

Lessons for the development of initiatives to tackle the stigma associated with problem gambling

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Executive summary

Overview

There is no doubt that people who experience problems with gambling also experience significant stigma associated with these experiences [Thomas & Lewis 2015; Carroll et al. 2013]. Research indicates that members of the community hold stigmatising attitudes towards people who develop problems with gambling [Arbour-Nicitopoulos et al. 2010; Horsch & Hodgins 2008], and that stigma may have a major negative impact on the ability of gamblers to seek help [Evans & Delfabbro 2005; Pulford et al. 2009; Suurvali et al. 2009; Clarke et al. 2007; Cooper 2004]. While community campaigns in gambling have traditionally focused on providing information to encourage individuals to seek help, we are unaware of any evidence to suggest that these campaigns may be working effectively to reduce gambling stigma, and in some cases may have unintended negative consequences for those experiencing harms with gambling [Thomas et al. 2012].

What is less clear from the research are the factors that may be leading to stigmatising attitudes towards gamblers. Research in other areas of addictions suggest that one of the main causes of stigma is that individuals perceive that addiction is a condition associated with personal responsibility and control, and that individuals are personally to blame for their condition [Pescosolido et al. 2010]. Similarly in gambling, some researchers have argued that personal responsibility frameworks (from governments, the gambling industry and media) may be contributing both to negative public perceptions of 'problem gamblers', and gamblers' own perceptions of themselves [Carroll et al. 2013; Miller et al. 2014; Miller et al. 2015].

It has been proposed that stigma can be understood as a combination of problems of knowledge (ignorance), attitudes (prejudice), and behaviour (discrimination). Understanding the broader drivers of gambling stigma, and the range of initiatives that have been undertaken in other areas of health to reduce stigma, will help to address the urgent need for research into the *'complex causes and consequences of stigma and the most effective way to address and reduce the stigma associated with problem gambling'* [Parliamentary Joint Select Committee on Gambling Reform 2012].

Aims and research questions

This study had three key aims.

1. To summarise the research evidence relating to the effectiveness of anti-stigma initiatives in other areas of health.
2. To review the range of appeal strategies used in a range of anti-stigma campaigns being undertaken in gambling and other areas of health.
3. To explore the attitudes and opinions of expert stakeholders about the range of factors that may contribute to gambling stigma, and strategies that may be used to respond to these.

Methods

Three distinct phases of research were employed in this study.

A strategic literature review

We conducted a review of published literature to identify evidence relating to anti-stigma or stigma reduction programs in other areas of health. We grouped research into a number of distinct thematic categories including a) mass media campaigns; b) contact strategies; c) educational strategies; and d) advocacy strategies. We discuss how these strategies may apply in gambling stigma reduction strategies.

A review of mass media campaigns

The aim of this part of the report was to review a range of existing social advertising campaigns relating to stigma across three areas of health – mental health, HIV/AIDS, and gambling. We aimed to understand the different appeal strategies and approaches used in the campaigns, and how these campaigns may be used to inform anti-stigma initiatives in gambling.

We conducted an interpretive content analysis of social advertising campaigns identified via an internet search. We searched for campaigns relating to HIV/AIDS, mental health and gambling. We used broad, inclusive search terms such as 'HIV and stigma', 'mental health and stigma', 'gambling and stigma'. Campaigns were identified through websites and YouTube was used to source video campaigns when required. We included a range of social advertising campaigns – including videos, as well as visual campaigns that included posters and photo blogs.

To be included in the analysis, campaigns were required to have a focus on anti-stigma and/or reducing stigma in the aims, objectives or in the published campaign material. Because very few campaigns were able to be identified for gambling, we decided to include gambling campaigns that displayed a theme either in their campaign relating to reducing associated stigma even if they did not specifically state that they had a focus on anti-stigma and/or reducing stigma in the campaign aim or description.

A total of 64 campaigns were reviewed in the study from mental health (n=30); HIV/AIDS (n=24) and gambling (n=10).

A qualitative study of expert stakeholders

This phase of the study aimed to examine expert opinion about the causes and consequences of gambling stigma. We also aimed to assess different solutions to help prevent the stigma experienced by people who develop gambling problems. This phase of the study is to help inform potential ways of creating anti-stigma initiatives that may specifically target issues contributing to the stigmatisation of 'problem gamblers'. The study was based on three distinct research questions:

- What are the contributing factors to problem gambling stigma?
- What is the impact of this stigma on people who experience problems with gambling?
- What are the existing responses to stigma, and how effective are these responses?

The study design followed a constructivist grounded theory approach [Mills et al. 2006]. This approach recognises the role that the researcher plays in the construction and analysis of the data, including the subjective nature of data collection and analysis [Mills et al. 2006; Charmaz, 2000]. Consistent with the principles of qualitative methodology, the interview schedule was revisited and revised as the interviews progressed, with new questions added as the study progressed.

Participants for this study were recruited using convenience sampling [Creswell & Plano Clark, 2011; Patton 1990], and twenty expert stakeholders from Australia, New Zealand and the United Kingdom who had engaged in the development of campaigns, research and work around stigma in gambling and associated mental health conditions were approached to participate. These individuals worked in non-government organisations, government organisations and academia. The study received ethical approval from a University Human Research Ethics Committee and followed specified ethical protocols including providing full information about the study and obtaining consent prior to participation.

Data were collected using semi-structured interviews with an open-ended style of questioning, during October and December 2014. Interviews lasted between 30 and 45 minutes; they were audio recorded and transcribed within one week of being conducted. Data were anonymised and each participant was allocated a unique identifying number. Data was analysed using a constant comparative thematic analysis, and were presented in thematic networks. This involved grouping the data into basic themes (the lowest-level theme that is derived from the data), organising themes (middle order themes that group basic themes together) and global themes (the overall concept associated with the data) [Attride-Stirling 2001; Thomas et al. 2014].

Key findings

Strategic literature review

Our review showed that there are a range of different strategies that may contribute to the reduction of stigma in some population groups. Many of these initiatives focus on responding to stigma after it has occurred, with very few comprehensive initiatives that aim to exert influence at numerous levels (including individual, interpersonal, community, institutional and structural – or systems – levels).

Four key categories of anti-stigma initiatives emerged from our review:

- a) *Mass media campaigns*: Stigma reduction campaigns are perhaps the most well-known strategy aimed at tackling stigma. However, the evidence base about the effectiveness of these campaigns is limited. Our findings suggest that these types of responses may be resource intensive. However, if underpinned by a comprehensive suite of initiatives that sit alongside the campaign, they have the potential to change attitudes and behaviours relating to stigma.
- b) *Contact strategies*: Contact strategies relate to direct contact with a person who has been impacted by a stigmatised condition. This may either be at the individual level, or via social marketing initiatives. Contact strategies have generally only been evaluated with specific audience segments, and most examine short-term change in attitudes. However, most of these studies show at least a short-term shift in attitudes towards people who are stigmatised.
- c) *Educational strategies*: Educational strategies (which aim to challenge inaccurate stereotypes and provide facts about the condition) have also shown promise in reducing the stigma

associated with particular population subgroups, particularly when used with contact strategies. While again the evidence is limited about these types of strategies, there is some suggestion that they at least may prompt discussion and raise awareness about an issue.

- d) *Advocacy strategies*: Advocacy strategies perhaps hold the most promise for challenging and reducing gambling stigma. Advocacy is a core component of public health and has been critical in changing discourses in other health conditions. Our review suggested that there are two specific type of advocacy strategies that may help to reduce gambling stigma.
- First are the use of *national summits* which bring together advocates, consumers and experts. These summits have been used in other areas of health to develop frameworks for tackling stigma, including changing discourses, developing comprehensive strategies to change attitudes and lobby for public policy change.
 - Second are *protest strategies*. This involves establishing groups that are able to respond to inaccurate representations of stigmatised individuals. These strategies are often targeted towards media portrayals, but could be extended to other negative or misleading information about gambling harm.

What is less clear from our current understanding of mass media anti-stigma campaigns is the way in which stigma can be reduced when that stigma is caused by individuals interacting with products which are known to cause harm. A combination of help-seeking campaigns, public education initiatives, and advocacy tactics aimed at exposing the harms associated with gambling products and industry tactics, may help change public perception away from 'problematic and irresponsible' individuals, and towards problematic industries.

Mass media campaigns

Our review of mass media stigma reduction campaigns found some differences between the appeal strategies in mental health, HIV/AIDS and gambling campaigns.

- Mental health campaigns utilised personal stories more frequently.
- Gambling campaigns featured more confronting and challenging appeal strategies, and focused on personal responsibility.
- More mental health campaigns used information provision as compared to HIV/AIDS and gambling campaigns.
- While mental health and HIV/AIDS campaigns contained a range of different primary messages across these two categories, the primary message of gambling campaigns fell into two categories – help-seeking and awareness-raising. The messages in these campaigns were primarily about individual actions, controls and responsibilities.
- No gambling campaigns specifically highlighted the impact of stigma or discrimination on individual gamblers, encouraged support, or broader community discussions about 'problem gambling' stigma as their primary message.

Qualitative study

Three main themes emerged from experts in the qualitative study.

Factors contributing to the stigmatisation of gamblers

There were four key factors that participants perceived contributed to the stigmatisation of gamblers.

1. Community misconceptions that the general community had about the causes and consequences of 'problem gambling' – and a dominant belief that 'problem gamblers' were individually responsible and 'to blame' for their addiction.
2. The framing of 'problem gambling' as an issue of 'personal responsibility' by dominant institutions such as governments and the gambling industry.
3. The language used to describe people who developed problems with gambling was also problematic. For example, some stated that the use of the term 'problem gambler' implied that individuals were the problem.
4. Government and industry discourses which highlighted the benefits associated with gambling, rather than the harms that gambling could cause to individuals and communities.

The impact of stigma

It was perceived that stigma had three main impacts on gamblers.

1. Gamblers' negative perceptions of themselves.
2. The concealment of gambling harm.
3. Preventing individuals from seeking help.

Responses to stigma

A number of suggestions emerged about the way in which agencies could better respond to the stigma associated with gambling.

1. Learning the lessons from other stigmatised issues. The successes in mental health anti-stigma campaigns were mentioned by participants. This included raising awareness about the causes of gambling stigma, and to advocate for a more compassionate public response to those who experience harm.
2. Shifting campaign strategies away from personal responsibility discourses, and towards a broader agenda of reforming harmful gambling (similar to tobacco reform).
3. Moving towards a public health approach to gambling harm, and having high-profile individuals champion this approach.
4. Rethinking campaign messages about help-seeking, and complementing these with a 'big picture' approach, which raised awareness in the community about the multiple factors that contributed to gambling harm.

5. Shifting the language surrounding 'problem gambling', and moving campaigns away from 'problem people' and 'personal responsibility'.
6. Providing community forums to engage communities in dialogues and discussions about harm.
7. Collecting robust data on initiatives aimed at changing community attitudes towards the causes and consequences of gambling harm.

Conclusions and recommendations

There are clear gaps in our understanding of the factors that may contribute to the stigmatisation of people who experience gambling harm, and in developing effective anti-stigma and stigma reduction initiatives. To date, campaigning in the area of gambling has focused on help-seeking. While this is important, evidence suggests that it is unlikely that these types of campaigns will have a major impact on stigma. While it is clear that there are negative community attitudes towards gamblers, there have only been limited efforts to reframe the community discussion about the causes and consequences of gambling. In our review of current campaigns that aimed to tackle stigma we found that most gambling campaigns were still focused on individualised notions of stigma, rather than seeking to change broader public attitudes and discourses about 'problem gambling'.

To effectively respond to stigma there needs to be a shift away from the current primary focus on help-seeking. Participants in our study suggested a broader focus on reframing discussions away from individual responsibility and towards the role of industry (and government) behaviours in the creation of gambling harm, as well as building community capacity through education programs. One avenue of response could include a strong 'user led' approach to the development and design of programs, and also strengthening advocacy initiatives to develop campaigns at multiple levels (including government and community) to address industry behaviour, thus shifting community attitudes and opinions away from the idea that 'problem gambling' is simply a matter of personal responsibility.

Based on the research conducted in this study we have four key recommendations that may help organisations in addressing the stigma associated with problem gambling.

- 1. Implementing strategies that seek to challenge and transform the individualistic focus on personal responsibility and problematic individual behaviours associated with gambling harm.**
- 2. Developing community-based education campaigns that seek to shift public opinion about the broader causes of gambling harm.**
- 3. Considering clear advocacy and 'protest' strategies, including user engagement and empowerment mechanisms, which seek to monitor and respond to dominant and negative discourses about gambling.**
- 4. Monitoring the effectiveness of anti-stigma initiatives at multiple levels of change.**

Part one: Literature review

1. Theoretical perspectives on the causes and consequences of stigma

1.1 What is stigma?

Stigma was defined by Erving Goffman as an attribute that was 'deeply discrediting', where there is a *'special discrepancy between [an individual's] virtual and actual social identity'* [Goffman 1964, p. 12-13]. Goffman used the term 'virtual social identity' to describe the attributes placed on an individual by society, and 'actual social identity' to refer to the attributes the individual actually possessed. Goffman then categorised these two groups of stigmatised individuals as: the 'discredited' (where an individual assumes his differentness is already known or assumed) and the 'discreditable' (whereby their difference is not immediately perceived or known, or is able to be hidden), although acknowledged that most individuals would experience both situations. He used these categories to identify three groups of individuals who would experience stigma: (1) those with physical deformities; (2) those with blemishes of character; and (3) those with tribal stigmas (including race and religion). Crocker et al. [1998], further state that *'a person who is stigmatized is a person whose social identity, or membership in some social category, calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others.'* [p. 504].

'Problem gamblers' fall into the group of individuals that Crocker and colleagues refer to as living with a 'concealable stigmatised identity'. Research has shown that living with a concealable stigmatised identity, and the associated anticipated stigma, impacts negatively on a range of health outcomes [Quinn et al. 2009]. An added complexity here is associated with the longer-term difficulty faced by individuals with a concealable stigma about if and/or when to 'reveal' their stigmatised identity to others. As Quinn [2005] describes, one of the biggest 'stressors' for those who experience a concealable stigma is *'Will others find out? Am I leaking any cues that would make them suspect my status? Have they heard anything about me?'* [Quinn. 2005, p. 86].

In understanding the causes of stigma, it is important to recognise the difference between 'stigma' and 'deviance' – a distinction that is particularly important in public health and health promotion research. In problem gambling, as with some other public health issues such as obesity [Lewis et al. 2012], this difference between viewing 'problem gamblers' as a 'stigmatised' group, and a 'deviant' group is particularly pronounced because of the way in which problem gambling is framed by social agencies as an issue of extremity, responsibility and control (whereby an individual is deemed responsible for being in control, or being able to control, his or her health and social behaviours). As Scambler [2009] outlines in his review of health-related stigma and contemporary sociology, many theories of stigma are limited because they overlook social structure. Similarly, he argues that many stigma reduction programs which are based biomedical or individualistic approaches, aim to empower using on 'top down' models information giving and self-empowerment, may not be *'without value (they may be pragmatic best options); but they are likely to be exercises in damage limitation'* (pg. 452). We contend that this is because these types of programs do little to challenge and change the socio-cultural and structural issues that lead to the stigmatisation of individuals and population sub-groups.

2. The stigma associated with problem gambling: a review of current evidence

'Problem gambling', falls into the group of 'discreditable' stigmas (along with issues such as alcoholism, mental illness, and HIV/AIDS) described by Goffman. For individuals who experience a discreditable stigma, there is a tension about whether s/he chooses '*to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where*' [Goffman 1964].

When comparing the immense amount of literature on the causes and consequences of stigma in other health issues – such as mental illness [Corrigan et al. 2005; Corrigan et al. 2002], obesity [Puhl & Heuer 2010; 2009; Lewis et al, 2013] or HIV/AIDS [Bayer 2008; Deacon 2006; Taylor 2001] – it is evident that research into the stigma associated with gambling behaviours is very much still in its infancy. The available research suggests that people who develop addictions (for example with drugs and alcohol) experience a much higher level of stigma than individuals with mental health problems [Schomerus et al. 2011]. Studies into the stigma associated with individuals who experience addictions suggest that these issues are amplified because of the inherent link between addiction and personal responsibility. For example, studies have shown that individuals who experience addictions are often viewed by the public to be personally responsible, or to blame, for their conditions [Pescosolido et al. 2010]. Studies also suggest that the general public desires a high level of social distance from those people who experience addictions (for example heavy drinkers or drug addicts) compared to other stigmatised groups (such as people with mental illnesses) [Halman 2001; Schomerus et al. 2006].

While studies into public opinions of problem gamblers remain limited, some argue that the public framing of problem gambling as a problem predominantly associated with individual (ir)responsibility, lack of control and extreme behaviour (such as criminality), may intensify and embed stigmatising attitudes towards problem gamblers [Miller et al. 2014; Miller et al. 2015]. Although it is widely believed that stigma has a profound impact on the lives of problem gamblers, it is less well understood how and why this stigma is created, and by whom. Current empirical evidence about the consequences of gambling stigma falls into three distinct categories of study.

2.1 The impact of stigma on help-seeking for people who experience harm associated with gambling

The majority of research in the area of gambling has explored the impact of stigma (amongst other factors) on help-seeking behaviour [Evans & Delfabbro 2005; Pulford et al. 2009; Suurvali et al. 2009; Clarke et al. 2007; Cooper 2004]. Most of these studies have shown that elements of stigma – and in particular shame and fear of being negatively judged by others – impacts on an individual's ability to seek help formally from health services, and informally through social networks. For example, in a New Zealand comparative study of 125 gamblers who used a national gambling helpline, and 104 who had not, Pulford and colleagues [2009] found 84% of non-help-seekers and 73% of help-seekers reported that shame was a barrier to help-seeking.

2.2 Community attitudes towards people who experience harm associated with gambling

A second group of, mainly, Canadian studies have investigated community attitudes towards problem gambling. These studies suggest that the general community holds stigmatising and

negative attitudes towards individuals who develop problems with gambling. It is noteworthy here, though, that most of these studies have been conducted with school or university-based samples so the generalisability of results may be limited.

A survey study of Canadian secondary school students (n=2790) explored stigmatising attitudes towards a range of different health and social conditions. It found over half of participants held stigmatised attitudes towards a family member who was addicted to gambling (53.7%), and were higher than attitudes towards a family member who had a mental illness (25.9%), who required a wheelchair (5.5%), and who had asthma (2.2%), similar to those attitudes towards a family member who was addicted to alcohol (54.9%) and lower than a family member who was addicted to drugs (68.3%) [Arbour-Nicitopoulos et al. 2010]. Horch and Hodgins [2008] explored the stigmatising attitudes of 249 university students and found that participants expressed the need for more social distance from men with problem gambling, than men with cancer or those experiencing a mental illness. The results of another study has suggested that ethnicity may play an additive role in the stigmatisation of problem gambling, finding that non-Caucasian Canadians were more stigmatising of problem gambling, than Caucasian Canadians [Dhillon et al. 2011]. However, it is unclear whether this information has been used to guide broader social marketing or advocacy initiatives that seek to shift public perceptions about the broader causes of problem gambling.

2.3 Experiences of gambling stigma

The third group of studies have explored how problem gamblers and their family members experience stigma. For example, in a qualitative study of 24 adults participating in treatment for gambling problems, Dunn and colleagues [2012] found that many participants hid their gambling problems from friends and family members because they feared being negatively judged [Dunn et al. 2012]. Yi and Kanetkar [2011] found that while low-risk, moderate-risk and problem gamblers all experience guilt after a gambling loss, problem gamblers were more likely to feel shameful about their gambling behaviours than other gamblers, which subsequently led these individuals to hide their gambling and deny that they had a problem. Some research has specifically explored whether stigma differs between gamblers with different socio-demographic characteristics. For example a survey of 975 online gamblers found women were significantly more likely to experience guilt and shame than males [McCormack et al. 2012]. Some research also suggests that women may experience feelings of guilt and personal responsibility for a partner's harmful gambling behaviours [McMillen et al. 2004].

Finally, two Australian studies have shown that problem gamblers from Asian (Vietnamese and Chinese) and Mediterranean (Greek) cultural groups experience shame and stigma more acutely than other cultural groups [McMillen et al. 2004, Scull & Woolcock 2005]. Importantly, a recent study conducted with a specific group of problem gamblers – those experiencing homelessness as a result of their gambling problems – found that shame and stigma led individuals to hide their gambling from housing services, with the authors arguing that this was caused by power imbalances and social discourses which emphasised personal responsibility [Holdsworth & Tiye 2012].

The most comprehensive Australian study to date was conducted by Carroll and colleagues [2013]. This report, based on qualitative interviews with service providers, individuals who gambled on Electronic Gaming Machines (EGMs), self-identified problem gamblers, and problem gambling counsellors, concluded that there is significant stigma attached to problem gambling. Feelings of 'shame' in particular, limited individuals from seeking help. Perhaps most importantly, Carroll and colleagues [2013] found that EGM gamblers perceived that problem gambling was

caused by individual personality traits (including a lack of control), and that these individuals did not need any particular protection from risky gambling products [pg. 8].

2.4 Gaps in knowledge

What is less clear from the current investigations into the stigma associated with problem gambling are the underlying socio-cultural and structural causes of problem gambling stigma and how to address these. The study conducted by Carroll and colleagues [2013] gives some indication that powerful individualised discourses about responsibility may be contributing to negative public perceptions of problem gamblers, but also gamblers' own perceptions of the causes of problem gambling. They also suggest that structural issues – including the language used in problem gambling campaigns such as 'gambling responsibly' – may at worst contribute to stigma, or may be counterproductive because it puts the onus on the individual to control their behaviour (without acknowledging the risks caused by the product) [pg. 51].

Without an evidence base about the socio-cultural factors that may drive stigma towards problem gamblers, it is perhaps unsurprising that many of the proposed 'solutions' for problem gambling stigma do little to tackle the broader societal causes of stigma, and instead focus on the individual shame and embarrassment associated with help-seeking. While tackling the shame associated with help-seeking is important, research from other areas of health shows that these help-seeking based initiatives can be problematic, largely ineffective, may indeed increase perceived individual stigma [Thomas et al. 2012; Thomas et al. 2008], and perhaps most importantly do very little to (and may increase) negative public perceptions associated with the stigmatised issue [Thomas 2010].

This lack of research into the broader socio-cultural drivers of stigma (including the role of social agencies in the creation and perpetuation of stigma), led the Parliamentary Joint Select Committee on Gambling Reform [2012] to recommend the urgent need for research into the *'complex causes and consequences of stigma and the most effective way to address and reduce the stigma associated with problem gambling'* [Parliamentary Joint Select Committee on Gambling Reform 2012].

We would argue that stigma is created and perpetuated at many different levels (and agencies) within social structures. These include within government (as evidenced in the discourses created by government policymakers about an issue) [Carroll et al, 2013]; the media (evidenced in the framing of reports and media articles) [Miller et al. 2014]; from the medical community; from the general public and family members; from the gambling industry [Miller et al, 2015]; and the self-stigma experienced by individuals. It is thus important to recognise that stigmatisation (and the construction of deviance) occurs when individuals (either through their behaviours or characteristics) are labelled, and when these labels are then associated with negative connotations [Fortney et al. 2004]. The results of this are that the identities of these individuals are devalued [Shih 2004]. Research in other areas of public health have shown that this occurs in particular when individuals are held personally responsible for a negative behaviour [Thomas et al. 2010]. Research in the area of addiction has shown that the use of different slogans within campaigns, or individualistic labels – such as drug addict, alcoholic or alcoholism – may increase the stigma towards individuals [O'Hare 2004; Dean & Rudd 1984].

There are also many different methods of communication and behavioural change strategies used in stigma reduction initiatives. These include mass media campaigns, advocacy initiatives, contact initiatives, consumer empowerment initiatives, and education initiatives. The following literature review aims to provide a summary of the evidence base relating to anti-stigma initiatives in other

areas of health. We identify the key types of initiatives used, the evidence relating to the effectiveness of these interventions, and the gaps in knowledge and approach.

3. Anti-stigma initiatives: a summary of published evidence

It has been proposed that stigma can be understood as a combination of problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination). Writing about mental illness, Thornicroft and colleagues [2008] propose that a range of advocacy strategies are needed at the local, national and international platforms to address stigma to tackle each of these components of stigma. There is also a clear association between public views and discourses about an issue and the extent to which individual's stigmatise themselves [Evans-Lacko et al. 2012]. The following section reviews some of the initiatives that have been used to reduce stigma in other areas of health (also see Appendix One and Two).

3.1 Mass media campaigns

The most common tool used to tackle stigma has been mass media (or social advertising) campaigns. Anti-stigma social advertising campaigns are one part of the social marketing mix, and have been used throughout the world to reduce the stigma associated with a range of health and social issues such as mental health [Callard et al. 2008], HIV/AIDs [Vidanapathirana et al. 2005; Brown et al. 2003], dementia [Devlin et al. 2007], and addiction [Lavack 2007].

These campaigns are sometimes termed Stigma and Discrimination Reduction or 'SDR' interventions. Outside of mental health, published evaluations of SDR campaigns are scant, and the evidence associated with the long and short-term effectiveness of campaigns is at best, contradictory [Philo et al. 2010]. As such (and as will be shown in the reviews below), our understanding of the effectiveness of SDR mass media campaigns is hampered by the lack of robust and transparent independent measurement which follows up campaigns over time.

Some research suggests that SDR mass media campaigns are resource intensive (particularly financially), but that if they are underpinned by clear theoretical frameworks, and a comprehensive suite of initiatives that sit alongside the campaign, they may have the potential to change attitudes and behaviour to reduce the stigma and discrimination of different community subgroups [Clement et al. 2010]. However to date, existing empirical evidence has not systematically demonstrated that SDR mass media campaigns have enduring shifts in either attitudes or behaviours relating to the stigma (such as discrimination or prejudice). The following reviews provide examples of this.

- In 2013 a Cochrane Systematic review conducted by Clement and colleagues of 22 studies relating to people who had seen or heard a mass media intervention as compared to those who had not [Clement et al. 2013]. The review focused on two specific dimensions of stigma – discrimination and prejudice, and concluded that mass media interventions may reduce, increase, or have no effect on discrimination, and may reduce prejudice. However the authors concluded that the quality of evidence provided in the studies was poor, so there was an element of uncertainty about the findings.
- Similarly, a review into mental health Stigma and Discrimination Reduction (SDR) initiatives in the United States [Collins et al. 2012] concluded that the research evidence about the effectiveness of anti-stigma mass media campaigns was limited. The researchers concluded that further research was needed to: 1) understand the impacts of these programs on a broad

set of outcomes – including non-discriminatory policy or behaviour, as well as treatment seeking; 2) understand how SDR programs impact on the attitudes of different population subgroups; and, 3) understand whether attitudes are maintained over time. The authors argued that increased rigour was needed in the evaluation of SDR campaigns.

This raises a question about the types of information that evaluations of SDR campaigns should collect. For example, while collecting information about visits to information sources such as websites may be good indicators of the reach of the campaign, they do not, in and of themselves indicate attitudinal change such as a reduction in stigmatising beliefs [Adam et al. 2011; Trussler & Marchand 2005; Ramirez-Valles et al. 2013]. As such, further research is needed to develop evaluation tools that adequately demonstrate short and long-term behavioural change towards those experiencing stigma.

3.2 Contact strategies

A second group of anti-stigma initiatives have evaluated the effectiveness of direct contact with a person who has been impacted by a stigmatised health condition. The strongest evidence for effective interventions at present is for: (i) direct social contact with people with mental illness at the individual level, and (ii) social marketing at the population level [Thornicroft et al. 2008]. This contact may be direct (face-to-face contact) or indirect (watching a media campaign or video of someone sharing their story) [Brown et al. 2010; Chan et al. 2009; Reinke et al. 2004; Gherman et al. 2008; Corrigan et al. 2007].

Direct contact strategies are generally used with very specific audience segments. The majority of these studies in mental health show that direct contact has at least a short-term impact on reducing stereotyping and negative attitudes [Nguyen et al. 2012; Patten et al. 2012; Brown et al. 2010; Seo & Kim 2010; Chan et al. 2009; Walachowska et al. 2009; Corrigan et al. 2007; Reinke et al. 2004; Alexander & Link 2003; Schulze & Angermeyer 2003; Gherman et al. 2008; Corrigan 2012; Patten et al. 2012; Pinfold et al. 2005; Griffiths et al. 2014]. However, it is important to note that the majority of these studies have only been conducted with very specific population subgroups, such as university students, undergraduate students from a medical degree, or high school students, and most of these only examine very short-term changes in attitudes.

3.3 Educational strategies

Education strategies have also shown promise in reducing the stigma associated with particular population subgroups. For example, there is evidence that individuals who possess more information about mental illness are less stigmatising than individuals who are misinformed about mental illness [Corrigan & Penn 1999]. Watson and Corrigan [2005] write in relation to education strategies aimed at tackling mental health stigma:

Educational approaches to stigma change attempt to challenge inaccurate stereotypes and replace these stereotypes with factual information. This can be accomplished by providing basic facts about mental illness to an audience, or by contrasting myths with facts about mental illness. The goal is not to make the audience experts on mental illness, but to provide basic facts so that many of the myths about mental illness crumble. [Page 283]

Some research in mental health suggests education in conjunction with contact strategies, produces the most significant positive results that are more likely sustained at the follow up [Chan et al. 2009; Rusch et al. 2005; Griffiths et al. 2004]. However research about the outcomes of education alone on stigma reduction in other areas of health varies [Penn et al. 1999; Economou et

al. 2014; Economou et al. 2012; Romer & Bock 2008; Griffiths et al. 2004; Corrigan et al. 2012]. This most commonly relates to the long-term effectiveness of single, one-point-in-time interventions in 'transforming' young people's attitudes towards issues [Ramirez-Valles et al. 2013]. While these types of education programs may prompt discussion and raise knowledge and awareness, it is much more difficult to reduce stigma towards individuals who are stigmatised [Ramirez-Valles et al. 2013; Trussler & Marchand 2005].

3.4 Advocacy strategies

Finally are advocacy strategies aimed at challenging stigma. Advocacy is a central part of public health and social marketing and has also been critical in changing the discourse around stigmatised health and social issues [Corrigan & Penn, 1999]. Two forms of advocacy employed to reduce stigma include:

- *National summits*: These have played a major role in developing frameworks for tackling stigma. They have included summits of advocates, consumers and experts aimed at redefining the framing of health issues, and developing campaign goals to tackle stigma. In addition, these have included summits to develop comprehensive strategies to change attitudes about the causes and consequences of alcohol addiction as well as to develop public policy agendas to change and lobby for new policies and laws [cited in Lavack, 2007].
- *Protest*: Proposed by Corrigan and Watson [2002] to challenge stigma this approach is reactive, but involves establishing groups that challenge inaccurate and hostile representations of stigmatised individuals. This form of advocacy has commonly been directed at the media (e.g. to stop inaccurate representations of individuals in reporting) or towards the general public – to stop believing negative views about stigmatised individuals. Protest has been instrumental in getting these negative or stigmatising images withdrawn.

4. Conclusion: lessons for anti-stigma initiatives and research in gambling

This review has shown that there is no 'quick fix' to address the stigma associated with problem gambling. While research from other areas of health shows us that there are certain strategies that may help to reduce stigma in some population groups and stigmatised individuals, it is clear that these initiatives have mainly focused on tackling stigma after the stigma has already occurred. Very few initiatives have comprehensively aimed to tackle the factors that may contribute to stigma including at the individual, interpersonal, community, institutional and structural – or systems – levels.

What is less clear from our current understanding of mass media anti-stigma campaigns, is the way in which stigma can be reduced when that stigma is caused by an individual interacting with a dangerous consumption product. Initiatives in tobacco for example showed us that as well as promoting 'Quit' campaigns for smokers, considerable effort went into exposing the tactics of the tobacco industry. Similar strategies may also be necessary in gambling, whereby a combination of help-seeking campaigns, public education initiatives, and advocacy tactics aimed at exposing the harms associated with products are incorporated. This includes protesting against or challenging stigmatising discourses about gambling harm.

The next section of this report reviews the content and appeal strategies used in a range of social marketing campaigns aimed at combating stigma.

Part two: A review of social marketing campaigns

1. Aims

The aim of this part of the report was to review a range of existing social advertising campaigns relating to stigma across three areas of health – mental health, HIV/AIDS, and gambling. We aimed to understand the different appeal strategies and approaches used in the campaigns, and how these campaigns may be used to inform anti-stigma initiatives for gambling.

2. Methods

2.1 Approach

We conducted an interpretive content analysis of social advertising campaigns identified via an internet search. We searched for campaigns relating to HIV/AIDS, mental health and gambling. We used broad, inclusive search terms such as 'HIV and stigma', 'mental health and stigma', 'gambling and stigma'. Campaigns were identified through websites and YouTube was used to source video campaigns when required. We included a range of social advertising campaigns – including videos, as well as visual campaigns that included posters and photo blogs.

To be included in the analysis, campaigns were required to have a focus on anti-stigma and/or reducing stigma in the aims, objectives or in the published campaign material. Foreign language campaigns were included, provided they had an English language component in addition to the non-English version. Campaigns were excluded if they had a focus on changing ideas and opinions surrounding HIV, mental health and gambling addictions, but did not specify that they were targeting stigma or providing an anti-stigma message. Campaigns that had material that was not available to be viewed in full were also excluded. Because very few campaigns were able to be identified for gambling, we decided to include gambling campaigns that displayed a theme in their campaign relating to reducing associated stigma even if they did not specifically state that they had a focus on anti-stigma and/or reducing stigma in the campaign aim or description.

A total of 64 campaigns were included in the study. These included mental health (n=30); HIV/AIDS (n=24) and gambling (n=10).

2.2 Coding templates

Coding templates were developed to document the content of campaigns based on an initial review of campaigns. We aimed to explore the following concepts:

- *The overall creative approach of the campaign:* This identified whether the campaign used emotional (designed to bring an emotional response from the audience) or rational (using informational or statistical information) creative approaches.
- *Primary appeal strategy:* The creative appeal strategy was divided into nine categories. Aspirational; challenging; confronting; fear; fun; humour; information; personal story; and social acceptance.
- *Messaging strategy:* We aimed to identify two different types of messaging strategies. The first set of categories explored messages that aimed to stimulate individual actions to reduce stigma. These included help-seeking, messages about achievements or accomplishments, changing individuals' perceptions of themselves, overcoming adversity, and problem solving. The second set of categories explored ways in which stigma could be reduced within the community. These included messages

which encouraged discussion; promoted inclusion; highlighted the negative impacts of discrimination, normalised the issue; and encouraged support for an individual experiencing stigma.

- *Actors:* We documented the main actors within the campaigns. We categorised these into celebrity; child; general population; health professional; male; female; person experiencing the health issue; family member/friend; none.

2.3 Data analysis

We used an interpretive approach to content analysis to analyse the data. Each researcher was trained and clear definitions for each category were developed. Quantitative techniques were used to numerically classify the number of times a certain approach or theme arose across the campaigns. Data was analysed using SPSS (version 19). Descriptive statistics and frequency counts were used to analyse the campaigns once they had been coded.

3. Results

3.1 Overall approach and appeal

Table 1 provides the results of the analysis of the appeal strategies of the campaigns. Slightly more of the campaigns analysed in this study used an emotional (n=35) rather than rational (n=29) creative approach.

A variety of primary appeal strategies were used. Mental health campaigns (9, 31%) utilised personal stories more frequently than campaigns in HIV/AIDS (5, 21%) and gambling (2, 20%). As a percentage of all campaign primary appeals, problem gambling campaigns (6, 60%) featured more confronting and challenging appeal strategies as compared to mental health (4, 13%) and HIV/AIDS (6, 25%) campaigns. Information provision was also used as an appeal strategy in about a third of mental health campaigns (10, 33%), a quarter of HIV/AIDS campaigns (6, 25%) and a fifth of gambling campaigns (2, 20%).

Table 1. Overall approach and primary appeal strategy

	Mental health n=30 (%*)	HIV/AIDs n=24 (%*)	Gambling n=10 (%*)
Overall approach			
Emotional	16 (53%)	13 (54%)	6 (60%)
Rational	14 (47%)	11 (46%)	4 (40%)
Primary appeal strategy			
Aspirational	2 (7%)	2 (8%)	0
Challenging/Confronting	4 (13%)	6 (25%)	6 (60%)
Fear	0	1 (4%)	0
Fun/Humour	2 (7%)	3 (13%)	0
Information	10 (33%)	6 (25%)	2 (20%)
Personal story	9 (30%)	5 (21%)	2 (20%)
Acceptance	2 (7%)	2 (8%)	0

* Numbers rounded to nearest whole %

3.2 Primary and secondary messages

The primary and secondary messages found within campaigns fell into one of two broad categories. These included encouraging behaviours to help individuals overcome stigma, and strategies aimed at reducing stigma in the community.

While mental health and HIV/AIDS campaigns contained a range of different primary messages across these two categories, the primary message of gambling campaigns fell into two categories – help-seeking (8, 80%) and awareness-raising (2, 20%). The messages in these campaigns were primarily about individual actions, controls and responsibilities. No gambling campaign highlighted the impact of stigma or discrimination on problem gamblers, encouraged support, or broader community discussions about problem gambling stigma as their primary message.

In contrast, mental health campaigns used a range of primary messages, with approximately three-quarters (n=22) related to community-based stigma and discrimination of people experiencing mental health issues. These included primary messages related to awareness-raising about the causes and consequences of mental health problems (5, 17%), the impact of stigma and discrimination (4, 13%), encouraging discussions about mental health (5, 17%) and supporting someone with a mental health problem (5, 17%). Similarly, HIV/AIDS anti-stigma campaigns were focused on reducing stigma in the community (23, 96%), with an emphasis on campaigns that normalised HIV/AIDs as an issue impacting on many different types of individuals in the community (6, 25%); raised awareness (8, 33%); and highlighted the impact of stigma and discrimination on individuals (5, 21%).

Table 2. Primary campaign messages

	Mental health n=30 (%*)	HIV/AIDs n=24 (%*)	Gambling n=10 (%*)
Individual actions			
Help-seeking	7 (23%)	0 (%)	8 (80%)
Personal achievement	1 (3%)	-	-
Changing self-perception	-	1 (4%)	-
Problem solving	-	-	-
Overcoming adversity	-	-	-
Reducing stigmatising attitudes in the community			
Normalising health issue	3 (10%)	6 (25%)	-
Awareness-raising of health issue	5 (17%)	8 (33%)	2 (20%)
Awareness of impact of stigma/discrimination	4 (13%)	5 (21%)	-
Encouraging discussions	5 (17%)	2 (8%)	-
Support	5 (17%)	1 (4%)	-
Inclusion	-	1 (4%)	-

* Percentages rounded to nearest whole number

Gambling campaigns had more secondary messages related to reducing stigma in the community (6, 60%). These included messages which aimed to raise public awareness (3, 30%), encourage discussions (1, 10%) and support for people with gambling problems (2, 20%). Secondary messages for mental health and HIV/AIDS anti-stigma campaigns were also concentrated upon reducing stigma in the community, with secondary messages associated with awareness-raising about the health issue (mental health, 11, 37% and HIV/AIDS 10, 42%).

Table 3. Secondary campaign messages

	Mental health n=30 (%*)	HIV/AIDs n=24 (%*)	Gambling n=10 (%*)
Individual actions			
Help-seeking	1 (3%)	-	2 (20%)
Personal achievement	-	-	-
Changing self-perception	2 (7%)	6 (25%)	2 (20%)
Problem solving	-	1 (4%)	-
Overcoming adversity	2 (7%)		-
Reducing stigmatising attitudes in the community			
Normalising health issue	3 (10%)	6 (25%)	-
Awareness-raising of health issue	11 (37%)	10 (42%)	3 (30%)
Awareness of impact of stigma/discrimination	6 (20%)	1 (4%)	
Encouraging discussions	5 (17%)	2 (8%)	1 (10%)
Support	1 (3%)	1 (4%)	2 (20%)
Inclusion	-	1 (4%)	-

* Percentages rounded to nearest whole %

3.3 Actors

Table 4 outlines the actors in the campaigns. Most campaigns included a person (or actor representing a person) who had experienced the health condition. Only two campaigns, from HIV/AIDS used a health professional. While celebrities were used in both mental health and HIV/AIDS campaigns, no problem gambling campaigns featured a celebrity advocating for stigma reduction of public awareness of the issue.

Table 4. Actors

	Mental health n=30	HIV/AIDs n=24 (%*)	Gambling n=10 (%*)
Person (actor or real) experiencing health issue	18 (60%)	14 (58%)	8 (80%)
General public	7 (23%)	8 (33%)	-
Family/Friends	6 (20%)	3 (13%)	3 (30%)
Celebrity	7 (23%)	4 (17%)	-
Children	-	2 (8%)	1 (10%)
Health professional	-	2 (8%)	-
Voice over / no actor	3 (10%)	4 (17%)	1 (10%)

* Campaigns may contain more than one type of actor so numbers do not equal 100%

Part three: Interviews with stakeholders about gambling stigma

1. Introduction

This phase of the study aimed to examine expert opinion about the causes and consequences of problem gambling stigma. We also aimed to assess different solutions to help prevent the stigma experienced by people who develop gambling problems. This phase of the study aimed to identify potential ways of creating anti-stigma initiatives that may specifically target issues contributing to the stigmatisation of gamblers.

2. Methods

2.1 Research questions

The study was guided by three key research questions:

1. What are the contributing factors to the stigma associated with problem gambling?
2. What is the impact of this stigma on people who experience problems with gambling?
3. What are the existing responses to stigma, and how effective are these responses?

2.2 Approach

The study design followed a constructivist grounded theory approach [Mills et al. 2006]. This approach recognises the role that the researcher plays in the construction and analysis of the data, including the subjective nature of data collection and analysis [Mills et al. 2006; Charmaz, 2000]. Consistent with the principles of qualitative methodology, the interview schedule was revisited and revised as the interviews were conducted, with new questions added as the study progressed.

2.3 Participant recruitment

Participants for this study were recruited using convenience sampling [Creswell & Plano Clark, 2011; Patton 1990]. Twenty expert stakeholders from Australia, New Zealand and the United Kingdom who had engaged in the development of campaigns, research and work around stigma in gambling and associated mental health conditions were approached to participate. These individuals worked in non-government organisations, government organisations and academia. The study received University Human Research Ethics Committee approval and followed specified ethical protocols including providing full information about the study and obtaining written consent prior to participation.

2.4 Data collection

Data were collected using semi-structured interviews with an open-ended style of questioning, during October and December 2014. Interviews lasted between 30 and 45 minutes, and were audio recorded and transcribed within one week of being conducted. Data were anonymised and each participant was allocated a unique identifying number.

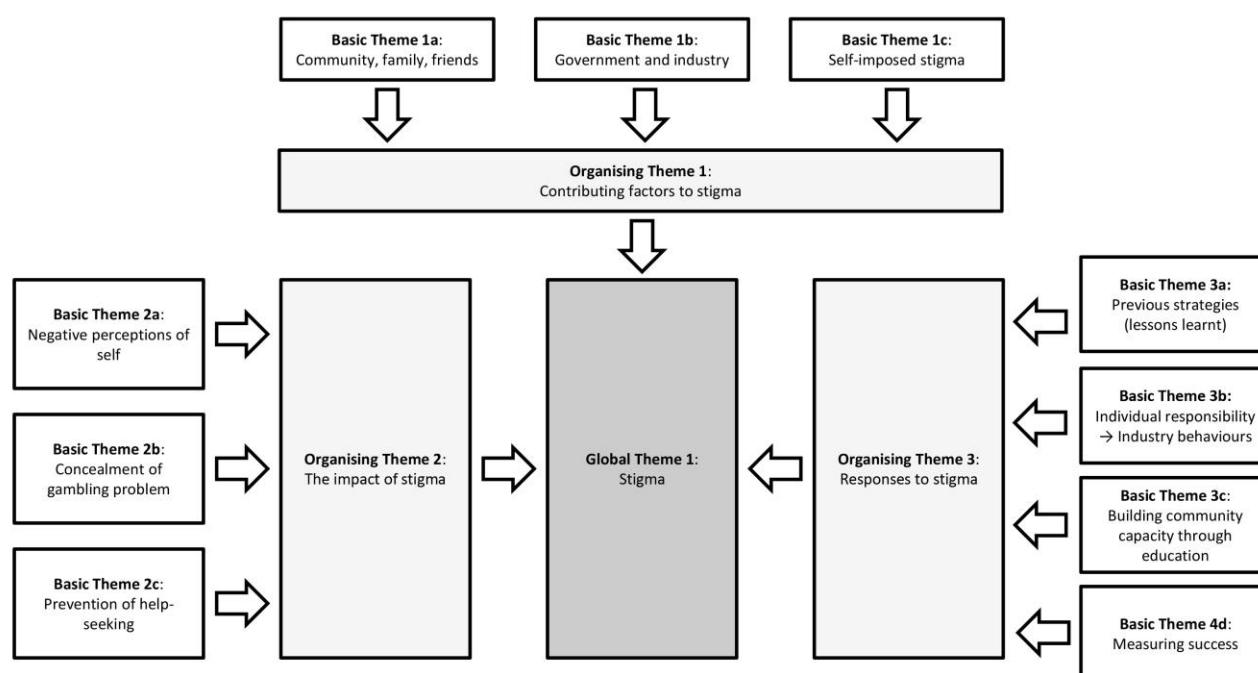
2.5 Data analysis

Using QSR NVivo (QSR International version 10.2) to manage the data, we undertook a constant comparative thematic analysis [Miles and Huberman, 1994]. The researchers met regularly to discuss themes that emerged, reading and re-reading the transcripts, making notes about ideas that emerged, and categorised the data into themes and subthemes. During this process we also reflected on how the research related to the literature and to our research questions. Data were presented in thematic networks, which involved grouping the data into basic themes (the lowest-level theme that is derived from the data), organising themes (middle order themes that group basic themes together) and global themes (the overall concept associated with the data) [Attride-Stirling 2001; Thomas et al. 2014].

3. Results

The key themes to emerge from the data are presented in Figure 1.

Figure 1. Key themes



3.1 Organising theme 1: contributing factors to stigma

There were a number of perceived antecedents of stigma towards problem gamblers.

The first theme to emerge from participant narratives were the misconceptions that the general community had about the causes and consequences of gambling harm. Participants described how this in turn lead to stereotyping and stigmatising attitudes. Most stated that the main stereotype associated with 'problem gamblers' was that they were individually responsible and 'to blame' for their addiction.

'I think there is a lot of ignorance about problem gambling in the community despite the entrenchment of it everywhere. There is a lot of ignorance about what it actually means to people, how harmful it can be, how it infects and entraps people and the effects on not only the individual but the family and others who care for them.' Participant 1

The second theme to emerge related to the way in which 'problem gambling' was framed as an issue of 'personal responsibility' by dominant institutions such as governments and the gambling industry. This included discourses that that 'problem gambling' was a consequence of individual irresponsibility, poor choices, and a lack of control. Some participants stated that one of the challenges in tackling gambling stigma related to shifting the government focus on (and language relating to) personal responsibility, towards an acknowledgement of the multiple drivers of gambling harm. For example, one participant commented that these discourses were entrenched within government policies and approaches:

'I think the government is very wedded to an individual responsibility kind of paradigm ...'

Participant 11

Some participants perceived that the language used to describe people who developed problems with gambling was also problematic. For example, some stated that the use of the term 'problem gambler', implied that individuals were the problem, and that a different term should be used to describe those impacted by gambling harm.

'... coming back to some of the terminology like "problem gambler"; the gambler is the problem then also things like where we talk about responsible gambling. So I think that implies anyone that develops a gambling problem is irresponsible ...' Participant 3

Participants also commented that industry and government discourses were skewed towards the benefits associated with gambling, rather than the harms that gambling could cause to individuals and communities. Again some perceived that this could reinforce that gambling was overwhelmingly positive, with the harms associated with gambling being limited to a very small, extreme group of individuals.

'I think if you're looking at society as a whole not many people gamble regularly so it's difficult for them to understand how it's possible to become addicted whereas say someone to become addicted to cocaine or to smoking they could probably understand "well actually yes you can become addicted to that". And also I think it's because it is not a substance, people think "how could you get addicted to that, it's an activity it's not a physical substance?" Obviously here the industry itself is very keen to point out that it's an entertainment, leisure activity. It's very difficult, the marketing also oriented around that and that doesn't help I don't think.' Participant 6

Finally, some participants believed that gambler's own preconceptions about the types of people that experienced gambling harm contributed to self-stigma. For example, some stated that gambling was not viewed in the same way as other addictions, and was seen by individuals as a character flaw or a sign of personal weakness. For example the following participant stated that individuals who developed problems with gambling felt that they were 'stupid' or 'weak':

'I think it makes people feel sometimes maybe as though they're a bit stupid for falling into that trap or that they're a bit weak and deficient in some way. So I think it comes with all these things around "this must be my fault" or it comes with a narrative around "there was some other reason, or some other excuse" you know.' Participant 11

Some reinforced that gambling problems were seen as characters flaws rather than more traditional conceptualisations of the aetiology of other addictions:

'I think they conceal the problem and they don't then seek treatment ... I think if they realised that this was an addiction, like a drug addiction, then they would be more likely I think to get treatment, they'd be more inclined to deal with this health issue. Whereas I think that the gambling addiction has been associated with weakness, and a propensity to lie, throw away money, carelessness, irresponsibility and all of those things. Character traits rather than actual traits of addiction.' Participant 6

3.2 Organising theme 2: the impact of stigma

When discussing the impact of stigma on individuals who experience harms with gambling, three themes emerged. The first was contributing to gamblers' negative perceptions of themselves. The second was the role stigma played in the concealment of gambling problems. And finally was the way in which stigma prevented individuals from seeking help.

Participants described how stigma contributed to gamblers' negative perceptions of themselves. A few participants in this study stated that the idea that gambling harm was caused due to individual's personal choices, and how this contributed to feelings of failure. The following participant commented on in-group stigma between gamblers who do not develop problems, and those who do:

'So by people, particularly people who gamble who don't experience problems yet that kind of like "well they should have known better and they should've stopped and they should've controlled themselves". And when that's the dominant discourse it leaves those people who do develop problems thinking "Oh shit, you know this was all about me and my failures" rather than understanding the kind of broader issues and how they'd been sucked in and how the machines operate and how the gambling industry seduces people into feeling this is a good thing to do.' Participant 11

Participants perceived that this lack of community understanding, also put additional pressure on gamblers to deal with their issues on their own. This was because they did not want to be associated with being a 'problem gambler'. This in turn led gamblers to try and conceal the problems that they were experiencing.

'I think that many of those folks are probably feeling a lot of pressure to deal with the really significant issue on their own and are reluctant to put themselves into a category of people that they see as problematic or shameful.' Participant 5

Inevitably, this led people who experienced problems with gambling to try and conceal their problem from family members and friends. This also stemmed from 'problem gambling' being an issue that was not broadly talked about or acknowledged within the community.

'I think it impacts in terms of not wanting to actually talk about it or tell anyone about it. I think that there is also a judgement around.' Participant 3

'I wouldn't want to be identified as the person who has gambling issues in front of my friends and family, you know I just wouldn't put my hand up because it's the un-talked about addiction.' Participant 4

Finally, participants stated that stigma impacted on help-seeking. Some stated that it was the main reason why those experiencing gambling harm did not seek help, and tried to deal with the problems on the own. For example, the following participants commented that shame often meant that individuals did not seek help until they reached crisis point:

'The number one reason our clients cite for not coming to see us earlier is that they were trying to deal with the problem themselves ... I think that many of those folks are probably feeling a lot of pressure to deal with the really significant issue on their own and are reluctant to put themselves into a category of people that they see as problematic or shameful.'

Participant 5

'I guess the shame and stigma it was always there for them and it had just got to a real crisis stage for them where they sought some support, when really that should have happened well in advance. There should have been better interventions in place and much earlier in what currently exists with people who have got right down to that crisis stage.' Participant 4

3.3 Organising theme 3: responses to gambling stigma

A number of themes emerged about how agencies could better respond to the stigma associated with gambling.

The first was learning the lessons from other stigmatised issues such as mental health. This included raising awareness about the causes of gambling stigma, and to advocate for a more compassionate public response to those who developed problems. For example, the following participant stated that other areas of addiction had managed to create a more compassionate response to those experiencing those addictions. There needed to be an understanding of how advocates had engaged the community in this type of response:

'There just seems to be more compassion around drugs and alcohol. I would be curious to know why that is. You know it can happen to anyone ...' Participant 3

One participant mentioned a specific campaign which encouraged individuals to see the person, not the problem:

'Using social media and advertisements, and there was fantastic ad in Victoria a few years ago by another disability organisations and they had a guy sitting at a railway station listening to music and he was in a wheelchair and he was obviously a person with a disability. The theme of the ad was "see the person not the disability" and that was really effective. And I thought, we could learn something from that kind of campaign and see the "industry not the person" and/or "the problem person or the problem industry?"' Participant 1

Similarly, participants advocated for campaign strategies to shift away from personal responsibility discourses, and towards a broader agenda of gambling reform (similar to tobacco reform). Some perceived that moving towards a public health approach to gambling harm, and having high-profile individuals who could champion this approach, would help to shift community attitudes towards individuals who experience gambling harm:

'I think we need a champion, I think we need someone in government to champion and push through our whole public health message around that the gambling industry is actually creating an addiction, addictive populations ...' Participant 2

While participants acknowledged that stigma prevented individuals from seeking help, they described the need to rethink campaign messages about help-seeking. Some stated that although help-seeking campaigns had a role to play, they did not think that they were an effective way of changing stigmatising attitudes, and would not help to effectively tackle stigma. Some stated that there was a need for a 'bigger picture' approach, which raised awareness in the community about the multiple factors that contributed to gambling harm. Shifting the language surrounding 'problem

gambling', and moving campaigns away from 'problem people' was raised by a number of participants as a way forward in tackling stigma:

'I think that if we can shift the discourse away from the "problem gambler", towards the "problem product" that that could be helpful ...' Participant 11

Community-based education was also part of reforming stigmatising attitudes. Participants talked about the need to engage communities in dialogues and discussions about harm. Some stated that the first step in tackling stigma was to tackle the misconceptions about the causes of gambling harm. The following participant spoke about the need to speak with, and engage, different audiences in the discussion:

'There is a lot of ignorance about what it actually means to people, how harmful it can be, how it in flares and entraps people and the effects on not only the individual but the family and others who care for them. There is a lot of not knowing about that. So what we are going to do is going out to community groups hopefully and professional groups and people will be sharing their own experiences with gambling harm in a community education framework.' Participant 1

Another participant stated that it was important to acknowledge that community education takes time, but that with the right investment, there could be a reduction in stigma:

'There has been some huge gains in the last ten years around education of problem gambling in our communities. We have seen huge leaps and bounds around the reduction of stigma. It's all because you know people are now open to discussing it. It didn't happen overnight. You know what ever campaign or whatever project needs to be long term and it needs to have some great investment behind it. We were also really successful in engaging with our own communities, so whether it be in the language that we use, making sure that we were appropriate in the language, in the culture and in the delivery and that we were working with families and not individuals ... We've tried really hard to tear down those walls ... Now kids talk about it, it's a safe thing. And everybody discusses because it's safe and no-one is pointing the finger at you. We've used a lot of that indirect approach to raise discussion and get people to talk about it in our communities in a way that they are open and they can come forward. That's led to DJs on the radio having talk back conversations on it, that's led to church ministers preaching or talking about it from the pulpit, that's led to us being invited to talk to community groups about things.' Participant 2

Participants stated that it was important that organisations started to collect robust data on the impact of anti-stigma initiatives. Most importantly, participants stated that there was a need to collect population-based data on attitudes towards the causes and consequences of gambling harm, and the short and long-term impact of anti-stigma campaigns on public attitudes and perceptions.

'... you can measure things on a population level and that's the ideal measurement, is to go out to your population and see if you are making a difference. So that if you run some kind of mass media type campaign, television advertising strategy. Then really, ideally you get a measure of stigma before the campaign and another measure after (that's quite expensive to do) but that would be a scenario.' Participant 11

Part four: Discussion and recommendations

1. Overview

In part one of this report we showed that there were clear gaps in understanding why gambling stigma occurs, and the different mechanisms that may be used to address this stigma. Based on our review of the existing literature, we concluded that much of the existing research – focused on the relationship between stigma and help-seeking – has done little to tackle the broader drivers of stigma for gamblers who experience harm, and at times, their family members. While it is clear that there are negative community attitudes towards ‘problem gamblers’, there have only been limited efforts to reframe the community discussion about the causes and consequences of gambling harm.

As with other public health issues the overwhelming dominance of the personal responsibility rhetoric, a) does very little to open a broader dialogue about gambling harm, and b) may indeed increase negative public perceptions associated with the stigmatised issue [Thomas 2010; Thomas et al, 2013]. In our review of current campaigns that aimed to tackle stigma we found that most gambling campaigns were still focused on individualised notions of stigma and help-seeking, rather than seeking to change broader public attitudes and discourses about ‘problem gambling’ and gambling harm.

This is perhaps not surprising. Many anti-stigma campaigns, including in mental health, started with these approaches. However, we have learned from these initiatives that mass media campaigns about help-seeking have done very little to shift stigmatising attitudes and discourses. As approaches to stigma in these two areas of health matured, strategies aimed to exert influence at numerous levels (including individual, interpersonal, community, institutional and structural – or systems – levels).

At present, and as evidenced in our review of mass media campaigns, many of the primary messages contained in gambling campaigns focused on the ‘lower levels’ of gambling stigma (for example related to family members and individuals), as well as removing individual barriers to shame and seeking help. However, it should be recognised that campaigns generally did not have a primary aim of stigma reduction. Nevertheless, the current individualised approach is largely inconsistent with stigma theory which suggests that stigma reduction initiatives should be focused on numerous levels in order to achieve change. Stigma theory asserts that the only way to truly change negative attitudes and beliefs about a stigmatised population subgroup requires the production of mutually reinforcing changes at multiple levels – including institutions, societies and individuals [Hornik, 2002]. For example, writing about the most effective ways to tackle mental health stigma, Collins and colleagues [2012] argue that:

‘This model of change suggests that reductions in mental illness stigma will likely occur to the extent that social norms, individual actions and beliefs, and institutional practices and policies converge to support acceptance of people with mental health problems and to the extent that intervention is targeted at these multiple levels.’

Similarly, efforts in tackling gambling stigma must focus on interventions at each of these levels – shifting social norms, changing individual (and community) actions and attitudes, and reforming institutional practices and discourse (including the framing of responsibility rhetoric’s). As such we might conclude that current attempts to reduce stigma which focuses on individual shame may be

necessary, but as Scambler (2009) noted in relation to other stigma reduction programs '[these] *are likely to be exercises in damage limitation*' (pg. 452). The findings from our interviews with experts working in gambling and more broadly in associated mental health issues confirmed the conclusions in our literature review, and added further information about the key causes and consequences of gambling stigma, the solutions for gambling stigma, and the current barriers to addressing stigma.

There were three identified 'layers' of agencies that experts believed were key in the creation of stigma: 1) The community level – including from the general public, family and friends; 2) the institutional level – including the messages and framing of 'problem gambling' by industry and government; and 3) the individual level – whereby individuals internalised the stigmatising discourses about gambling to themselves. The impact of stigma included: 1) negative perceptions of self; 2) the concealment of gambling harms; and 3) the prevention of, or delay to, help-seeking.

To effectively respond to stigma there needs to be a shift away from the current focus on help-seeking. Participants suggested a broader focus on reframing discussions away from individual responsibility and towards the role of industry (and government) behaviours in the creation of gambling harm, as well as building community capacity through education programs. One avenue of response could include a strong 'user led' approach to the development and design of programs, and also strengthening advocacy initiatives to develop campaigns at multiple levels (including government and community) to address industry behaviour and shift community attitudes and opinions away from the idea that 'problem gambling' is simply a matter of personal responsibility.

2. Key recommendations

Based on the research conducted in this study we have five suggestions for addressing the stigma associated with gambling.

Implementing strategies that seek to challenge and transform the individualistic focus on personal responsibility and problematic individual behaviours

There is no doubt that the dominant discourses associated with gambling harm are related to individual responsibility [Miller et al, 2014; Miller et al, 2015; Carroll et al. 2013, Thomas et al, 2013]. As mentioned by participants in this study, the stigma-related outcome of this is that when people do develop 'problems' with gambling, it is assumed that they have lost control or have been irresponsible with their behaviours. This has also been seen in other areas of public health, such as obesity. However, industry and governments appear to have a vested interest in continuing with this approach. We agree with Carroll and colleagues [2013] that responsibility messages may do more harm than good, and that public messages about gambling should be carefully designed to avoid stigmatising individuals who experience gambling harm.

If the discourse shifts to the roles of government or industry in the creation of gambling harm, then it follows that there would be a mutual obligation for industries, governments *and* individuals to change the behaviours that lead to gambling harm. At the moment, we would argue that the discourses related to gambling harm skews the obligation towards the individual (also evident in the amount of emphasis placed on individuals to seek help if they feel that they are developing a problem with gambling). Direct contact initiatives (for example, gamblers telling their stories), may also place an emphasis on individual behaviours, rather than 'problem products' or 'industry

behaviours'. Some argue that even the term 'problem gambling' places an emphasis back upon individuals.

If agencies are serious about tackling gambling stigma they must employ a comprehensive approach that seeks to understand the way we think and speak about harmful gambling at multiple levels, and the impact this has on individuals who experience gambling harm. Central to this is an understanding of the difference between the causes and consequences of stigma, and the difference between public (or institutional) stigma, and self-stigma. Learning the lessons from anti-stigma initiatives in other areas of health will be important in helping organisations think through how issues associated with 'problem gambling' are framed. For example, shifting to more morally neutral language such as 'gambling harm' or 'individuals who experience gambling harm' may facilitate non-stigmatising discourses and open up a broader discussion about the causes and consequences of gambling for communities. This is similar to initiatives in mental health which have sought to shift labels which pathologies individuals (for example the mentally ill, to people who experience mental health problems). As discussed by participants in this study, it is important that these discourses are considered without the input of the gambling industry or those associated with the gambling industry.

Developing community-based education campaigns that seek to shift public opinion about the broader causes of gambling harm

Providing the community with information about the range of factors that may lead to gambling harm (including the role of industry, government and individuals in this cause) may be effective in decreasing the stigma and stereotypes associated with 'problem gamblers' as 'irresponsible' or lacking control. One of the central questions to be considered here is whether there is a target group of interest in the community, or whether to employ a whole of population approach. This is especially the case when resources are finite. Further research will need to examine where the most 'gains' can be made in the short, medium and long term in terms of shifting community attitudes and institutional discourses. For example, can there be exceptional added value gained by partnering with media sources to effectively reframe the language associated with gambling harm, and to develop a broader public awareness of the causes and consequences of gambling harm?

There may be a natural progression from both traditional and social media engagement aimed at facilitating personal stories, and imparting facts, through to other community-led initiatives. The ultimate aim of campaigns should be to shift public opinion away from a perception that 'problem gambling' is predominantly caused by individual irresponsibility and towards an understanding of the broader causes of gambling harm.

Considering clear advocacy and 'protest' strategies, including user engagement and empowerment mechanisms, which seek to monitor and respond to dominant and negative discourses about gambling

Perhaps the most important element in challenging the stigma associated with different illnesses has been the role of consumer engagement and empowerment strategies. These strategies are almost completely missing in gambling. The consumer movement in mental health has moved individuals with mental health problems from passive recipients of services to active participants in the development of policy, research, campaigns and advocacy initiatives. Yet this comprehensive embedding and empowering of people who have experienced problems with gambling is almost completely missing from gambling. The consumer movement in mental health and HIV has shown

us that engaging and empowering consumers is not only ethical, but has clear evidence base in tackling stigma at multiple levels in the community – from the individual through to the healthcare system [Thornicroft & Tansella, 2005; Tomes 2006].

In gambling, protest strategies may also be particularly useful in challenging some of the stereotypes about ‘problem gamblers’ that are perpetuated by, for example, the gambling industry or within media reporting. Protest initiatives may also be useful in challenging events or campaigns that give overwhelming messages about ‘individual responsibility’ with no focus on the responsibility of other groups in the creation of gambling harm. However, it is important in any ‘protest’ initiative that exposing negative or stigmatising messages should also be complemented with a positive evidenced-based alternative [Corrigan & Watson 2002]. Based on the responses from experts in this study, these alternatives should be created by organisations independent from the gambling industry.

Monitoring the effectiveness of anti-stigma initiatives at multiple levels of change

Of fundamental and practical importance is the need to assess the perceived level of effectiveness of any anti-stigma initiatives in tandem with their inception and development. The starting point for this will be to determine what is meant by ‘effective’ and to operationalise what the outcomes are that are being sought and what can realistically be achieved in the short, medium and longer term.

It is recommended that these outcomes be broken down into ‘bite-size’ chunks and that process-related outcomes be considered as well as bigger picture, longer-term outcomes. As well as helping to capture tangible, discernible steps towards these outcomes, this kind of approach allows for the celebration of the small successes along the way. A realistic timeframe for this overall strategy will need to be negotiated and plotted out against these various outcomes to help guide targeted timing and roll-out of the various components of the initiatives.

It is important that effectiveness is conceptualised, monitored and measured at multiple levels. The broad range of stakeholders involved at this interface will undoubtedly have different, yet arguably equally valid, perceptions of what would constitute a valid or tangible indicator of change. Each stakeholder group may also, quite naturally, have divergent and, at times, conflicting views about what would be considered potentially significant or indicative of a move in the right direction.

The engagement of stakeholders at a ‘grassroots’ level has proven to be an effective strategy in cognate areas. For example, recent reports by the Victorian Equal Opportunities and Human Rights Commission (VEOHRC, 2008) and Ethnic Communities Council of Queensland (ECCQ, 2012) have clearly delineated the importance of engaging with stakeholders from the start of the process to make sure that a common language is used that resonates with the various organisations/ groups/ individuals. Using a common language will help facilitate engagement with the various sectors and groups and thus allow for greater momentum with the initiation and acceptability of anti-stigma initiatives. This, in turn, will lend itself to a more conducive environment to support and sustain these initiatives and thus provide the means for change starting from grassroots levels through to policy and, in the longer term, practice and behavioural change.

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Appendices

Appendix one: research examining the effect of initiatives in reducing mental health stigma

Authors (year)	Aims and objectives	Study design	Type of mental health illness	Population studied	Key findings
Economou et al. (2014)	To explore the influence of an anti-stigma intervention on adolescents' attitudes to schizophrenia.	Randomised control intervention – Survey	Schizophrenia	High school students (13-15 years), Greece.	Statistically significant changes found in the intervention group in their beliefs, attitudes and social distance scores. The intervention was found to have an anti-stigma effect. There was a decrease in derogatory terms post intervention and slight increase in words that indicate a positive attitude towards the person with a mental illness. Post intervention most of the feelings mentioned were positive.
Evans-Lacko et al. (2013)	To assess the effectiveness of the mass media component and mass social contact events of England's 'Time to Change' social marketing campaign.	Online interviews	General	24-45 years, England.	Mass media component effective in influencing intended behaviour. No significant longitudinal improvement in overall knowledge. Only one intended behaviour item was sustained ('live with'). Social contact had a significant impact on attitudes, those with more contact more confident to challenge stigma.
Janalis et al. (2013)	To investigate the mechanisms of stigma towards people with substance disorders.	Survey	Substance Abuse Disorders	Psychology students at college.	For alcohol dependence, there was no significance indirect different between familiarity of condition and social distance. For heroin, there were significant indirect difference between familiarity and desired social distance.
Papish et al. (2013)	To evaluate the impact of contact-based educational interventions in reducing mental health stigma.	RCT-Survey	General	Medical undergraduate students, Canada.	Stigma scores for both the control and intervention groups did not significantly change following the one-time contact-based educational intervention.

Authors (year)	Aims and objectives	Study design	Type of mental health illness	Population studied	Key findings
					Confidence working with those mentally ill increased.
Evans-Lacko et al. (2012b)	To investigate the impact of mass social contact interventions on mental health-related stigma and intended discrimination in the 'Time to change' campaign.	RCT- Survey	General	24-45 years, England.	Social contact interventions can promote positive social contact if there are facilitating conditions. The facilitating conditions were associated with improved behavioural intentions which included equal status between groups, common group, intergroup cooperation and friendship potential. Contact was not predictive of future willingness to disclose mental health problems.
Livingston et al. (2012)	To review evaluated interventions that have been designed to reduce stigma against those with substance use disorders.	Systematic Review	Substance Abuse Disorder	-	Group-based acceptance and commitment theory can be effective in reducing self-shame (self-induced stigma). Programs targeted to address social stigma showed little effect on general population. All studies required replication for further insights.
Nguyen, Chen & O'Reilly (2012)	To compare the effectiveness of direct (face-to-face) and indirect contact (film-based) intervention in reducing mental health stigma of pharmacy students.	Non-randomised intervention-Survey	General	3 rd and 4 th year pharmacy students, Australia.	Both groups showed significant improvement with reduced mental health stigma. The direct contact intervention had a stronger impact than indirect contact. However the stigma reduction was comparable for both groups.
Economou et al. (2012)	To explore adolescents' beliefs and attitudes towards schizophrenia and to assess the effectiveness of an anti-stigma intervention.	RCT	Schizophrenia	High school students (13-15 years), Greece.	Post intervention there were positive changes in students' beliefs, attitudes and desired social distance with those suffering from schizophrenia. However only the changes in beliefs and attitudes were maintained at the 12-month follow up.
Brown et al. (2010)	To compare the impact of two brief interventions in reducing	RCT- Survey	Schizophrenia	Undergraduate medical students (18-24 years),	Filmed contact intervention decreased two aspects of mental illness stigma (social

Authors (year)	Aims and objectives	Study design	Type of mental health illness	Population studied	Key findings
	schizophrenia stigma: filmed personal contact and hallucination simulations.			USA.	distance and negative emotions) which was sustained at the one-week follow up. The simulation increased schizophrenia stigma.
Patten et al. (2010)	To assess the effectiveness of contact-based education intervention for reducing mental illness-related stigma in pharmacy students.	RCT-Survey	General	3 rd and 4 th year pharmacy students, Canada.	Contact-based education reduced stigma, with significant findings. There was a minor and non-significant change during mental health education sessions and a substantial change post contact-based education. This suggests contact-based education sessions has a more substantial effect.
Evans-Lacko et al. (2010)	To evaluate whether short-term anti-stigma campaigns are effective in reducing mental health-related stigma, using the 'Time to Change' campaign as an example.	Face-to-face Interviews	General	24-45 years, England.	There were significant and sustained shifts in mental health-related knowledge post campaign exposure. This included changing knowledge on what people can do to help those suffering from a mental illness. However these changes were not evident for attitudinal or behaviour-related questions.
Keyes et al. (2010)	To examine the relationship between perceived stigma and utilisation of treatment for alcohol addiction disorders.	Questionnaire from the 2004–2005 National Epidemiologic Survey of Alcohol and Related Conditions	Substance Abuse Disorder	General Population.	Those who experience the highest rates of stigma were least likely to use alcohol services. Increases in stigma was associated with a decrease in likelihood of the individual getting treatment. (OR ¼ 0.91, 95% CI: 0.87, 0.97).
Seo & Kim (2010) (Seo and Kim, 2010)	To assess the effectiveness of an educational program using online media to reduce negative attitudes and stigma towards those with mental health problems.	Intervention	General	University students, Korea.	The overall attitude toward community mental health was better in the experimental group than in the control group. However knowledge about mental illness, authoritarian, social restrictiveness and social distance did not differ between groups. The online video group enhanced general knowledge and helped reduced stigma.

Authors (year)	Aims and objectives	Study design	Type of mental health illness	Population studied	Key findings
Bayar et al. (2009)	To assess the effectiveness of a web-based mental disorder stigma education program for mental health professional.	RCT- Online survey	General	Medical professionals in psychiatry, Turkey.	Post intervention the experimental group had less stigmatising attitudes, with significantly higher overall questionnaire scores. Findings suggest that web-based anti-stigma campaigns delivered to medical professionals can be effective in reducing stigma.
Chan, Mak & Law (2009)	To examine the effects of three versions of school-based mental health stigma reduction programs- education, education followed by video-based contact (education-video) and video-based contact followed by education (video-education).	RCT- Survey	Schizophrenia	High school students (13-18), Hong Kong.	Stigmatising attitudes were significantly improved when adding video-based contact to education; however this result was only found when video-based contact was presented after and not before education. Participants in the education-video group showed the most significant reduction in stigmatising attitudes at post-test, in social distance at both post-test and follow up, and increase in knowledge at follow-up. However for the video-education group there was no difference from the education-alone condition.
Corrigan et al. (2009)	To examine the stigma surrounding mental illness, drug addiction and physical disability and compare the way each of these is stigmatised.	Survey	Substance Abuse Disorder	General population.	People with drug addictions were viewed as responsible for their condition. This group was perceived as most able to overcome their condition. Participants were most likely to avoid a person with a drug addiction compared to the other conditions.
Markström et al. (2009)	To examine the changes in stigmatising attitudes towards mental illness post completing education and clinical placement among health professional students.	Survey	General	Undergraduate medical students (nursing, occupational therapy and medicine), Sweden.	Attitudes towards mental illness in general were less stigmatising after the placement however attitudes toward specific mental health illnesses did not show any significant changes.

Authors (year)	Aims and objectives	Study design	Type of mental health illness	Population studied	Key findings
Ronzani et al. (2009)	To investigate the views of primary health care professionals in Brazil regarding individuals with alcohol and drug dependence.	Questionnaire	Substance Abuse Disorders	Primary Healthcare Professionals in South East Brazil.	Nursing assistants scored the highest in judgement scales tests. Older professionals showed more moral judgement against alcoholics than younger workers.
Walachowska et al. (2009)	To evaluate the effectiveness of three interventions: film, contact and an educational presentation in reducing stereotypes and prejudice towards people with schizophrenia.	RCT- Survey	Schizophrenia	Undergraduate students, Poland.	Film – most successful in reducing prejudice, which was sustained at the follow up. However it increased stereotyping. Meeting – reduced stereotyping and prejudice. Only reduced stereotypes was sustained at follow up. Educational presentation – effective in reducing stereotypes and reducing prejudice which were both sustained at follow up.
Finkelstein et al. (2008)	To assess whether a computer-assisted intervention program can reduce mental health-related stigma in special university students.	RCT –Survey	General	Graduate students, USA.	Both the reading group and computer program group had significant results with reduced stigma scores post intervention. However at the 6 month follow up the computer program group had the most sustained results, with the majority of scores in the reading group returning to baseline scores.
Gherman et al. (2008)	To report on the effects of anti-stigma approaches that included social activism, education of the public and social contact with persons with a mental illness.	Film – then survey	OCD and Specific Phobia	High school students (14-18 years), Romania.	Results indicate positive answers as a result of watching the movie, with stigma reduced. The use of the media in anti-stigma campaigns may facilitate access to information and at the same time fight prejudices.
Kerby et al. (2008)	To assess the effect of two anti-stigma films on medical students' attitudes to serious mental illness and psychiatry.	RCT- Survey	General	4 th year undergraduate medical students, England	There was a significant change in scores in the intervention group after watching the films, signifying that the students' attitudes were less stigmatising.
Luty et al. (2008)	To assess the effectiveness of two procedures on	RCT- Survey	Schizophrenia and Substance Misuse	General population, UK.	If presented in a positive manner a short illustrated pamphlet can

Authors (year)	Aims and objectives	Study design	Type of mental health illness	Population studied	Key findings
	decreasing stigmatised attitudes of the general public towards those with mental disorders (schizophrenia and substance misuse).				reduce stigmatised attitudes towards substance misuse, however it is less effective for attitudes towards people with schizophrenia.
Romer & Bock (2008)	To assess the effectiveness of presenting counter stereotypical information about the effectiveness of treatment for depression in reducing stigma.	Survey	Depression	Youth (14-22 years), USA.	Respondents' reported lower levels of unfavourable stereotype expectations and reduced stigma towards an individual with depression who has been successfully treated compared with one who was not treated. The results indicate promoting individuals with depression who have been successfully treated is a potential strategy for reducing mental health stigma.
Corrigan et al. (2007)	Examine the impact of two anti-stigma programs, education and contact (on videotape) in reducing mental health-related stigma.	RCT	General	University students, USA.	The education videotape had limited effects, mainly showing significant reduction in responsibility (sufferers not to blame for condition). This was sustained at follow up. The contact video was more effective significant and sustained improvements in pity, empowerment and coercion. There was significant and sustained reduction in avoidance and segregation. Filmed version of contact led to greater stigma improvement compare to education.
Finkelstein et al. (2007) (Finkelstein and Lapshin, 2007)	To compare the sustainability of the effect of two anti-stigma education programs.	RCT	General	Undergraduate students (special education teachers), Russia.	Stigma scores reduced post intervention for both the reading group and the web-assisted program group; however the greatest reduction was those in the web-assisted program group. In six months after the intervention the level of stigma in the web-

Authors (year)	Aims and objectives	Study design	Type of mental health illness	Population studied	Key findings
					assisted program group was significantly lower compared to the control group and reading group.
Luoma et al. (2007) (Luoma et al., 2007)	To investigate the impact of stigma on individuals receiving treatment for substance abuse disorders.	Questionnaire	Substance Abuse Disorders	Individuals receiving treatment for substance abuse disorders.	Most individuals reported a stigmatising experience as hearing others say they heard unfavourable or offensive things about people who have been in treatment for substance use. 60% of participants received above average scores on the perceived stigma scale.
Luty et al. (2007)	To evaluate the effectiveness of factsheets from the Changing Minds campaign on reducing stigmatised attitudes of the general public towards those with mental illness.	RCT- Survey	Schizophrenia and Substance Use Disorders	General public.	There was no difference in scores between the experimental and control group and thus the factsheets were ineffective in reducing stigmatised attitudes towards those suffering from mental illness.

Appendix two: research examining the effect of initiatives in reducing HIV/AIDS stigma

Authors (year)	Aims and Objectives	Study Design	Way in which Stigma was Addressed	Population Studied	Key Findings
Ramirez et al. (2013)	Description of the development and dissemination of a film-based intervention to address stigma.	Program evaluation	Youth targeted educational film addresses three areas of stigma (religion, family and school) through the life experiences with stigma of 5 individuals.	Gay men, bisexual men and transgender women. Persons living with HIV/AIDS.	Educators (50) who viewed the film (≥85% agreed/strongly agreed) that the film was potentially highly effective in reducing stigmatisation. The film was effective in generating initial (although limited) change.
Adam et al. (2011) Ross & Rynard (2010)	Report on the implementation of the website hivstigma.com and evaluation of the campaign.	Program evaluation	Encouraged discussion on stigma by highlighting the rejection individual's face when they disclose their HIV status.	Website Users.	Exposure to campaign increased awareness of HIV stigma and the negative health consequences associated with it.
Devos-Comby & Salovey (2002)	To develop a framework for understanding the effectiveness of messages in HIV communications.	Content analysis	Campaigns that use fear may trigger helplessness and denial in Those who are HIV positive.	-	AIDS campaigns should focus on personal vulnerability and increasing self-efficacy rather than fear. Message framing (loss-framed message versus gain-framed message) and personal relevance in campaigns can influence behaviour change.
Golub & Gamarel (2011)	Examination of the association between expected stigma and HIV testing behaviours.	Self-administered survey	-	Men who have sex with men and transgender women in New York City.	Anticipated stigma was not associated with sexual risk behaviour but with risk perception (in individuals who had not been tested for 6 months reported higher anticipated stigma scores than those who had been tested recently).
Johnny & Mitchell (2006)	Analysis of the World AIDS campaign posters and evaluate their effectiveness in reducing stigma and discrimination.	Content analysis	The purpose of posters was to create a new image for HIV/AIDS and reshape society's image of the virus by breaking down stereotypes.	-	Campaigns may have repositioned stigma and discrimination, whilst also reinforcing and producing new forms of stigma and discrimination.

Authors (year)	Aims and Objectives	Study Design	Way in which Stigma was Addressed	Population Studied	Key Findings
Johnson et al. (1997)	Investigation of 317 mass marketing public service announcements (PSAs) regarding HIV in 33 countries.	Content analysis	Ways stigma has been increased: Many have faceless male narrator. Inexplicit, lack of recommendations, heterosexual emphasis.	General public.	Majority of PSAs are non-controversial, heavy on information but provide little recommendations and encourage information seeking (25% lacked recommendations; 30% had general advice – for example 'be careful') PSAs produced in first decade of pandemic were heavy on information with very little storytelling.
Mahajan et al. (2008)	Review of current literature on HIV and AIDS to identify gaps and summary of the challenges to effective interventions in reducing stigma.	Content analysis	-	Individuals with HIV.	HIV and AIDS stigma is considered a barrier to effective HIV prevention and treatment services. Recommends: reform of policy that enable stigma and discrimination and more assessment of the impact of HIV/AIDS stigma on programs.
Trussler & Marchand (2005)	'Think Again' Raise attention to the faulty assumptions about the safety of having unprotected sex. Stimulate gay men to rethink their assumptions.	Evaluation report	Inclusion of varying ethnicities. Lack of focus on information gaps. Focus on why individuals do not use condoms and associated assumptions.	Gay and bisexual men in Canada.	'Call to action:' 36 851 visits to website in 3 months. The campaign reached a diverse gay population. Those potentially most at risk were those most affected by campaign.
Vidanapathirana et al. (2005)	To review and assess the most effective form of mass media intervention in relation to changes in HIV testing.	Content analysis	-	General public and target populations including; commercial sex workers, drug users, men who have sex with men, bisexual people, pregnant women and adolescents.	Barriers to voluntary HIV counselling and testing include stigma and discrimination. High-risk groups for HIV/AIDS report less health care seeking behaviour than others due to stigma.

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