the stigma surrounding mental health. The subject can be very sensitive, and some cultures view mental health as something that shouldn't be discussed. Often, it takes the trust of a cultural group to begin talking about these more sensitive topics, which is difficult to attain in a 7-week period. These realizations pushed us away from spending too much time to contact cultural groups given the time constraint.

4.3.3. beyondblue

Through our liaison, Ms. Ace, we were able to get in touch with Andrew Thorp, the Project Manager of Men and Stigma at beyondblue. The first topic we discussed was stigma and the effects of it on people and in developing a campaign. Mr. Thorp went through some background research they did to develop their campaign, centered around the three types of stigma identified in [Section 2.2.3](#). He mentioned that self-stigma, public stigma and institutional discrimination have to be addressed because they discourage people from seeking mental health care. He mentioned that in order to use these concepts in campaigns, the wording must change to avoid identifying shame, prejudice and discriminating attitudes. It is the role of organizations to provide resources to individuals so that they do not feel ashamed, to provide resources to the media to accurately convey ideas of mental health while preventing prejudice, to provide service and advocacy to people who are being discriminated and to educate companies, organization and the government about mental health care services. He also mentioned that it is very hard to challenge stigma as it is present in different forms and in different levels of society, so that what they intend to do is promote mental health literacy

through their campaigns to make people understand and be aware of the importance of mental health.

The second big topic we discussed was concerning their Man Therapy. Mr. Thorp said that the campaign, which focuses on the middle-age Caucasian population, was very successful. He said that 77% of the people exposed to the campaign enjoyed the site's humor, and many commented that presenting a manly doctor as the face of the campaign was very helpful. Another contribution to beyondblue's successful campaign may be over their 90% name recognition. However, he particularly focused on Davo, a blue-collar worker character used as part of the Man Therapy campaign, who was not very successful on reaching out the blue-collar population. To analyze the effectiveness of the campaign, beyondblue used three methods which included website analytics, community response through search engine optimization (SEO) tools and focus testing. After looking into the Davos part of the campaign, they notice that the response per dollar spent was very low. They determined that the language and the message was not adequately framed for the audience they wanted to reach, causing the character to be insulting the population to a certain extent. For this, Mr. Thorpe mentioned that it is essential to identify the target audience of the campaign as early as possible to be able to convey a message that accurately reaches them.

4.4 Website Focus Group

After completing a full version of the website, we conducted a focus group with VCPS psychologists, general practitioners, and other employees to gain their feedback regarding the website's structure and content. We received comments pertaining to the readability of the text, such as making the text on the main page of the site bolder so it was easier to read against the photo background. We were also encouraged to use a selection of photos on the main page instead of only one static image. There were also minor sections of the quizzes and resources pages that we reworded at the suggestion of some of the psychologists, such as changing mentions of mental health care practitioners to specifically refer to psychologists or psychiatrists, such that visitors to the site would be less confused. Members of the focus group also suggested that the question asking visitors if they had been diagnosed with a mental disorder was

unnecessary, since such information would be gathered anyway if someone wanted to make an appointment with a VCPS psychologist. Finally, we needed to change the video link description to tell the visitors that they could chat with our team instead of speaking directly with a psychologist, since all chats and video conferences go to the intake team, instead of to the psychologists and practitioners.

5. DELIVERABLES

The main deliverable for this project is the 'I See A Psychologist' campaign website. The website guides the users through several steps, or a journey, to learn more about mental health and mental health care as they take a quiz, watch videos and have access to a variety of resources. In order to start this journey, the homepage of the website will include a video of people living their lives, pointing out how people experience different feelings throughout their everyday lives. The introductory video (screenshot shown in Figure 8), included in the homepage, first seeks to grab the attention of the viewer and engage them in the campaign. It is meant to be interesting and attention grabbing while exposing individuals to the subject of mental health. The video also serves to encourage the user to proceed forward in the journey through the website. The sometimes-overwhelming stresses of daily life are portrayed through a progression of video clips, in which each clip is shorter than the one before it. This accelerates to the point where each video clip is about a third of a second long. The final couple of seconds show how one can be overwhelmed with all the small things we do in life. In conjunction with the quickening video clips, the background music also crescendos with the music. At the climax, the screen goes black and the music transition to a slower, normal pace as the video then changes to show slower, more pleasurable activities. These activities represent ways for an individual to maintain his or her mental health to help manage the stresses of daily life. Throughout the video, there are voice overs that help guide the users through the experience.



Figure 8: Introduction video screen-shot.

At the conclusion of the video people will be invited to learn about their journey through life and learn how they can maintain their well-being. Below the video, there will be a button with an empty space and the message “begin my journey,” where people can click on it to follow to the following page. Alternatively, there will be a button offering the option to contact someone immediately in case an individual needs immediate help. In this regard, the Lifeline contact information will be on every page for those experiencing extreme emotional distress that need immediate support. When selecting to continue their journey, the users will be asked some preliminary questions regarding demographics. This information will be useful in driving web analytics in the future. Following this, the user will be prompted to select an avatar to follow through a normal day in the life of that avatar.

The “avatar story” videos include a set of clips of three different characters, of which one is a student, another is an employed white collar adult, and the last is an employed blue collar adult. Each video will go through a day in the life of the actor and show how a mental health practitioner can be helpful at many stages in life and in

solving daily life concerns. The expansion of the avatars in the future will provide more options for individuals to follow. As we learned from beyondblue, it is important to be sensitive to who people identify with as an avatar. The goal of the avatar is not to create someone that the visitor should absolutely relate with, but rather, it serves to provide an example of a person's daily life which includes using a psychologist for maintaining well-being. It is there just to show a possibility of what someone can do to normalize mental health, not to demonstrate the only way for someone to do so.

The next step in the campaign is a self-assessment quiz, which will be used to identify the emotional distress levels of the users. We drew inspiration from similar quizzes from existing mental health campaigns such as Man Therapy by beyondblue. The quiz itself is adapted from a Kessler 10 (K 10) survey that is commonly used by psychologists. The quiz responses will be able to alert the user of their emotional distress level, whether low or high, and recommend any further actions such as speaking to a mental health care practitioner or otherwise. We consulted with VCPS to ensure that the questions are well designed and that the information provided to visitors is accurate and useful. The last question of the quiz serves as a gateway question to determine which path on the journey the user will proceed. If they have seen a mental health care professional in the past they will be taken to the resources page. If they have not seen a mental health care practitioner in the past, they will be taken to the psychologist video to learn more about what that would entail.

The "psychologists' experiences" videos consist of psychologists discussing three topics: why to see a psychologist, what to expect during a first appointment, and what the expected outcomes are. These videos will be displayed when the visitor indicates that he or she has not had any experiences with a psychologist or if their quiz results suggest that they exhibit symptoms of mental illnesses. The purpose of these videos is to allow a mental health care professional to answer some of the most common questions people have when it comes to seeing a psychologist. Each video shows multiple psychologists commenting on the same topic so that the message is communicated through many different people that the user can relate to or learn to trust. With many people reinforcing the same point, it adds validity to the point the videos make. These will allow people to be informed as to the process so that uncertainty in

process is not an obstacle in deciding whether to seek help. These videos have a very heavy emphasis on normalization.



Figure 9: Psychologist video screen-shot.

Once completed, the user will then be guided to a resources page. All of the appropriate and related videos will be available to visitors on the resources page after they have completed their journey. They will be able to re-watch any of the videos, from the psychologist videos, to the different character videos or even the introduction video. Additionally, there will be some digital resources that provide additional information, such as specific mental illness information, Medicare rebate information and more. A more detailed guide through the 'I See a Psychologist' portion of the EasyHealth website can be found in Appendix L.

One feature that will set our campaign apart from others is the ability to connect with psychologists from VCPS directly via the campaign's website. VCPS already uses a video link technology on their primary website, and it will be our goal to seamlessly integrate that existing service into the campaign's website. This integration will allow visitors to easily contact a psychologist to discuss any potential concerns or simply to

learn more about mental health care directly from practitioners. We hope that the ease of use and lack of commitment involved in contacting a psychologist in this manner will make the option more appealing to people visiting the campaign's website. After making their way through this campaign, visitors will have an understanding of the benefits of using mental health care as a preventative health measure as well as knowledge about what the experience will be like.

6. RECOMMENDATIONS

When we began the project term, we had ambitious plans for what we wanted to achieve with the 'I See A Psychologist' campaign. While we were able to accomplish many of these plans, there were some sections of the project that we needed to adjust or reduce due to the relatively short amount of time we had available. We still want to present these ideas to VCPS as ideas that they can implement in the future, potentially with future student teams from WPI. Our project can stand on its own to promote and normalize mental health care, but with future efforts to build upon what we have started, we think that our project can serve as the foundation of something with a much wider impact. We hope that VCPS incorporates the campaign into their wider platform of resources to increase the reach and effectiveness of all of the web content.

6.1 Cultural Outreach and Research

As we discovered during our conversation with Yonas, it can take time to form working relationships with the various cultural organizations in Victoria. The project term was simply too short for us to be able to form lasting relationships with the groups that we want our campaign to reach. Additionally, as foreigners, there was an additional level of difficulty to convincing organizations to work with us, since some organizations were hesitant to trust us. However, we think that VCPS has the ability and time to form these relationships. VCPS is well established in the community with offices all around Victoria. Furthermore, there will be no time constraint for forming these relationships if they are facilitated by representatives from VCPS who are members of those communities themselves, so the relationships will be able to grow and thrive naturally. If VCPS were able to work closely with Victorian cultural organizations, then they can gather additional research in order to make EasyHealth and the 'I See A Psychologist' campaign even more effective for these demographics, which will in turn improve the quality of their mental health care.

6.2 Expanding the 'I See A Psychologist' Campaign

In order to extend the reach of the campaign, we recommend that more character videos be created for the website that showcase a more diverse group of individuals and professions. The three videos that we made show the format and lay

down the foundation of the avatar concept, but due to our time constraints, we had to use actors whose schedules matched our filming schedule, and this limited the selection of demographics that we could represent. Based on our research, the campaign will be most effective if many different occupations and cultural groups are represented, as this will create opportunities for more people to be able to relate to the campaign's message. We specifically recommend representing demographics such as the Chinese, Indian, and Italian immigrant communities, since these groups make up a large portion of the Victorian population.

Another potential expansion to the website could include the addition of actual stories from people who have personal experiences with mental health care. An original goal we had was to include personal stories on the website that people could watch and relate to, however, due to several constraints we were unable to proceed with actual stories and instead moved to the actors that we came up with. The actors are effective in conveying the normalization of mental health care and its importance, whereas personal stories would present more realistic situations that people can relate to and be more apt to identify with.

6.2.2 Growth of Social Media in Parallel with the Campaign

We also think that the campaign should be promoted via social media, particularly Facebook and Instagram. Our research of previous social campaigns and the Humans of New York social media pages (see [Section 2.4](#)) show that the kinds of stories that are told through the character videos are engaging for people browsing social media sites. Based on this research, we think that images or short clips from the avatar videos should be shared on these platforms to increase interest in the campaign and drive traffic to the website. We did not have time to amass a social media following during our project term, but we think it is essential to the campaign's future success.

6.2.3 Extensive Focus Testing

An important element of the campaign will be extensive focus testing on all components of the campaign. This includes the videos as well as the website layout itself. Through preliminary focus testing we were able to learn about some areas of improvement of the campaign, however, this preliminary focus testing was limited. The

results of the preliminary focus test can be found in [Appendix N](#). More focus testing outside of the VCPS network will be important to gain a perspective of the campaign from someone that is not in the mental health care industry.

6.3 Growing the EasyHealth Brand

In addition to expanding the 'I See A Psychologist' campaign, we think it is also important for VCPS to add new initiatives to the EasyHealth brand. There should be more specialized sections of the website, like the Early Care program, which will make EasyHealth a more full-featured health platform. By gathering more topics under the name of EasyHealth, it can become a brand to which people can turn for any concerns related to mental health or mental health care. By including more specializations, a wider range of people can find the site useful, and this will naturally lead to more people discovering the site and the other connected initiatives. As a result, not only will adding new areas create new uses for EasyHealth, but it will also strengthen all of the existing initiatives under the brand.

7. CONCLUSION

Our project was to create a web-based campaign to normalize mental health care in Australia. We conducted research on a wide range of topics, including the prevalence of mental health stigma, specific demographic and mental health care statistics for Australia, and existing mental health and social outreach campaigns. After combing this research with our own survey and interview data, we created the 'I See A Psychologist' campaign as a part of the new VCPS EasyHealth platform. The quizzes and resources that we provided, along with the videos that we created for the website, promote mental health care in an appealing way that will expose visitors to the notion of mental health care as a proactive form of treatment instead of only a reactive treatment in response to a serious mental illness. In turn, this will gradually normalize the idea of seeking mental health care as a part of one's normal health routine. Over time, the normalization of mental health care will lead to the reduction of stigma surrounding seeking treatment from psychologists and other mental health practitioners.

We encountered several challenges during our research phase, especially with regard to surveys and interviews. When surveying the general public, we found that most businesspeople and other workers were not willing to fill out the survey. For this reason, this portion of our research was limited to the demographic of university students. Additionally, we found that cultural organizations were hesitant to speak with a team of American students whom they did not know, and we did not have the time needed to foster relationships with these organizations. This also restricted the data we received from the survey. When we interviewed mental health organizations in Australia, we discovered that some of the organizations could not share any internal information with us, particularly since VCPS is a for-profit company, and could therefore be seen as a competitor. We still managed to collect notes from several interviews, but we originally expected to be able to gather information from more organizations.

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Appendix A: Summary of Common Mental Illnesses

All gathered from the following source: Substance Abuse and Mental Health Services Administration, 2015.

Anxiety Disorders are disorders often indicative of excessive fear that is difficult to control that impacts a person's ability to function daily. These can range from phobias to more general fears. These are most prevalent in children aged 13 to 18 than any other age group. These are often a result of both biological and experiential factors.

Attention Deficit Hyperactivity Disorders, (ADHD), is characterized by inattention and hyperactivity impulse. People with ADHD can often lack in scholastic performance and social interactions. They can have a difficult time sitting still or completing tasks. ADHD seems to have a genetic root; however, other environmental factors can cause ADHD.

Bipolar Disorders are characterized by drastic mood swings and certain mood episodes. Bipolar disorder is most commonly seen within the same genetic line. Episodes can range from joy to depressive to manic episodes. These can interfere with normal life and certain episodes can pose other related risks (such as suicide risk during depressive episodes).

Depressive Disorders are among the most common mental illnesses. These disorders are characterized by sad, hopeless or empty moods and can cause cognitive changes that interferes with daily life. Suicidal thoughts can occur during an episode. There are many potential causes, including biologic, environmental or genetic.

Disruptive, Impulse Control, and Conduct Disorders are classified by the inability to control emotions or behavior that violate the rights of others or bring the individual into conflict with others; these are most common in children. Irritable mood is common for these disorders. These are most often brought on by environmental factors.

Obsessive-Compulsive and Related Disorders, (OCD), is characterized by persistent thoughts that are intrusive or unwanted or ritualistic and repetitive behavior in order to control obsessions. This tends to begin in childhood. The causes of OCD are unknown

but may be linked to genetic or environmental causes. OCD symptoms are time consuming and can cause serious dysfunction in life.

Schizophrenia Spectrum and Other Psychotic Disorders are classified in abnormalities in one of the following domains: delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms (such as diminished emotional expression and a decrease in interest in self-initiated activities). Causes of these disorders are believed to be a genetic predisposition coupled with environmental causes.

Trauma- and Stressor-Related Disorders are caused by previous exposure to a stressful event; the most common of these is Post-Traumatic Stress Disorder (PTSD). These are characterized by potentially debilitating symptoms such as flashbacks and nightmares. These can lead to hypervigilance, distractibility, and irritable or self-destructive behavior.

Appendix B: Summary of Mental Health Professionals

All gathered from the following source: National Alliance on Mental Illness, n.d.

Type of Mental Health Professional		Description
Those that can prescribe medication	Primary Care Physicians	Primary care physicians can prescribe medication and offer some preliminary insight into mental health. They often refer individuals to other professionals more specialized in mental health care.
	Psychiatrists	Licensed doctors that can diagnose mental health conditions. They can also help with counselling and therapy.
	Psychiatric or Mental Health Nurse Practitioner	Nurses can provide assessment and diagnosis of mental health conditions.
Therapists	Clinical Psychologists	Clinical psychologists hold a doctoral degree in psychology and can make diagnoses and provide therapy, such as cognitive behavioral therapy or other therapies.
	Psychiatric or Mental Health Nurses	These professionals may have varying degrees, they can assess and help treat mental health conditions and offer help with case management.
	School Psychologists	School psychologists can make diagnoses and work with teachers, parents and students to ensure a healthy environment, they may help determine individualized education plans.
Counsellors	Clinical Social Workers	They are trained to make a diagnosis and provide counselling and help with case management. They often work in hospitals, clinics or private practices.
	Counsellors	Trained to diagnose and provide counselling. Often have different focuses they specialize in.
	Pastoral Counselors	Clergy members with training in making diagnoses and providing counselling. They are highly trained in counselling equivalent to a

		doctorate in counselling.
	Peer Specialists	These individuals have lived through a mental health condition and have received training and certification and can assist with counselling.
	Social Workers	Social workers provide case management help and planning.
	Psychiatric Pharmacists	These professionals work directly with patients to aid with medication management and assess medications and help provide treatment, whether pharmaceutical or not.

Appendix C: Summary of Common Mental Health Treatments

<i>Type of Treatment</i>		<i>Description</i>	<i>Source</i>
Therapy	Cognitive behavior therapy	Works to determine thoughts and behaviors that lead to negative symptoms, using this knowledge, the patient can begin to make changes that will replace these behaviors and thoughts with others that prevent symptoms	American Psychological Association, n.d.
	Behavior therapy	Encourages rewarding activities to boost mental health as opposed to changing beliefs.	American Psychological Association, n.d.
	Psychotherapy	Learning about your condition, thoughts, mood and behavior. The learned insight often helps learn to cope and manage stress. Heavily dependent on the relationship between the therapist and patient.	Mayo Clinic, 2015
	Brain-Stimulation Treatments	Reserved for cases where psychotherapy and medications do not work. These include electroconvulsive therapy, transcranial magnetic stimulation, deep brain stimulation and/or vagus nerve stimulation.	Mayo Clinic, 2015
Medication	Anti-depressants	Medications that improve symptoms such as sadness, hopelessness, lack of energy, difficulty concentrating and lack of interest in activities.	Mayo Clinic, 2015
	Anti-anxiety medication	Treat anxiety, help reduce agitation and insomnia, may cause dependence in some and should only be used short term.	Mayo Clinic, 2015
	Mood-stabilizing medications	Commonly used to treat bipolar disorder to stabilize mood. Sometimes used for depression when coupled with anti-depressants.	Mayo Clinic, 2015
	Antipsychotic medications	Used to treat psychotic disorders like schizophrenia. May also be used for	Mayo Clinic, 2015

		bipolar disorder.	
Other	Hospital or Residential Treatment Programs	Reserved for individuals that cannot care for themselves when they are in immediate danger of harm.	Mayo Clinic, 2015

Appendix D: Relevant Data from the 2011 Census: Expanded Community Profile

Taken from: Australian Bureau of Statistics 2011 - Census of Population and Housing

Sample of Victoria: 227495.7 square-kilometers.

Country of Birth (a) of Person:

<i>Country</i>	<i>Persons</i>
Australia	3,670,937
Austria	4,563
Bosnia and H.	9,159
Cambodia	11,354
Canada	7,772
Chile	7,099
China, exc. SARs & Taiwan (b)	93,894
Croatia	17,248
Cyprus	8,177
Egypt	12,491
England	172,071
Fiji	9,714
Macedonia	18,309
France	5,614
Germany	28,022
Greece	49,994
Hong Kong (SAR of China)	18,204

(b)	
Hungary	5,566
India	111,785
Indonesia	15,404
Iran	7,445
Iraq	12,797
Ireland	14,588
Italy	76,906
Japan	6,818
R. Korea (South)	10,193
Lebanon	15,869
Malaysia	39,789
Malta	19,729
Mauritius	11,600
Netherlands	21,634
New Zealand	80,239
Northern Ireland	5,858
Papua New Gui.	2,534
Philippines	38,005

Poland	16,382
Scotland	29,805
Serbia	7,383
Singapore	13,698
South Africa	24,450
South Eastern Europe, nfd (c)	8,845
Sri Lanka	43,996
Sudan (d)	6,085
Taiwan	5,687

Thailand	10,764
Turkey	16,492
United States of America	16,844
Vietnam	68,294
Wales	4,831
Zimbabwe	3,783
Elsewhere (e)	157,549
<i>Total</i>	<i>5,354,041</i>

(a) This list consists of the most common 50 Country of Birth responses reported in the 2006 Census.

(b) Special Administrative Regions (SARs) comprise 'Hong Kong (SAR of China)' and 'Macau (SAR of China)'.

(c) Includes persons who stated their birthplace as Yugoslavia.

(d) Includes persons who stated their birthplace as South Sudan.

(e) Includes countries not identified individually, 'Australian External Territories', 'Inadequately described', and 'At sea'.

Country of Birth (Major Group) of Person:

<i>Region of Birth</i>	<i>Persons</i>
Oceania and Antarctica	
Australia	3,670,937

Other (a)	100,631
<i>Total</i>	<i>3,771,568</i>
North-West Europe	296,895
Southern and Eastern Europe	274,572
North Africa and the Middle East	88,786
South-East Asia	210,735
North-East Asia	135,547
Southern and Central Asia	186,322
Americas	49,543
Sub-Saharan Africa	59,467
Other (b)	2,834
Country of birth not stated	277,772
<i>Total</i>	<i>5,354,041</i>

(a) Includes 'Australian External Territories'.

(b) Includes 'Inadequately described', and 'At sea'.

Language Spoken at Home (a) By Proficiency in Spoken English/Language:

<i>Language</i>	<i>Count of Persons</i>
	<i>Speaks other language and speaks English</i>

	<i>Very well or well</i>	<i>Not well or not at all</i>	<i>Total</i>
Speaks other language:			
Arabic	56,545	11,019	67,564
Assyrian	6,996	2,670	9,666
Australian Indigen. Languages	435	34	469
Chinese languages:			
Cantonese	55,154	17,257	72,411
Mandarin	79,679	23,325	103,004
Other(c)	13,488	4,795	18,283
<i>Total</i>	<i>148,321</i>	<i>45,377</i>	<i>193,698</i>
Croatian	18,748	3,178	21,926
Dutch	9,078	319	9,397
French	15,471	643	16,114
German	19,262	574	19,836
Greek	94,443	21,211	115,654
Hungarian	6,395	892	7,287
Indo-Aryan languages:			
Bengali	6,285	537	6,822

Hindi	30,774	1,573	32,347
Punjabi	28,064	2,422	30,486
Sinhalese	26,211	1,636	27,847
Urdu	9,863	1,050	10,913
Other(d)	16,618	1,414	18,032
<i>Total</i>	<i>117,815</i>	<i>8,632</i>	<i>126,447</i>
Iranic languages:			
Dari	5,239	2,368	7,607
Persian (excluding Dari)	8,152	2,455	10,607
Other(e)	2,457	817	3,274
<i>Total</i>	<i>15,848</i>	<i>5,640</i>	<i>21,488</i>
Speaks other language (continued):			
Italian	103,485	19,466	122,951
Japanese	7,170	1,285	8,455
Khmer	7,596	4,077	11,673
Korean	7,239	2,947	10,186
Macedonian	25,257	5,344	30,601
Maltese	16,382	1,602	17,984

Polish	14,320	1,975	16,295
Portuguese	4,460	618	5,078
Russian	13,021	3,309	16,330
Samoan	6,841	571	7,412
Serbian	14,231	3,172	17,403
Southeast Asian Austronesian languages:			
Filipino	13,914	436	14,350
Indonesian	12,778	973	13,751
Tagalog	15,803	536	16,339
Other(f)	5,680	416	6,096
<i>Total</i>	<i>48,175</i>	<i>2,361</i>	<i>50,536</i>
Spanish	25,032	3,652	28,684
Tamil	15,824	1,418	17,242
Thai	6,260	1,289	7,549
Turkish	25,739	6,803	32,542
Vietnamese	57,498	28,293	85,791
Other(g)	102,244	21,020	123,264
<i>Total</i>	<i>1,010,131</i>	<i>209,391</i>	<i>1,219,522</i>

Language spoken at home not stated	13,794	3,243	17,037
Total	1,023,925	212,634	1,236,559

Speaks English only	3,874,860
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(a) This list of languages consists of the most common Language Spoken at Home responses reported in the 2006 Census.

(b) Includes the categories 'Proficiency in English not stated' and 'Language and proficiency in English not stated'.

(c) Comprises 'Chinese, nfd', 'Hakka', 'Wu', 'Min Nan' and 'Chinese, nec'.

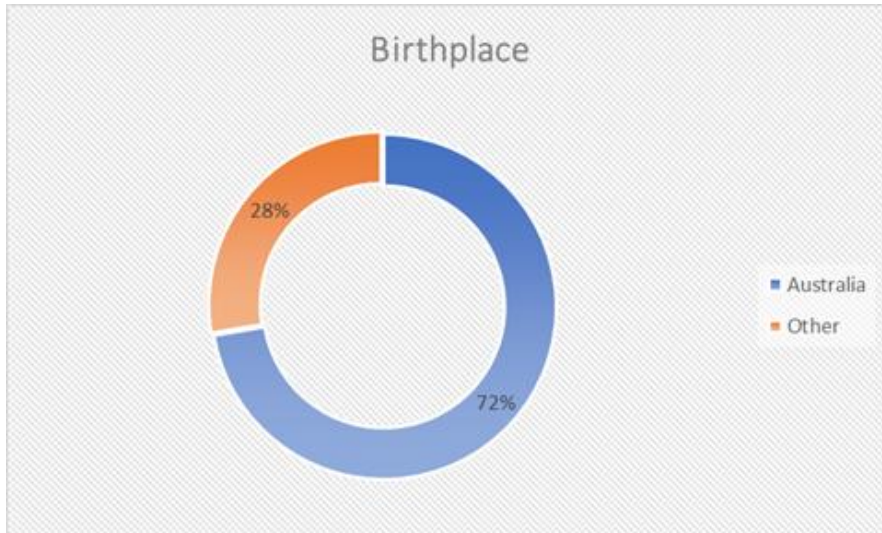
(d) Comprises 'Indo-Aryan, nfd', 'Gujarati', 'Konkani', 'Marathi', 'Nepali', 'Sindhi', 'Assamese', 'Dhivehi', 'Kashmiri', 'Oriya', 'Fijian Hindustani' and 'Indo-Aryan, nec'.

(e) Comprises 'Iranic, nfd', 'Kurdish', 'Pashto', 'Balochi', 'Hazaraghi' and 'Iranic, nec'.

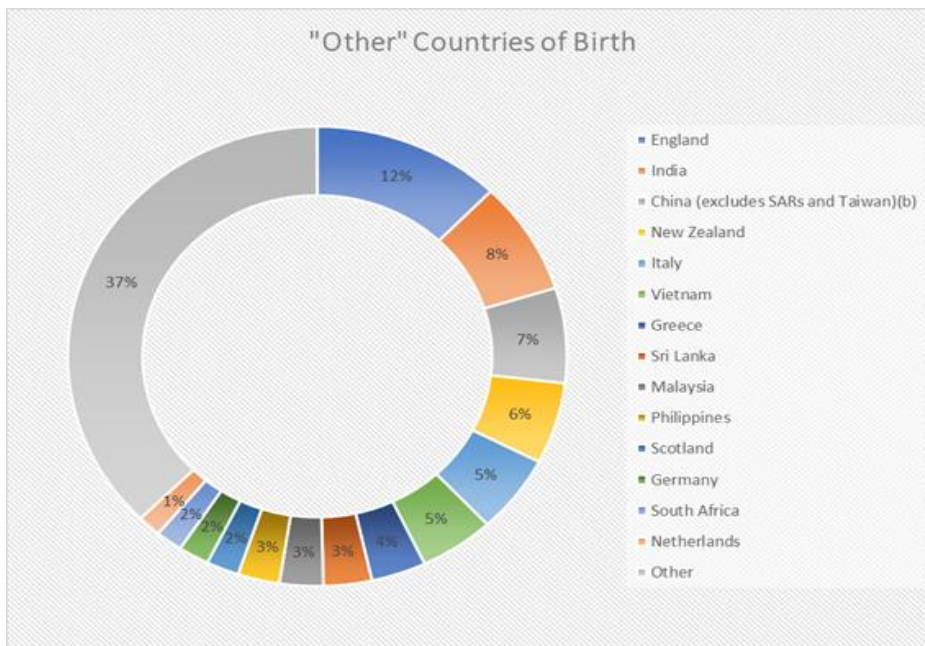
(f) Comprises 'Bikol', 'Bisaya', 'Cebuano', 'Ilokano', 'Ilonggo (Hiligaynon)', 'Pampangan', 'Malay', 'Tetum', 'Timorese', 'Acehnese', 'Balinese', 'Iban', 'Javanese', 'Southeast Asian Austronesian Languages, nec' and 'Southeast Asian Austronesian Languages, nfd'.

(g) Comprises languages not identified individually, 'Inadequately described' and 'Non-verbal, so described'.

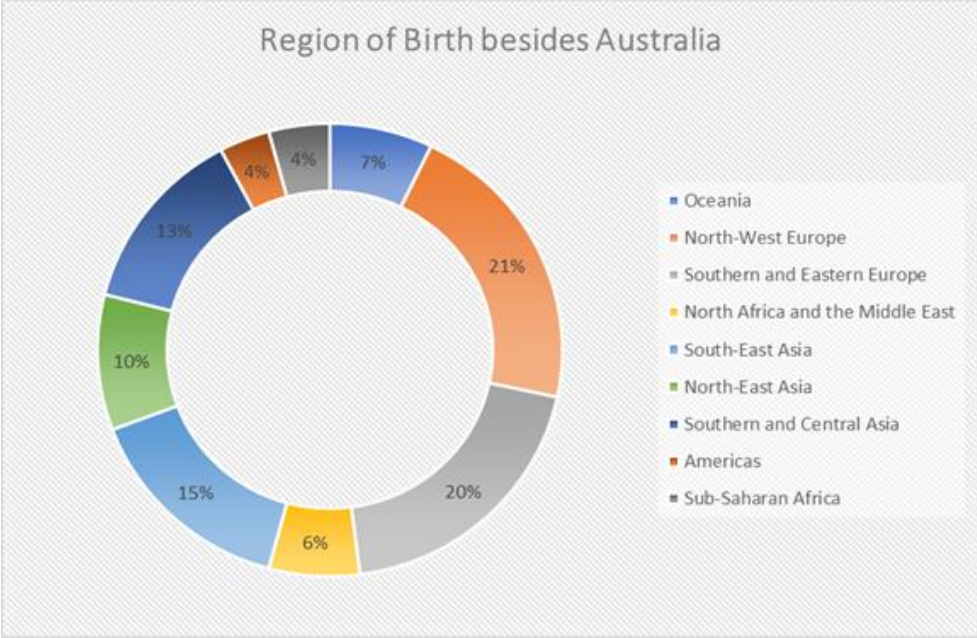
Appendix E: Graphs Derived from the 2011 Census: Expanded Community Profile



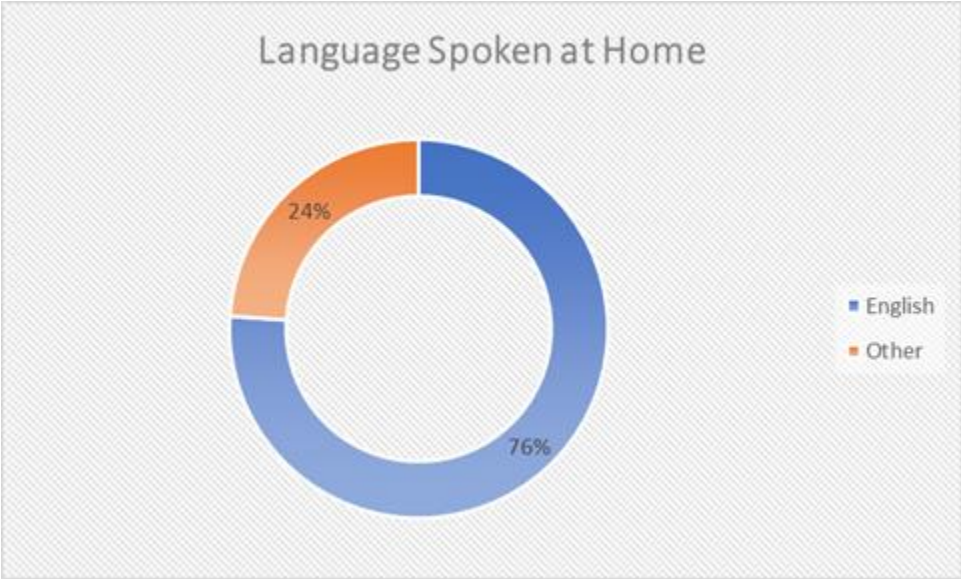
This graph represents the birthplace of the residents of Victoria.



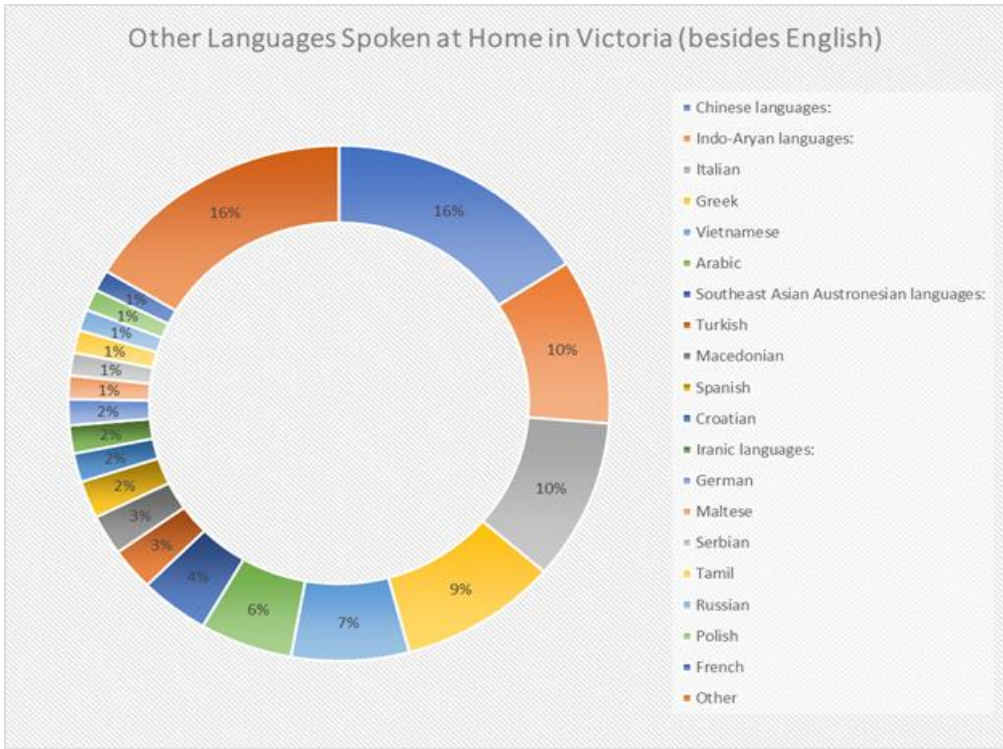
This graph represents the countries where those born outside Australia were born. It accounts for the 28% from the first graph.



This graph represents the geographic regions where those born outside Australia were born. It accounts for the 28% from the first graph.



This graph represents the percentage of people that speak languages other than English at home.



This graph represents the other languages that are spoken in Victorian homes. This accounts for the 24% of the previous graph.

Appendix F: Mental Health Profile of Countries of Origin

Culture	Conceptions	Source
England	England is a clear example of community care. There are well established networks of mental health care providers. Large scale national pushes to revolutionize mental health care and perceptions of mental health care have occurred in the past few years. England is at the forefront of mental health care in the world, with comprehensive services. There are still some accessibility issues but strides are being made towards closing the utilization gap.	(Hewlett et al, 2015)
India	India is very multicultural where many people seek religious and traditional healers for mental health issues. Where modern mental health services are offered, they are used. There have even been some judicial and policy actions that have tried to address the issues of stigma attached to mental illness and the rights of those diagnosed. There is limited access to mental health care and it is all focused in urban areas, however, over 30% of the country lives in rural areas.	(Khandelwal et al, 2004)
China	Mental health in China is a huge concern. At any time, 17.5% of individuals have some mental	(Qian, 2012)

	<p>illness. Over 90% of patients with serious mental illnesses are never given proper mental treatment. There is a lack of qualified doctors in china to deal with mental health.</p>	
New Zealand	<p>New Zealand has a comprehensive mental health plan which offers a wide variety of services and the integration of mental health into the primary health care system. There are still some accessibility issues but strides are being made towards closing the utilization gap.</p>	(WHO, 2011)
Italy	<p>Italy has had a transition from institutionalized mental health treatment to community based mental health treatment. In a survey in Northern Italy, it was determined that over 60% of people with mental health conditions never seek the proper mental health care.</p>	(Forti, 2014)
Southeast Asia	<p>Generally, mental health care is characterized by unclear policy and poor criticality. About half the countries in the region have no mental policy, or mental health care in the community. A quarter of the countries in the region do not have proper psychological drugs to address issues. There is low utilization of mental health services due to the lack of existing services and the general use of traditional medicine rather than mental health professionals.</p>	(Niemi et al, 2010)

Greece	There is a national mental health policy, which places a strong emphasis in the development of community networks that are not present yet. Much of the mental health care is taken care of through general practitioners as opposed to mental health professionals. The economic recession of 2009 contributed negatively to the mental health of many Greek citizens. There is a stigma towards those who are mentally ill.	(WHO, 2011)
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Appendix G: Cultural Groups in Melbourne

All information below was taken from each group's website.

Country	Association	Contact Information
India	<p>Federation of Indian Association of Victoria (FIAV)</p> <p>The FIAV's goal was to serve as an umbrella organization for all the Indian community organizations in Victoria bringing together all the individual organizations as a unified body in order to strengthen the community and provide improved services to the Indian origin population in Victoria.</p>	<p>Address: 3/85, Foster Street, Dandenong, Victoria - 3175.</p> <p>Contact: Dr Sharad Gupta - President, Phone: +61 400 226 793,</p> <p>Email Address: president@fiav.asn.au</p> <p>Website: http://www.fiav.org.au/AboutFIAV.aspx</p>
India	<p>Australia India Society of Victoria</p> <p>Since its inception our organization has been committed to supporting new migrants and advancing the needs of established Indian Australians. Our ongoing mission is to support the hopes and aspirations of newly arrived Indians in Australia, as well as</p>	<p>Address: 1401 Ferntree Gully Road, Scoresby - Victoria 3179, Australia</p> <p>Email Address: secretary@aisv.org.au</p>

	<p>promote active participation in and contribution to a just and multicultural society.</p> <p>Our membership includes a wide range of individuals from all walks of life and places of origin.</p>	<p>Website: http://www.aisv.org.au/aboutus.php</p>
China	<p>Chinese Association of Victoria</p> <p>We encourage integration with Australian society, and actively support multiculturalism in Australia. The Chinese have a rich cultural heritage which we can share with other Australians and ethnic communities. We promote greater understanding and appreciation of the Chinese Community in Australia. At the same time, we look after the Chinese welfare and cater to our special needs.</p>	<p>Address: 8 Ashley Street Wantirna, Victoria 3152</p> <p>Telephone: 03 9800 3388,</p> <p>Email Address: memberservicescav@gmail.com</p> <p>Website: http://www.cavinc.com.au/</p>
China	<p>Australian Chinese Community Association</p> <p>ACCA is a non-political, non-religious, and a not-for-profit organization that was specifically formed to serve the Chinese-Australian community in New South Wales. Since its foundation in 1974, ACCA has been providing community services such as aged</p>	<p>Address: 2 Mary St, Surry Hills NSW 2010 - PO Box K489, Haymarket NSW 1240</p> <p>Telephone: (02) 9281 1377</p> <p>Email Address:</p>

	<p>home care, aged day care, dementia service, interest classes and Chinese language classes as well as organizing various cultural and Chinese festival events throughout the year. ACCA has also organized and been involved in various activities promoting multiculturalism and anti-racism as well as fundraising for victims of natural disasters.</p>	<p>info@acca.org.au</p> <p>Website: http://www.acca.org.au/drupal/</p>
<p>China</p>	<p>Chinese Australian Cultural Society</p> <p>The Society was formed in October 2008 in recognition of the changing needs of the Chinese community in Ballarat. In that time the Society has quickly developed strong relationships with the City of Ballarat, Sovereign Hill and Mt Clear College.</p> <p>There are over 200 members in the Society with 85% being either Chinese or of Chinese descent with the remainder being Australian. Several are fourth generation descendants of Chinese migrants to Ballarat in the 1800s while many have only recently come to Ballarat from overseas.</p> <p>President Michelle Philips is the first non-Chinese president of the association and is also the first female president. Michelle firmly believes that the society is blessed with both its friends and supporters as we all work</p>	<p>Telephone: 0421 608783 [President: Michelle Philips]</p> <p>Email Address: info@chineseballarat.org.au</p> <p>Website: http://www.chineseballarat.org.au</p>

	<p>towards bridging the cultural gap.</p> <p>At last count, members come from eight different countries and speak at least 12 different languages. The Society conducts weekly Chinese language lessons and strongly supports the Mt Clear Confucius Classroom. Training is also available in Tai Chi, Chinese folk dancing and Chinese Lion dancing.</p>	
Vietnam	<p>Vietnamese Welfare Resource Centre</p> <p>The Vietnamese Welfare Resource Centre is based in the high-rise housing estate at Flemington and has been responding to the settlement and support needs of the Vietnamese community in North and West Melbourne for over 18 years. Services offered by the VWRC include the provision of information and referrals, counselling and community groups for young people, families and the aged, and the fostering of community and cultural activities such as forums, classes, information sessions, training programs and festivals.</p>	<p>Address: 58 Holland Court, PO Box 55, Flemington VIC 3031</p> <p>Telephone: 03 9376 2033</p> <p>Website: http://www.icmscreatingconnections.org.au/resource/vietnamese-welfare-resource-centre</p>
Vietnam	<p>Australian Vietnamese Women's Association</p>	<p>Address: 30-32 Lennox St, Richmond VIC 3121</p>

	<p>To provide a framework for mainly Vietnamese women to collaborate and learn to lead and operate a not-for-profit organization to assist the settlement and harmonious integration of refugees and migrants of Vietnamese and other backgrounds in Victoria. To help Victorians, irrespective of age, gender, religion or ethnic background, obtain the information they need, know their rights, responsibilities, options and opportunities, realize their full potential and improve their health, happiness and well-being.</p>	<p>Telephone: + (613) 9428 9078</p> <p>Email Address: info@avwa.org.au</p> <p>Website: http://www.avwa.org.au</p>
Italy	<p>NOMIT</p> <p>NOMITs mission is to create a community directed at the new Italian immigrants in Melbourne, to support and inform our fellow nationals so that they can integrate more quickly and more consciously, to spread a newer and more contemporary vision of the Italian culture, through social as well as artistic projects that are aimed towards information and education.</p>	<p>Address: 1/509 St Kilda Rd, Melbourne VIC 3000</p> <p>Telephone: 0481 983 702,</p> <p>E-mail Address: info@nomit.com.au</p> <p>Website: http://nomit.com.au</p>
Greece	<p>Australasian Hellenic Educational</p>	<p>Address:</p>

	<p>Progressive Association (AHEPA)</p> <p>A broad-based community participation in Cultural, Charitable, Educational and Social activities through a structured and coordinated process which allows us to strengthen and improve Australian – Greek (Hellenic) Relations by encouraging Australian citizenship and participation in the civic and social fabric of our country Australia.</p>	<p>8A Church Street, Hawthorn, Victoria 3122</p> <p>Email Address: ahepa@ahepa.org.au</p> <p>Website: http://www.ahepa.org.au</p>
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Appendix H: VCPS Focus Group Questions and Notes

Questions

Purpose

This focus group is aimed to understand our sponsor's initiatives for the project 'I See a Psychologist'. This campaign is to look at ways we can normalize stigma around mental health. The idea is to work with innovative ways to encourage the "worried well" to reach out and work with a psychologist. We are looking to explore the different views that members of the VCPS team have on running this campaign.

Statement of Consent

Your participation in this interview is voluntary, and you may choose to opt out of answering any of the questions. This focus group will take 30-45 minutes.

Due to this interview being for research purposes, we will be taking notes and audio recording the session. If you are uncomfortable with this, please advise.

Confidentiality

We are using this focus group for research purposes which will provide a benefit to others. Should we use any specific information from this focus group in a public forum, we will not disclose any personal information. Unless you state otherwise, your participation in this interview allows us to use select information from this interview in a de-identified manner.

Questions

- What are your roles at VCPS?
 - What does your work involve?
- What demographics do you believe are or are not seeking mental health care?
Why?
 - What do you see as effective community public outreach methods?
 - Where is there room for improvement?
- What do you think it means to "normalize" mental health care?
 - Do you any obstacle in normalizing mental health care?

- Why would VCPS be interested in normalizing mental health care?
 - How should a campaign try to normalize mental health care?
 - What techniques should we use in our project to achieve these goals?
- What recommendations do you have as we move forward to implement this campaign?

Notes

Attendees

- Lauren (L): general psychologist with a PhD in psychology.
- Emma (E): clinical psychologist.
- Siobhan (S): general practitioner and sensory medical psychotherapist.
- Pana (P): business development at VCPS.
- Jan (J): receptionist at VCPS.
- Natasha (N): operations manager at VCPS.
- Aude (U): general psychologist with a PhD in psychology.

Questions and answer/comments provided

- What are your roles at VCPS? What does your work involve?
 - U: psychologist, four days a week
 - E: four days here, one day Richmond. Substance abuse, and relationships
 - Pana: external business
 - S: gp/psychotherapists, emotional system overwhelms
- What demographics do you believe are or are not seeking mental health care? Why?
 - E: lowest socio-economic that cannot afford the service. Multidisciplinary team
 - S: marginalize populations, small select of people -> system of priorities. They must know about the therapy before do it.

- U: males, white professional rich men, do not tend to seek help; do not keep coming -> need a quick fix, it is about being in a process. Avoid the problems
- S: certain type of personalities tend to go to other methods of solutions
- L: most males are gay
- J: younger generation are more seen
- E: many students from a foreign background. Prevention. Parent has pushed them to come -> normally in substance abuse.
- L: mixed culturally in Kuluru.
- U; as soon as Medicare runs out people stop the use
- S: In Melbourne drugs and opium is in the Vietnamese population. Out in the country there is more physical effects of mental illness.
- What do you see as effective community public outreach methods?
- Where is there room for improvement?
- What do you think it means to “normalize” mental health care?
 - E: anyone can benefit from therapy. “not having it connected to an idea or pathology” “move towards the preventative model” to have a healthier society
 - U: there is not enough money in the system
 - E: put their money in other things (paint their nails, gym subscription) -> well-being
 - U: A part of a population cannot afford dental care, not at all mental health care
 - J: people do not want it on the record
 - U: “political”
 - S: philosophical: pedestalized medicine as a profession, break down in parenting and communities -> health professionals and professors would do everything to troubleshoot (music, dance). You would talk about everything and have support. Enormous pain -> social construct.
 - U: renormalizing -> reclaiming what was lost
 - L: bipolar patient example, takes a long time.

- E: open discussion in the community. More normal to have mental health issues, still, no one speaks about it.
- P: earlier education in our schools
- U: mindfulness classes at school
- L: taking care of the body is not stigmatized, compared to the mental health.
- S: gut -> surface area and nerves. Deepest understanding of stuff is through your entire body. Real continuum
- Do you see any obstacle in normalizing mental health care?
 - S: "I SEE A THERAPIST" -> the whole spectrum, dietician, science physiologist, complete split. Mind and body.
 - N: it is going to take a village to change your thinking
 - S: there is a reason behind the care -> emotional, physical, spiritual.
 - S: codependency model, value everything. Ego of practitioners should be left aside.
- Why would VCPS be interested in normalizing mental health care?
- How should a campaign try to normalize mental health care?
 - E: Integration between the system. Systemic issue, working in opposition. Bridging the gaps and try to bring people.
 - P: what are we trying to get individuals to do. What is the basic equation? Then think about integration (conversing, communication?)
 - S: it is ok to talk about it! Whatever it is, we can talk about it -> we have stopped feeling
 - J: how other people feel the same as you

Appendix I: Survey Questions

We are a team of students from Worcester Polytechnic Institute in the United States. We are working with Victorian Counseling and Psychological Services to create an online campaign to normalize mental health care. This survey is aimed to understand the public's experience with and/or perception of mental health care and mental health professionals, particularly psychologists and psychiatrists. Your participation in this survey is completely voluntary, and you may refuse to answer any of the questions, except to confirm that you are at least 18 years of age. The survey should take less than 5 minutes. Your responses will be kept anonymous. Thank you very much for your time! If you have any questions, comments, or concerns, you can contact us at MPC17-VCPS@wpi.edu.

Are you above 18 years of age?

- Yes (1)
- No (2)

Condition: No Is Selected. Skip To: End of Survey.

What is your gender?

- Male (1)
- Female (2)
- Other (3) _____
- Prefer not to answer (4)

What is your age range?

- 18 - 25 (1)
- 25 - 35 (2)
- 35 - 45 (3)

- 45 - 65 (4)
- Above 65 (5)

What is your ethnic background?

- Australian (1)
- English (2)
- Indian (3)
- Chinese (4)
- New Zealanders (5)
- Italian (6)
- Vietnamese (7)
- Greek (8)
- Other, please specify: (9) _____

Please select the option that best describes your current employment status.

- Employed (1)
- Casual Employment (2)
- Self-Employed (3)
- Not Employed (4)
- Homemaker (5)
- Retired (6)
- Student (7)
- Other (8) _____

Please select your annual household income.

- Up to \$25,000 (1)
- \$25,000 to \$50,000 (2)
- \$50,000 to \$75,000 (3)
- \$75,000 to \$100,000 (4)
- \$100,000 to \$125,000 (5)
- \$125,000 to \$150,000 (6)
- \$150,000 to \$175,000 (7)
- \$175,000 and above (8)

What is the primary language you speak at home?

- English (1)
- Other, please specify (2) _____

Have you ever been diagnosed with a mental health disorder?

- Yes (1)
- No (2)
- Prefer not to answer (3)

Have you ever consulted with a mental health care practitioner?

- Yes (1)
- No (2)
- Prefer not to answer (3)

Display This Question:

If Have you ever consulted with a mental health care practitioner? Yes Is Selected

For how long did you consult with a mental health care practitioner?

- Less than 1 month (1)
- 1 to 3 months (2)
- 3 to 6 months (3)
- 6 to 12 months (4)
- 1 to 3 years (5)
- 3 years or more (6)

Display This Question:

If Have you ever consulted with a mental health care practitioner? Yes Is Selected

In the past year, how many times have you seen a mental health practitioner?

- None (1)
- 1-5 (2)
- 5-10 (3)
- 10-20 (4)
- 20-50 (5)
- 50+ (6)

Display This Question:

If Have you ever consulted with a mental health care profession? Yes Is Selected

How helpful do you think your sessions were or are?

- Extremely helpful (1)

- Very helpful (2)
- Moderately helpful (3)
- Slightly helpful (4)
- Not helpful at all (5)

Display This Question:

If Have you ever consulted with a mental health care profession? Yes Is Selected

How likely are you to go see a mental health care practitioner again?

- Very Likely (1)
- Somewhat Likely (2)
- Neither likely nor unlikely (3)
- Somewhat Unlikely (4)
- Very Unlikely (5)

Display This Question:

If Have you ever consulted with a mental health care profession? Yes Is Selected

How likely are you to tell someone that you see a mental health care practitioner?

- Very Likely (1)
- Somewhat Likely (2)
- Neither likely nor unlikely (3)
- Somewhat Unlikely (4)
- Very Unlikely (5)

Display This Question:

If Have you ever consulted with a mental health care profession? No Is Selected

How likely are you to tell anyone if you are having mental health concerns?

- Extremely likely (1)
- Somewhat likely (2)
- Neither likely nor unlikely (3)
- Somewhat unlikely (4)
- Extremely unlikely (5)

Display This Question:

If Have you ever consulted with a mental health care profession? No Is Selected

How likely are you to consult with a mental health care practitioner if you are experiencing struggles in life?

- Extremely likely (1)
- Somewhat likely (2)
- Neither likely nor unlikely (3)
- Somewhat unlikely (4)
- Extremely unlikely (5)

Display This Question:

If Have you ever consulted with a mental health care practitioner? No Is Selected

How helpful do you think a consultation would be with a mental health care professional as a general mental health check up?

- Extremely helpful (1)
- Very helpful (2)
- Moderately helpful (3)

- Slightly helpful (4)
- Not helpful at all (5)

Treatment can help people with difficult moments in life.

- Strongly agree (1)
- Agree (2)
- Somewhat agree (3)
- Neither agree nor disagree (4)
- Somewhat disagree (5)
- Disagree (6)
- Strongly disagree (7)

People are generally caring and sympathetic toward people with mental health illness.

- Strongly agree (1)
- Agree (2)
- Somewhat agree (3)
- Neither agree nor disagree (4)
- Somewhat disagree (5)
- Disagree (6)
- Strongly disagree (7)

Do you feel mental health care services are accessible?

- Yes (1)
- No (2)

- Unsure (3)

Does Medicare pay cover mental health sessions?

- Yes (1)
- No (2)
- Unsure (3)

For general well-being purposes, how likely are you to consult with a mental health care professional?

- Extremely likely (10)
- Somewhat likely (12)
- Neither likely nor unlikely (13)
- Somewhat unlikely (14)
- Extremely unlikely (16)

How important is it for you to maintain good physical health?

- Extremely important (1)
- Very important (2)
- Moderately important (3)
- Slightly important (4)
- Not at all important (5)

How important is it for you to maintain good emotional health?

- Extremely important (1)

- Very important (2)
- Moderately important (3)
- Slightly important (4)
- Not at all important (5)

Appendix J: Interview Questions

Purpose

This interview is aimed at the various representatives of organizations that have created their own outreach campaigns.

Statement of Consent

Your participation in this interview is voluntary, and you may choose to opt out of answering any of the questions. This interview will take 30-45 minutes.

Due to this interview being for research purposes, we will be taking notes and audio recording the session. If you are uncomfortable with this, please advise.

Confidentiality

We are using this interview for research purposes which will provide a benefit to others. Should we use any specific information from your interview in a public forum, we will not disclose any personal information. Unless you state otherwise, your participation in this interview allows us to use select information from this interview in a de-identified manner.

Questions

1. What is your role in your organization?
2. What is the mission of your organization?
3. What are public outreach campaigns has your organization worked on?
 - a. What was the goal of your campaign?
 - i. Did you focus on addressing stigma at all?
 - ii. If so, what strategies did you use?
 - b. What were some of the successes?
 - c. What were the challenges?
 - d. How did you market your campaign to reach the target audience?
 - e. How did you determine if the campaign was effective?
 - f. What was the most effective component of your campaign?
 - g. What aspect of your campaign do you think was the least successful or most disappointing?

4. What other methods do you think are best for reaching the audience in this kind of campaign?
 - a. Did you specifically target any groups such as certain minorities, men, pregnant women, etc?
 - b. What were some effective ways you discovered to connect with your audience (i.e. humor, etc)?
5. Are you familiar with other mental health outreach initiatives or campaigns?
 - a. What aspects of other campaigns did you like or dislike?
6. Do you have any final thoughts or feedback as we begin to develop our own campaign?

Appendix K: Comparison of Current Mental Health Organizations and Campaigns Websites

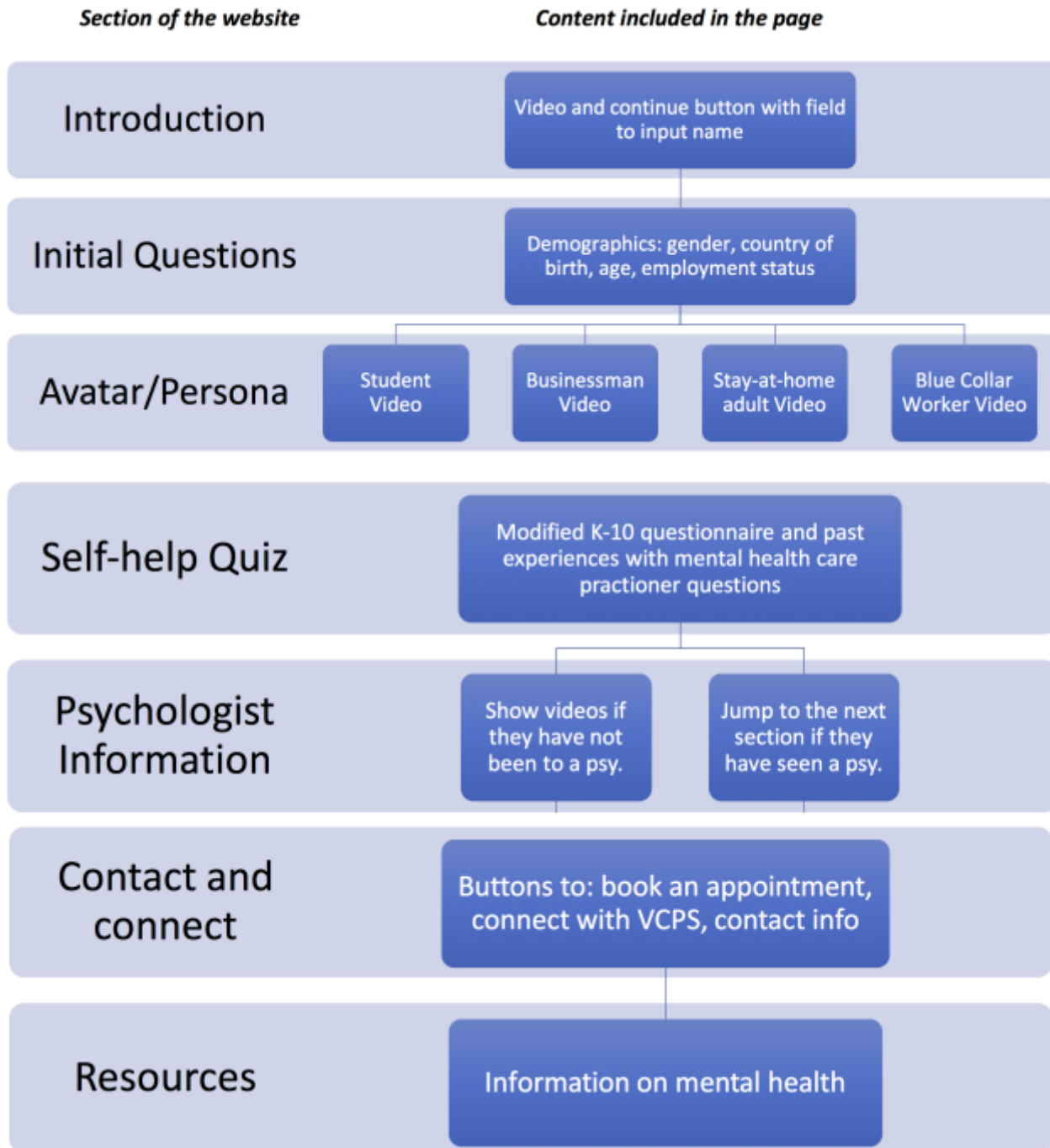
Campaign/ Website	Logo	Navigation Bar	Menu	Content Included in Home Page
Man Therapy Canada	Upper left corner. Has the word “mahogany”	Phone Login Sign up Menu	Explore Take head inspection Worried about someone About mental health Social Media	The main page looks like a blog. A lot of content and no way to discern which is necessary. The top of the page is simple and direct with just a picture and two main buttons: About Man Therapy and Take a Head Inspection.
Manda Therapy Australia	Both Beyondblue and Man Therapy logos on the upper left corner	Home Mind Quiz Man Therapies Tales of Triumph Support Services: number, email, chat, other	Mission Statement Worried About Someone Mind Quiz Support	The main page has an introduction video and the navigation bar buttons that seem necessary. It has a box for support that makes the contact information stand out.
SANE Australia	Upper right corner: not the first thing seen but it makes reader pay attention to the content of the page.	Mental health & illness Get Help Roads to Wellness Families& Carers Forums News Support us		Carrousel of photos with small introduction of people saying “Mental illness is real.” Have a few boxes below that are dedicated to their informational content; they include a picture, a title and a description.
Headspace	Big in upper right corner next to a “Donate Now” button	Start Here (Menu)	About headspace Young people Friends and family Health professionals Digital Work and	Very engaging and well designed, with a picture of young people and an introductory (“Welcome”) note with three buttons below it: get to know us, find a center, talk to someone.

			<p>Study</p> <p>School Support</p> <p>Telehealth Services</p> <p>Corporate and governance</p> <p>Get involved</p> <p>News</p> <p>Sign up for eNews</p>	<p>It also includes three icons to find help if you are a: young person, friend or family member, or health professional. It has multiple strips of how to be involved with headspace.</p>
Beyondblue	Upper left corner. Big and very present	<p>Get support</p> <p>The facts</p> <p>Who does it affect?</p> <p>Supporting someone</p> <p>Get involved</p> <p>Our stories</p> <p>Healthy places</p> <p>Media</p>	Each item on the navigation bar has 3-12 pop-up buttons when you put the cursor on top of them.	<p>In the top right corner, there is a good amount of space dedicated to communication, which can be beneficial for immediate support. It includes a carousel with several advertising images or news. The rest of the main page is separated into the following sections: depression and anxiety info, information “for” (ex. Older people, LGBTI, women), resources for (ex. Schools/universities, workplace), and get involved. Very crowded and a lot of content.</p>
Mental Health Australia	Big logo on the left upper corner.	<p>About Us</p> <p>Our Work</p> <p>Get Involved</p> <p>Media</p> <p>Resources</p> <p>Membership</p> <p>Contact Us</p> <p>SANE Forums</p> <p>Need Help</p>		<p>Organized as a news feed page with strips of their informational content with a picture to the left and a title and description to the right. Text is too long and pictures do not seem to relate to the content right next to it.</p>
Lifeline	Very big logo in the upper left corner.	<p>Get Help</p> <p>Support Lifeline</p>		<p>In the upper right hand corner, there is three buttons to call, chat and</p>

	The logo is straight forward with what the organization does with the words “Sving Lives: Crisis Support, Suicide Prevention.”	About Lifeline Donate Now		get access to “help resources.” There is a photo carrousel with updated content or facts with appropriate links. Below that there is a very brief introduction to the work of the organization and four buttons with resources.
Believe in Change	Logo is located in the upper left corner by itself. Makes you easily identify the organization.	About Us Our Stories Psychological Topics Steps to Change		Big picture of someone using boots in the rain: goes with the slogan of “we walk in your shoes (to take steps towards change).” Together with this, there is a video available that is their main ad for the campaign. Below you find eight boxes with different written experiences of people with psychology, and ways that APS is helping other people. It includes some more informational content tabs that pushes you to learn about psychology, Medicare and access to help.
Conclusion	Logo in the upper left corner seems to work better as it establishes ownership and contexts. Having logo and contact info in the same line seems to be the common	The use of too many tabs on the navigation bar can be confusing. Going with a few like Lifeline or Believe in Change seems to make it easier to decided where to go next. Probably include the following: Understanding Where I Am, People	Some websites have both a navigation bar and a menu, which is confusing because the navigator does not know which one has the important content. The most appropriate way must be to choose one or the other. On a big website (like headspace) it makes sense to go for a menu as it can	The carrousel idea seems to be and efficient way to present different types of content in a sequence. The idea of Believe in Change of having a strong slogan might help to make the campaign stand alone and be recognizable. SANE Australia does something similar with the “Mental illness is real” statement that is maintained as different

	<p>way to layout the website, and it offers a link between the organization and their contact info.</p>	<p>Experiences, Psychologists Experiences, Getting Support</p>	<p>include many different tabs. As the navigation bar is always showing, there should be few general tabs that direct you to the content of the website. As the campaign will predominantly have videos of people, videos of psychologists, self-help quizzes and information, we should have tabs that direct directly to these.</p>	<p>people appear with different stories. Having multiple examples to support an idea or slogan appears to make the content or overall idea of the organization more reliable. The use of boxes in several of the websites with a title and very small description to guide the navigator to specific content must be useful as an organizational and engaging tool.</p>
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Appendix L: Website Outline



*this illustration includes the recommended next avatar video to be added, the stay at home adult

Outline of content to be included

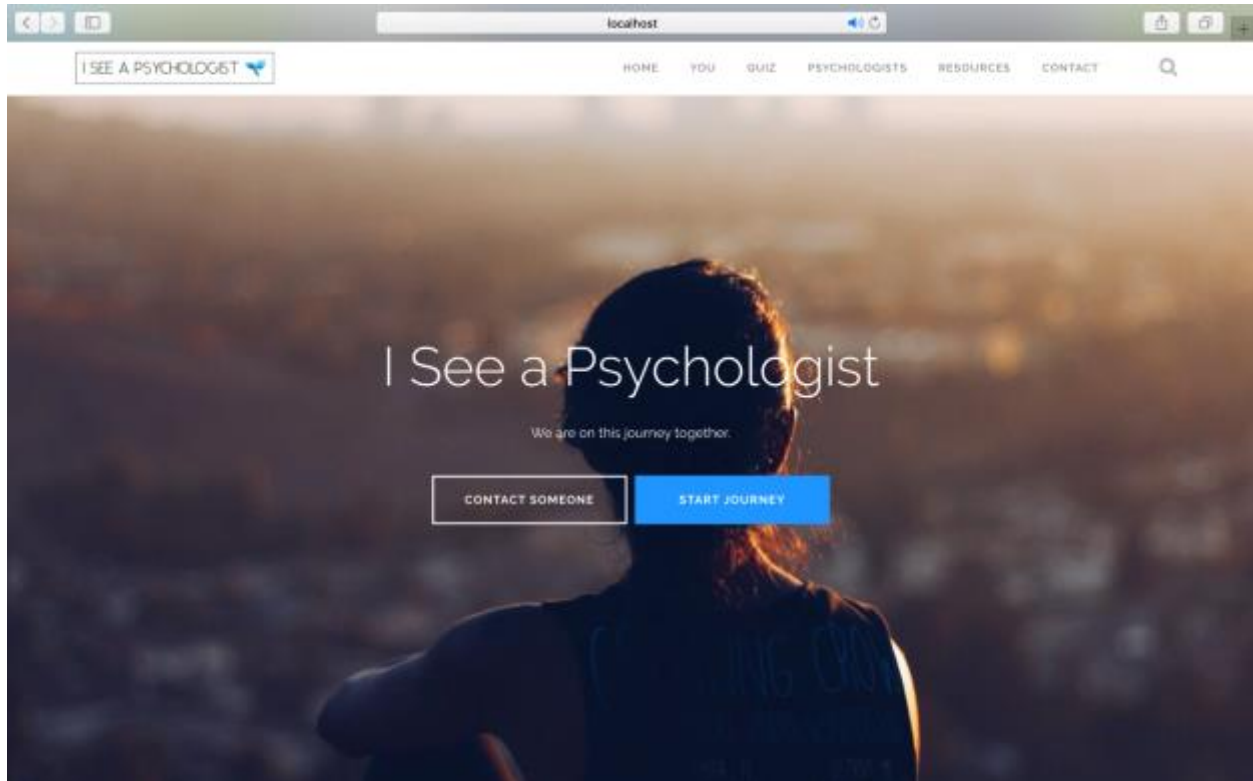
1. Introductory video about life in general
 - a. Theme: life has ups and downs
 - b. People to be included: dancers, skateboarders, couple, bikers, singers
 - c. Scenery: river, train/tram/bus, business district, cultural centers
2. Demographics questions
 - a. What is your age range?
 - b. What is your gender?
 - c. What is your ethnic background?
 - d. What is your employment status?
3. Persona videos: telling the story of their life. Determine the avatar given based on employment status question from last question.
 - a. Student
 - b. Businessman
 - c. Stay-at-home
 - d. Blue collar worker
4. Self-help quiz:
 - a. K-10 questions
 - i. During the last 30 days, about how often did you feel tired out for no good reason?
 - ii. During the last 30 days, about how often did you feel nervous?
 - iii. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?
 - iv. During the last 30 days, about how often did you feel hopeless?
 - v. During the last 30 days, about how often did you feel restless or fidgety?
 - vi. During the last 30 days, about how often did you feel so restless you could not sit still?
 - vii. During the last 30 days, about how often did you feel depressed?
 - viii. During the last 30 days, about how often did you feel that everything was an effort?

- ix. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?
 - x. During the last 30 days, about how often did you feel worthless?
 - b. Mental health practice in each individual's life (taken from survey)
 - i. Have you ever been diagnosed with a mental health disorder?
 - ii. Have you ever consulted with a mental health care practitioner?
- 5. Psychologist information videos
 - a. Why and when to see a psychologist
 - b. How a session (first session) looks like
 - c. What are the benefits/what you will get out of it
- 6. Connect
 - a. For video service: include coded video call service that VCPS already has
 - b. For booking an appointment: include a form to fill out with personal information
 - c. For contact information: link to site with telephone, email and maps of VCPS 8 locations
- 7. Resources
 - a. Determined by Natasha based on content they have already for VCPS

Appendix M: Website Screenshots

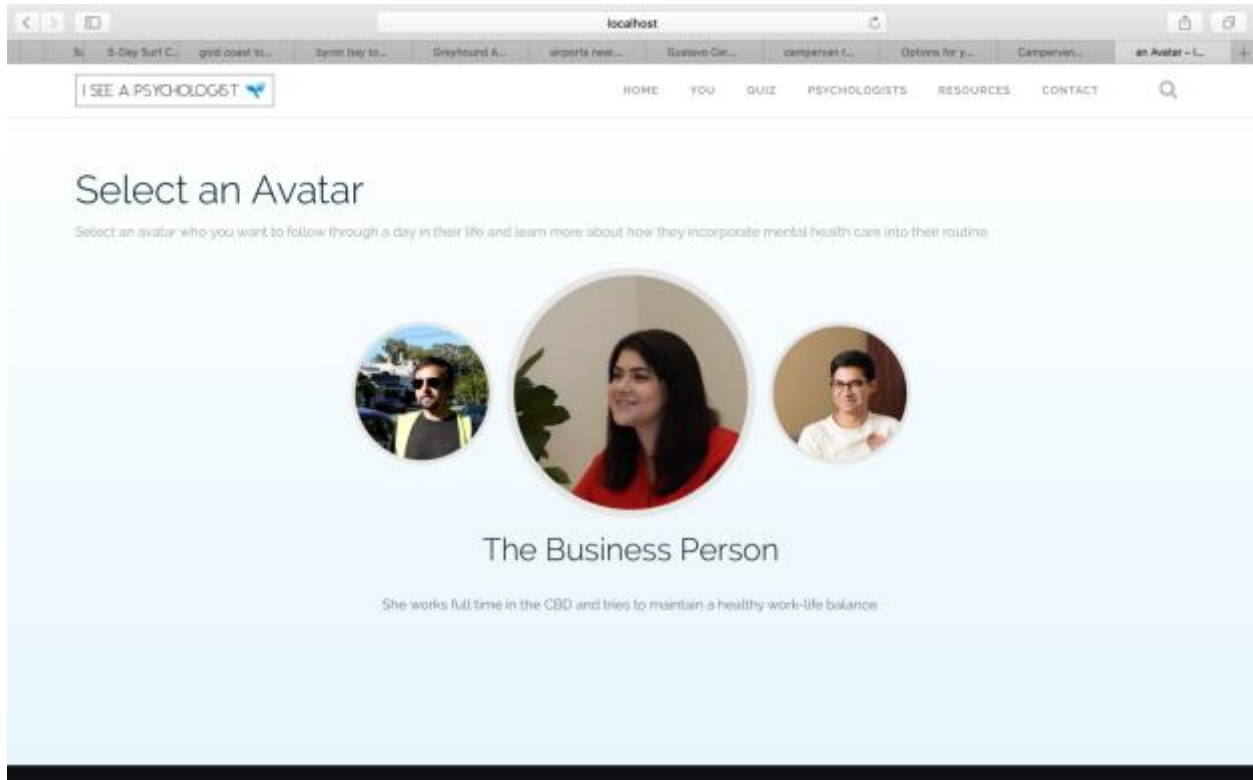
The pictures below are screenshots of the finalized website with the content specified.

Homepage (Introduction)



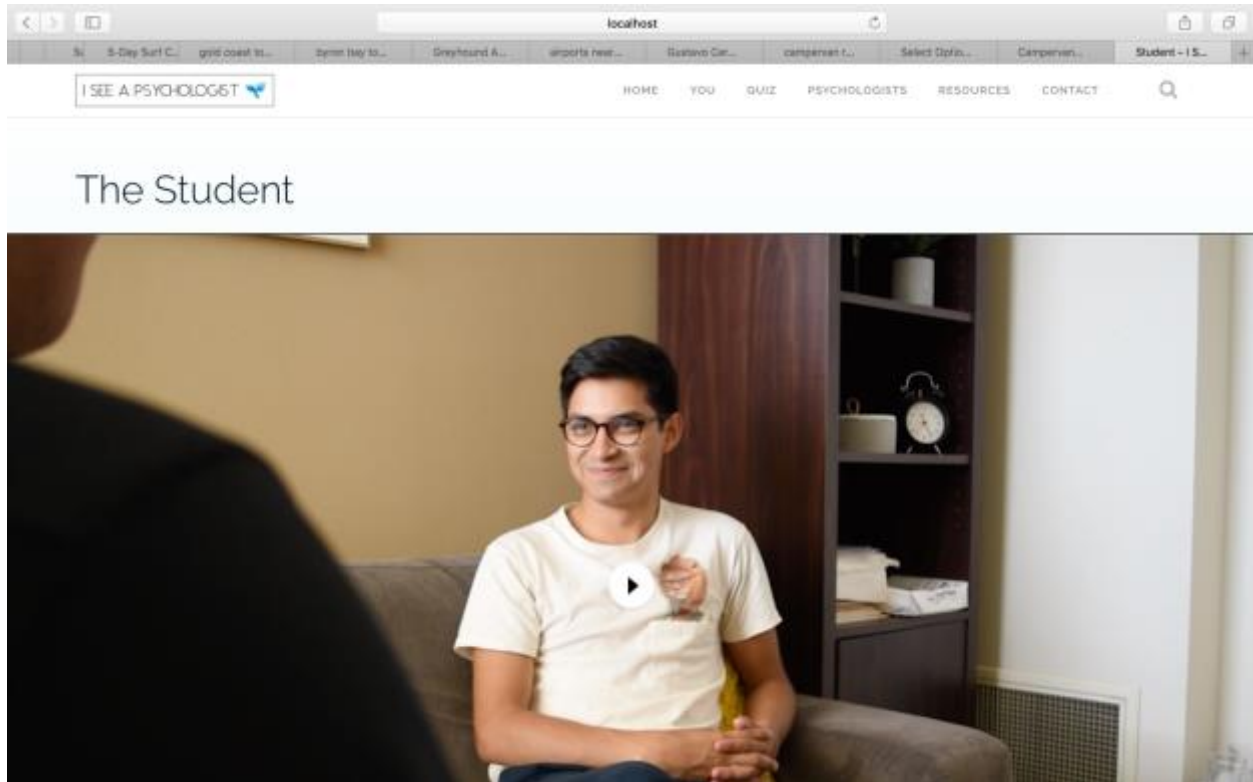
On the homepage, the introductory video is automatically played when the user comes onto the page. It then invites them to proceed further in the website.

Avatar Selection



The user is prompted to select an avatar to follow on their journey.

Avatar Videos



The user follows the user on a day in their life.

Emotional Distress Quiz

localhost

I SEE A PSYCHOLOGIST

HOME YOU QUIZ PSYCHOLOGISTS RESOURCES CONTACT

When is your birthday

- -

Day Month Year

In the past 4 weeks, about how often did you feel tired out for no good reason?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All time

In the past 4 weeks, about how often did you feel nervous?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All time

In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All time

Users are invited to take an emotional distress quiz to see if they may need more help/

Psychologist Videos



Psychologist videos inform the user about what to expect and why they should see a psychologist.

Resources Page

localhost

I SEE A PSYCHOLOGIST

HOME YOU QUIZ PSYCHOLOGISTS RESOURCES CONTACT

Resources

Find useful information below to help you continue your journey. You can also contact our team to book an appointment with a psychologist.

<p>Balance A balanced life helps to ensure that each area of your life receives proper attention.</p>	<p>Time management Not having enough time to meet the demands of our lives is frequently a cause of stress.</p>	<p>Dealing with problems Dealing effectively with problems is important for mental health, and several techniques are available.</p>	<p>Distance and perspective From a distance we see things differently and our mind becomes clearer.</p>
<p>Flow We cope better with life when we are able to establish and maintain a flow in our day.</p>	<p>Uplifts Remind yourself about the things that give you a lift and make them part of the rhythm of your life.</p>	<p>Resilience People who cope best with the demands of life are emotionally resilient, or psychologically hardy.</p>	<p>Social support We all have a need to feel wanted, to receive and to give affection, and to feel needed.</p>

The resources page offers many useful resources for the user to access.

Appendix N: Website Focus Group Notes

- Reading book scene is too long
- Minor adjustments to pacing of video
- Add “Start your journey.” to the end of the video
- Bold “I See a Psychologist” text on start page (more contrast)
- Change photo on first page (Too distracting)
- “Please tell us about yourself” on first quiz
- Change ethnicity question to open ended
- Legal Status -> Employment Status
- Student and blue collar videos lacks social interaction
- Adjust font of K 10 quiz.
- Remove “at” form K 10 intro sentences.
- Reword “mental health practitioner” to “psychologist, psychiatrist, ...”
- Remove diagnosis question
- Remove text from start of psychologist video page
- When to see a psychologist video 10/10 IGN, move up earlier in site?
- Incorporate Lifeline for urgent care
- “Organize” video chat instead of instant chat
- Chat with our team instead of with a psychologist directly