

Depression prevention and mental health promotion interventions: is stigma taken into account? An overview of the Italian initiatives

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Dear Editor

Depressive disorders represent a major public health concern in European countries and Italian epidemiological studies confirm that despite being highly prevalent in the general population and in clinical settings, their recognition and treatment are often inadequate (Balestrieri *et al.* 2004). Research suggested that the public stigma of mental disorders (defined as the general public's negative attitudes towards individuals with mental disorders) increases self-stigma (e.g. internalized attitudes held by people suffering from a mental disorder) with the consequences that individuals avoid seeking treatment and increase their social isolation (Kanter *et al.* 2008). In a survey on the Australian general population (Griffiths *et al.* 2008), personal stigma was associated with greater current psychological distress and lower depression literacy.

Based on this evidence, the European Union (EU) mental health conference in 2008 launched the European Pact for Mental Health and Well-Being indicating the prevention of depression and suicide and the fight against stigma as priorities for EU members. In Italy, the National Preventive Plan 2010–2012, launched by Ministry of Health, underlined the need to improve early detection of depression, the evaluation of prevention programmes and the use of evidence-based practices. A recent review on Italian anti-stigma campaigns toward mental illness (Zoppei & Lasalvia, 2011) found that only 12.7% of these initiatives were promoted at the national level and 80% were conducted at the local level. Remarkably, the majority of these studies did not report any information on their outcomes or effectiveness and the methodology was often inappropriate. However, the review was focused on campaigns addressing mental disorders in general, rather than depression *per se*.

This study aims to review anti-stigma activities in depression prevention programmes delivered to date in Italy in order to evaluate their impact from a public health perspective. Owing to the overlap between prevention and treatment, we considered a broad concept of prevention, including interventions occurring before the onset of depression and those aiming to prevent comorbidity, relapse, disability and the consequences of severe mental illness for families (NIMH, 1998).

Methods

This study was conducted within the framework of the Anti Stigma Programme European Network (ASPEN), a multisite project aiming to address stigma and discrimination against people with depression (Lasalvia *et al.* 2013). A detailed report on depression anti-stigma programmes across the ASPEN participating countries is given elsewhere (Quinn *et al.* 2013), and the findings of this survey as a whole are available at <http://www.antistigma.eu>.

We first identified studies or publications on prevention interventions towards depression that reported outcomes. When no formal evaluation was carried out, we described only the programmes. Inclusion criteria for studies were: either (a) depression or suicide prevention interventions and/or mental health promotion interventions; or (b) anti-stigma interventions towards depression and/or studies aiming to evaluate opinions and attitudes towards depression; or (c) both (a) and (b); (d) carried out in Italy and (e) written in Italian or in English. A comprehensive literature search of PubMed databases and WEB from January 1995 through July 2012 was conducted.

For the electronic database searches we used all the possible combinations of the following key terms: depression (MeSH Terms) OR mood disorder (MeSH Terms) OR suicide (MeSH Terms) OR mental health AND prevention (Title/Abstract) OR promotion (Title/Abstract) OR stigma (Title/Abstract) OR attitude (Title/Abstract) AND (ital*). Furthermore, web-based publications were identified through searching specific websites oriented to prevention of depression or

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stigma reduction. Records identified through web-search were included when outcomes were reported on or at least protocols were available; additionally, social events specifically aimed to prevent depression or suicide or fight stigma were included.

We adopted the definitions of universal, selective and indicated prevention, as laid out in the Institute of Medicine Report (1994), excluding any pharmacological interventions. We considered both the prevention of depression and the promotion of the mental health. *Universal prevention programmes* are referred to the entire population, regardless of their risk status. *Selective prevention programmes* are delivered to potential at-risk populations for the development of depressive or mental-health disorders. *Indicated prevention programmes* are applied to vulnerable or at-risk populations (i.e. people who display subclinical signs or symptoms of depression). Lastly, we included an additional fourth category named *Preventive treatment programmes* (adapted from NIMH, 1998) for selected interventions targeting people with a diagnosis of depression in order to prevent chronicity or lethal consequences. Studies targeting people identified with a diagnosis of depression, people who previously attempted suicide or who received treatment in the mental health system were included. Furthermore, we evaluated the use of three strategies that have been widely cited as a method to reduce public stigma of mental illness: Education, Protest and Contact-based education (Corrigan et al. 2012).

Results

Universal prevention programmes

One survey on opinions towards depression, seven awareness raising campaigns and 11 school-based interventions were found (Table 1). Anti-stigma activities were conducted in 14 programmes and the two strategies used against stigma were education and contact-based education. In particular, five of these stated stigma reduction as their objective and one aimed to change adolescents' attitudes towards mental illness.

Two studies included service users in their programmes: the multilevel programme delivered in Rovigo conducted a focus group with a stakeholder representative group (young people, older people and individuals after a suicide attempt) for planning the programme in the following executive phase (Poma et al. 2011): two focus groups with patients who attempted suicide (Ghio et al. 2011) in order to understand the main reasons leading to these attempts.

Different types of interventions targeted the general population and focused on two intervention levels: (1) public awareness campaigns to improve public attitudes on depression and help-seeking; (2) training sessions for target groups (i.e. gatekeepers, community facilitators and mental health professionals) to improve referrals of vulnerable people to local mental health services.

Tools used to facilitate public campaigns were: leaflets on help available locally, warning signals and treatment options; websites; open days, seminars, spots; testimonies of famous people who have successfully overcome depression; public events as 'Race for Life'.

Preliminary outcomes about the impact of an awareness campaign were only reported by Giupponi et al. (2008) in the framework of the European Alliance Against Depression (EAAD) prevention project. They conducted a survey based on 1000 questionnaire and 458 interviews among citizens of the Alto Adige Region and findings were compared with studies on public attitudes towards depression conducted in other geographical contexts. However, the lack of pre-intervention measures did not allow to establish the degree or persistence of the effect. Nine of the educational programmes targeted secondary-school students and five of those included a post-evaluation. Only two studies targeting students focused on prevention of depression: the first delivered by the National Centre for Epidemiology, Surveillance and Health Promotion (CNESP) included a follow-up at 6 months (data not yet available); the second one was an intervention for promoting protective factors against suicide delivered in Rovigo.

The aims of the educational interventions in schools was to increase the knowledge about mental illness and its beneficial effect on consequent public attitudes and to improve resilience and well-being as protective factors for individual positive mental health.

Tools used in the school-based programmes were: video, leaflets on psychiatric terminology, lessons on myths and facts about mental illnesses, a manual on life skills, laboratories and meetings with mental health professionals. Educational methods utilized peer education, interactive activities, role playing, group discussions. Few studies used *ad hoc* questionnaires for the evaluation of knowledge towards mental disorders at post-intervention or questionnaires on opinions regarding mental disorders.

Selected prevention programmes

Five programmes targeted groups potentially at risk of suicide or with the presence of a combination of risk factors for mental health problems, two interventions

Table 1. Characteristics of universal programmes

Name of the project or study's source	Organization (region)	Anti-stigma activities	Description	Objectives	Target group (duration)	Main findings	Website
1. Invito alla vita (call for life)	Autonomous Province of Trento (Trentino A. Adige)	Education	Two informative campaigns; seminars for medical and nurse professionals	Warning signals' detection	General population, community facilitators (2009–2010)		Retrieved 5 May 2012 from http://www.azisanrovigo.it
2. Evaluation and applying programmes for suicide prevention with the cooperation of stakeholders	LHU of Rovigo (Veneto)	Education	Multilevel approach: survey on depression; focus group and informative trainings for stakeholders; school-based programme, website	Identify main barriers to accessing care; promotion of students' well-being	General population, stakeholders, students (2009–2011)	1200 interviews on suicide (A. Grossi, personal communication, 2011)	Retrieved 10 May 2012 from http://www.azisanrovigo.it and http://www.perdersidanimomai.it
3. Ghio <i>et al.</i> (2011)	University of San Martino (Liguria)	No	Qualitative research on suicide attempters' experiences	Identify risk and protective factors	Suicide attempters (NA)	Interpersonal relationships and empathy as protective factors	
4. European Depression Day	EDA onlus	Education	Aware campaign: annual meetings	Awareness on depression	General population (since 2008)	NA	Retrieved 10 April 2012 from http://www.edaitalia.org
5. World Suicide Prevention Day	St. Andrea Hospital of Rome, IASPS (Lazio)	Education	Aware campaign: conferences, media, marathon 'Race for life'; media guideline for reporting suicide	Awareness on suicide	General population (since 2008)	NA	Retrieved 30 May 2012 from http://www.raceforlife-prevenzione-suicidio.it
6. Depressive diseases	ARETE Ass. (Lombardy)	Education	Informative brochures, website	Awareness on depression	General population (NA)	NA	Retrieved 12 April 2012 from http://www.depressionearete.it/stampa.htm
7. Depression and anxiety disorders: ask for help, do not be afraid	Ministry of Equal Opportunities (Lazio)	Education	Congress on depression	Awareness on depression and stigma	General population (2009)	NA	Retrieved 10 June 2012 from http://www.pariopportunita.gov.it

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Table 1. *Continued*

Name of the project or study's source	Organization (region)	Anti-stigma activities	Description	Objectives	Target group (duration)	Main findings	Website
8. A smile for moms	ONDA	Education	National informative campaign: spots, conferences, website	Awareness on post-partum depression	Women (2012)	NA	Retrieved 3 May 2012 from http://www.depressionepostpartum.it
9. EAAD Project	European Commission (Alto Adige)	Education	Regional public awareness campaigns and cooperation with media; training for community facilitators.	Awareness on depression and suicide	General population (2008)	More positive attitudes towards depression; negative opinion on drugs in national and international contexts	Retrieved 3 May 2012 from http://www.eaad.net/
10. Ruini <i>et al.</i> (2009)	University of Bologna (Emilia Romagna)	No	RCT	Improve psychological well-being	Students (NA)	Improvement in 'personal growth' as measured by PWB scale, at 6 months follow-up	
11. Development of an intervention in schools, with particular attention to primary prevention of depression	CNESP	Education	Psycho-educational sessions: peer education, structured manual on life skills. Controlled study.	Prevention of depression	Students (2007–2012)	Still in progress	Retrieved 10 May 2012 from http://www.ccm-network.it
12. Fuori come va? (How goes it?)	LHU 15 of Cuneo (Piemonte)	Education	Laboratories and interpersonal contacts	Change attitudes	Students (2004–2005)	NA	Retrieved 10 March 2012 from http://www.retepromozionesalute.it
13. National Programme of Communication and Information against Stigma and Prejudice in MH (Grossi & Toniolo, 2006)	Ministry of Health (Lombardy, Veneto)	Education	Brescia: informative materials and meetings for students and teachers. Pre–post design	Reduce stigma	Students (2005–2006)	Reduction of social stigma, improvement of knowledge of mental illness at 6 months follow-up	Retrieved 10 April 2012 from http://www.campagnastigma.it/campagnastigma/index.html

				Rovigo: contact with community facilitators and actors, peer education. Pre-post design				
14. Fight to stigma and mental illness	LHU of Mirano (Veneto)	Education	Psycho-educational interventions, pre-post design	Reduce stigma	Students (2007)	NA		
15. Chiamatemi per nome (Call me by name)	LHU of Perugia (Umbria)	Education	Meetings with professionals, laboratories, pre-post evaluation	Health education promotion	Students (2007)	Leaflets on mental illness (2012)	Retrieved 10 April 2012 from http://www.retepromozionesalute.it	
16. Siamo tutti un po' matti o siamo tutti un po' sani? (Are we a little crazy or a little healthy?)	LHU Collegno (Piemonte)	Education	Dance movement protocol, pre-post evaluation	Reduce stigma	Students (2006–2007)	NA	Retrieved 10 April 2012 from http://www.retepromozionesalute.it/	
17. Castiello & Magliano (2007)	University of Naples SUN (Campania)	No	Comparative study with case vignettes about schizophrenia and depression	Description of student's opinions	Students (NA)	PMI was described as unpredictable and dangerous		

NA, not applicable or not available; PMI, people with mental illness; MH, mental health; RCT, randomized controlled clinical trial.

Note: All references cited in the tables are available from the authors upon request.

supporting family members of people who committed suicide and a psychological consultation service for the general population were found (Table 2). There were various interventions oriented to facilitate access to professional help: crisis hotlines for elderly people, services and self-help activities for suicide bereavement and websites.

The educational strategy was used in the EAAD project in order to facilitate the access to care indirectly (i.e. seminars to facilitate cooperation between mental health professionals or to improve their abilities in detecting and managing people at risk). Lastly, a pilot study (Molinari *et al.* 2012) promoted a psychological consulting service in the neighbourhood aiming to reduce economic and proximity barriers. During the 2009–2011 period, 17% of service attendees reported depressive symptoms. None of the programmes included instruments for evaluating stigma reduction.

Indicated prevention programmes

These programmes aimed to screen high risk factors before the occurrence of a mental disorder (i.e. major depression or post-partum depression) (Table 2). We found only one programme aimed to improve identifying at-risk individuals for post-partum depression. This prospective comparison group study evaluated the efficacy of a preventive welfare programme: risk and vulnerability factors were measured and a brief psychotherapeutic intervention was delivered. Anti-stigma activities were not reported.

Preventive treatment programmes

Table 3 summarizes two interventions of screening for depression, two studies aimed to reduce relapse and a family support project. Anti-stigma activities or stigma measurements were not stated.

The screening interventions aimed to improve early detection and best management of mental health service users and general practice attendees, without any outcome measures about their indirect impact on stigma reduction. The ‘G. Leggieri Programme’ (Rucci *et al.* 2012) represented an initiative to promote integration between primary care and mental health services. Data indicated that among patients in contact with psychiatric services in Emilia Romagna, those less often referred by GPs were young adults living in the urban area and who were suffering from a depressive disorder.

Moreover, three different types of interventions for preventing relapse were conducted and none promoted anti-stigma activities. They targeted patients with recurrent depression, caregivers and adolescents with suicidal attempts. In particular, in the context of

the ‘Acute treatment of adolescents with attempted suicide’ programme, after admission to the emergency rooms, adolescents are hospitalized into the Paediatric Department because it is less stigmatizing than psychiatric settings and a specific protocol is used.

Discussion

The present overview summarizes the Italian programmes and campaigns for preventing depression and promoting mental health and our main aim was to assess whether anti-stigma activities were included.

Despite the National Health Plan 2006–2008 underlining the need to improve anti-stigma programmes, we noted a lack of specific national guidelines about best practice. We found that most Italian prevention programmes did not address public stigma nor internalized stigma related to depression; equally their impact on help-seeking for depression has not yet been adequately investigated. Moreover, prevention programmes which focused on reducing social stigma mainly targeted the general public (the wider public or target groups) and used education or personal contacts as strategies. Our data on anti-stigma programmes are consistent with those of Zoppei & Lasalvia (2011) indicating a low rate of anti-stigma programmes with outcomes evaluation (25%).

Despite the development of several instruments to support anti-stigma evaluations (Brohan *et al.* 2010), it should be underlined that few established scales to measure stigma have been employed. Scocco *et al.* (2012) reported the progressive internalization of the stigma towards suicide in people with a mental illness compared with the general population. A specific evaluation of the impact of anti-stigma activities would lead to the introduction of evidence-based interventions in prevention programmes that should be disseminated from a local level to a regional or national level. This topic is particularly relevant since negative attitudes and inadequate knowledge on depression may act as barriers to get care (Barney *et al.* 2006). In Italy, we observed an increasing attention to promote public awareness of depression or suicide, whereas, to our knowledge, no campaigns exist specifically aiming to decrease stigma of depression. This may suggest either a lack of appreciation of the importance of stigma as a barrier to help-seeking for suicide and depression or the lack of attention given to depression within anti-stigma work, which tends to be more focused on stigma of other severe mental disorders. The campaigns were conducted mainly at the local or regional level, whereas in other countries, national campaigns such as the ‘Defeat Depression Campaign’ in the UK

Table 2. Characteristics of selective and indicated programmes

	Name of the project or study's source	Organization (region)	Anti-stigma activities	Description	Objectives	Target group (duration)	Main findings	Website
Selective	1. EAAD Project	European Commission (South Tyrol)	Education	Multilevel approach: cooperation with GPs, psychologists and chemists; self-help groups; telephone counselling	Prevention of suicide	People at risk for suicide (2005–2007)	Decrease of suicide rate from 18.5 to 14.5% in men before (2001–2003) and during the EAAD project (2005–2007) (R. Pycha and G. Kemmler, personal communication, 2010)	Retrieved 10 April 2012 from http://www.eaad.net/
	2. Evaluation and applying programmes of prevention of suicide with the cooperation of stakeholders	LHU 18 of Rovigo (Veneto)	No	Multilevel approach: help-line for elderly people and support groups for survivors	Facilitate accessing to care	Older people and high-risk groups (2009–2011)	NA	Retrieved 5 May 2012 from http://www.azisanrovigo.it
	3. Invito alla vita (Call for life)	Autonomous Province of Trento (Trentino A. Adige)	No	Crisis Hotline; self-help groups for survivors; monitoring system in MH departments	Prevention of suicide	People at risk for suicide (2009–2010)	NA	Retrieved 3 May 2012 from http://www.apss.tn.it/public/ddw.aspx?n=49082
	4. Prevenire il suicidio (Prevention of suicide)	St. Andrea Hospital of Rome (Lazio)	No	Help-line, website	Prevention of suicide	Elderly people at risk (NA)	NA	Retrieved 15 May 2012 from http://www.prevenireilsuicidio.it
	5. De Leo <i>et al.</i> (2002)	Government sponsored (Veneto)	No	Tele-Help and Tele-Check system	Prevention of suicide	Elderly people (NA)	Lower than expected suicide rates among people over 65 years old than general population, at 4 years follow-up.	

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Table 2. Continued

	Name of the project or study's source	Organization (region)	Anti-stigma activities	Description	Objectives	Target group (duration)	Main findings	Website
	6. SOPRoxi project	Padua (Veneto)	No	Dedicated service	Supportive intervention	Survivors (2006–2012)	NA	Retrieved 20 May 2012 from http://www.soproxi.it
	7. The psychologist in the neighbourhood project	Catholic University of Milan, Health Department of Milan, FederFarma, ADMENTA (Lombardy)	No	Pilot study of a new psychological consultation service: free psychological consultations in 28 chemist's shops in Milan	Prevention of psychological diseases	Chemists' users with unexpressed psychological needs (2009–2011)	After a series of consultations, 78% of participants were redirected to territorial services or resolved their problems; 22.1% dropped out	
Indicated	1. Detection and prevention of post-partum depression	Trento's Provincial Health Services (Trentino A. Adige)	No	Evaluation of risk and vulnerability factors; brief psychotherapeutic intervention	Prevention of post-partum depression	Women before and after delivery (2007–2010)	NA	Retrieved 15 May 2012 from http://www.asplazio.it/

NA, not applicable or not available; PMI, people with mental illness; MH, mental health; RCT, randomized controlled clinical trial.

Note: All references cited in the tables are available from the authors upon request.

Table 3. Characteristics of preventive treatment programmes

Name of the project or study's source	Organization (region)	Anti-stigma activities	Description	Objectives	Target group (duration)	Main findings	Website
1. SET_DEP project	National Agency for Provincial Health Services (Lazio)	No	Randomized controlled trial: screening and depression management intervention	Primary care screening of depression	Clinical practice's attenders (2006–2009)	The screening showed to be feasible for a sample of 263 patients, no significant differences between two experimental conditions were found	Retrieved 30 May 2012 from http://www.agenas.it/agenas_pdf/Efficacia%20nella%20pratica%20e%20rapporto%20costi%20benefici.pdf
2. G. Leggieri Programme (Rucci <i>et al.</i> 2012)	Emilia Romagna Region	No	Diagnostic assessment, brief focused therapeutic interventions and consultation-liaison activities	Improve GPs management of patients with common psychiatric disorders	Service users (1999 to date)	Growing proportion of GPs referred patients to specialists in 1999–2004 period in Bologna and increased from 51.5 to 62.2% in 2007–2009 period	Retrieved 20 May 2012 from http://www.wpanet.org/detail.php?section_id=7&content_id=739
3. Fava (2004)	Affective Disorders Programme of University of Bologna (Emilia Romagna)	No	Sequential treatment for depression	Six-year follow-up of cognitive behavioural treatment <i>v.</i> CM	Forty patients with recurrent major depression	Significantly lower level of residual symptoms after drug discontinuation and a lower relapse rate of the experimental group at 2- and 6-year follow-up.	
4. Acute treatment of adolescents with attempted suicide	Fatebenefratelli and Oftalmico Hospital of Milan (Lombardy Region funded)	No	Specific treatment after suicide attempt	Relapses' prevention	Adolescents (aged 13–21 years) who attempted suicide (2006–2008)		

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Table 3. Continued

Name of the project or study's source	Organization (region)	Anti-stigma activities	Description	Objectives	Target group (duration)	Main findings	Website
5. Fiorillo et al. (2011)	Department of Psychiatry of the University of Naples SUN (Campania)	No	Two experimental groups: information protocol associated with social training <i>v.</i> informative brief intervention.	Evaluation of family burden	Families of seven Italian mental health centres (NA)	Personal and family difficulties caused by depression decreased and social contacts both in patients and relatives improved in the experimental group at post-intervention.	

NA, not applicable or not available; PMI, people with mental illness; MH, mental health; RCT, randomized controlled clinical trial. Note: All references cited in the tables are available from the authors upon request.

(Paykel et al. 1998) or the Australian depression initiative 'Beyondblue', demonstrated a positive impact on decreasing depression-related stigma (Jorm et al. 2005).

The identification of adequate contexts to perform anti-stigma and prevention programmes is a key point. Schools seem to be a suitable setting to promote resilience and education may produce short-term improvements in adolescents' attitudes towards mental illness (Watson et al. 2004). In Italy, school-based interventions are generally based on mental health promotion interventions or programmes of primary prevention for behavioural or emotional problems. Their universal approach might be less stigmatizing for students at risk compared with more individualized interventions; however, their efficacy should be evaluated using more rigorous study designs. In fact, some studies reported positive short-term change on attitudes and knowledge, but their long-term impact is unknown.

Experienced stigma and self-stigma are assumed to be barriers that delay the access to psychiatric services (Aromaa et al. 2011) and discourage people from continuing to get help for a mental health problem. The Italian Mental Health Epidemiological Surveillance system (SEME) found that median interval between the onset of psychiatric symptoms and the first contact with services was 2 years for patients with a major depressive episode with psychotic symptoms or suicide attempt (Gigantesco et al. 2012). This highlights the need to improve early detection of people at risk of severe depression symptoms and that primary care could have a key role in facilitating the access to services.

In addition, stigma associated with receiving care for a mental health problem might have a detrimental effect. In fact, the assessment of depression related stigma in primary care settings, revealed that patients reporting stigma were less likely to be able to manage their depression and had a higher number of missed scheduled appointment visits (Vega et al. 2010). For this reason, the assessment of anticipated and experienced stigma should be beneficial to improve preventive programmes against relapse and to increase help-seeking during a crisis.

Previous studies (Warner, 2008) highlighted the advantages of establishing a multidisciplinary local action committee, selecting a specific social target group and defining measurable goals. These aspects should be deepened in order to develop specific and practicable strategies for the wider Italian context.

Some limitations of the present study should be considered. Our data are mainly based on web resources and the heterogeneity of selected programmes did not allow us to perform a comparative analysis. Moreover, the lack of outcome measures prevents us from reaching clear-cut conclusions in terms of efficacy or cost-effectiveness of the identified programmes. Further

studies will need to assess the impact of depression preventive programmes on stigma reduction by using specific instruments including more comprehensive samples of people at different risk levels for depression. As recommended by Hogan *et al.* (2002), multilevel programmes involving a complex network of health professionals, caregivers and community target groups should be preferred for their impact on the different components of the process of discrimination. However, in order to optimize resource utilization, the possible synergies and the relative impact of interventions within multilevel approaches should be ascertained with controlled studies and longer follow-up.

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Conflict of Interest

None.

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