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Stigma Programme Best Practice

A Scoping Review

Authors: Imogen Martin, Cate Standing-Tattersall, Adriana D’Arcy, Phoebe Weston-Stanley, Dr Rosa Lau, Dr Sokratis Dinos

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NatCen Social Research
35 Northampton Square
London EC1V 0AX
T 020 7250 1866
www.natcen.ac.uk

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1 Glossary

Table 1:1 Terminology	
Academic literature	Papers published in academic journals.
Advocacy programme	A type of programme which involves formal efforts to support certain groups or issues, which can include objection to negative or stigmatising portrayals of these groups. Such advocacy efforts can be directed at media portrayals, politicians, community leaders or professionals.
Anti-stigma campaign	Public facing or targeted outreach and communication aiming to reduce stigma. Campaigns can involve mass media promotion to reach a large audience or be targeted to a smaller audience.
Contact-based programme	A type of programme which involves contact with people with lived/living experience of the stigmatised behaviour or condition.
Digital tools	Software, programmes and platforms that can be used with digital devices.
Education programme	A type of programme which uses factual information to address stigma by confronting negative beliefs and incorrect information.
Grey literature	Papers which are not published in academic journals.
Internalised stigma	The process by which negative messages and stereotypes about a stigmatised behaviour or condition are absorbed by a person towards whom those messages/stereotypes are directed, causing them to believe them and apply them to themselves.
Peer programme	A form of contact-based programme where people with lived experience are involved in directly providing programme activities.
Perceived stigma	Perceptions of how members of the stigmatised population might be thought of or treated if their stigmatised behaviour or condition becomes known.
Quasi-experimental design	A type of research design which aims to evaluate interventions. A comparison between groups is made but no random assignment of participants to groups occurs.
Randomised controlled trial (RCT)	A study in which a number of people are randomly assigned to two (or more) groups to test an intervention. One group (the treatment group) experiences the intervention being tested and the other (control) group experiences a dummy intervention or no intervention at all. Outcomes are measured in both groups to assess the effectiveness of the intervention.
Secondary data analysis	The use of existing research data to find an answer to a question that was different from that posed in the original work.

Table 1:1 Terminology

Stigma	A social process through which difference between individuals is labelled, with negative stereotyping following from this difference.
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2 Executive summary

The scoping review aimed to provide an overview of best practice methods when tackling stigma in gambling and adjacent sectors. The review summarised and synthesised evidence from 44 individual papers which covered best practice for designing, setting up, delivering and evaluating anti-stigma campaigns and wider programmes in sectors including gambling, mental health, HIV and dementia. The review found that evidence on best practice for designing and delivering anti-stigma campaigns and programmes was largely similar across these sectors, and consistent with the literature on best practice for delivering interventions more broadly.

The review identified several best practice recommendations for the set-up, delivery and evaluation of interventions which aim to tackle stigma:

- **Set clear objectives for the intervention prior to design and launch**
- **Collaborate with other anti-stigma campaigns and programmes throughout campaign set-up and delivery**
- **Incorporate theory (e.g. Theory of Change or behavioural change models) into the design of the intervention**
- **Consider the broader socioeconomic context and intersectional nature of stigma**
- **Build in independent evaluation from the beginning of the intervention**
- **Involve people with lived experience in the set-up and delivery of interventions**
- **Combine different types of approaches (e.g. campaigns, advocacy, contact programmes) to increase exposure to intervention messages**
- **Provide ways for people to continue to engage with the programme once it finishes (e.g. by archiving resources or toolkits)**
- **Ensure the intervention can be easily replicated and adapted for different audiences over time by recording detailed descriptions of all intervention components**

The review also identified several best practice recommendations specifically for the design and implementation of campaigns which aim to tackle stigma:

- **Use person-first language to show that gambling disorder is a condition that affects people, rather than an identity that defines someone**
- **Use positive framed ('competence based') messages which emphasise that people have their own unique identities, personalities and capabilities**
- **Use the word 'stigma' in messaging and describe its harmful consequences**
- **Include guidance about language to use when discussing gambling**
- **Use metaphors (linguistic or visual) in messaging**
- **Avoid language which places shame or blame on people who gamble**
- **Avoid language which may instil fear about gambling**
- **Avoid messaging which focusses on the causes of conditions or behaviours**

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- **Avoid linking gambling with other stigmatised conditions or behaviours**
 - **Use an interactive homepage/ personalised approach for campaigns**
 - **Use multiple digital channels (or print advertising methods) to reach different demographics**
 - **Create social media content which is shareable**
 - **Include information about where to access support on campaign materials**
 - **Use ‘opinion leaders’ to deliver messages**
 - **Use partnerships with other organisations and brands to reach relevant audiences**

3 Introduction

3.1 Background to the research

Stigmatisation refers to a social process through which a difference between individuals is labelled, with negative stereotyping following from this difference. This creates distinct 'us' and 'them' groups, resulting in status loss and/or experiences of discrimination for members of the othered group (Link and Phelan, 2001; Goffman, 1963). Stigmatisation is a significant negative consequence faced by people who experience gambling harms. Stigma attached to gambling acts as a barrier to individuals engaging with support services and can result in feelings of isolation (Hing et al., 2014; Hing et al., 2015).

There are different types of stigma, all of which could be experienced by people who struggle with gambling and may prevent them from seeking or accessing treatment. Many of those who struggle with gambling may internalise stigma (known as self-stigma), believing that negative stereotypes about those who gamble are true and apply to them, thereby affecting their self-worth and wellbeing and potentially causing them to delay taking action to address gambling harms (Brown and Russell, 2020). Furthermore, 'perceived stigma' refers to perceptions of how members of the stigmatised population might be thought of or treated if their participation in the stigmatised activity (such as gambling) becomes known. Experiences of stigmatisation are not limited only to those who partake in a stigmatised activity like gambling; 'associative stigma' also applies to the experiences of the friends and family of stigmatised groups (Stangl et al., 2019).

Changing how problems associated with gambling are perceived has been suggested as a means to address this stigma, aiming to reduce both the personal and social barriers to seeking treatment and support (Dinos et al., 2020). The stigmatisation of those who participate in gambling is an under-researched area and, correspondingly, there are few examples of anti-stigma campaigns or programmes that focus on gambling. However, GambleAware's commissioned scoping study, 'Building knowledge of stigma related to gambling and gambling harms in Great Britain', published in 2022, established that the stigmatisation process in people who struggle with gambling is very similar to stigmatisation in the context of other health behaviours and conditions, including mental health, drug and alcohol use, cancer, obesity and HIV (Pliakas et al., 2022).

3.2 Research aims

The scoping review aimed to provide an overview of best practice methods when tackling gambling stigma as well as stigma in adjacent sectors, with a view to applying findings to gambling. The review explored the following research questions (RQs):

1. Which **anti-stigma campaigns** (particularly media campaigns) have made an impact in tackling stigma, and how?
 - a. What were the aims of the campaigns?
 - b. How were they executed?
 - c. How were they evaluated?
 - d. What are the key lessons learned for running campaigns to tackle stigma?
2. Which **anti-stigma programmes** have made an impact in tackling stigma, and how?
 - a. What were the aims of the programmes?

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- b. How were programmes executed?
 - c. How were programmes evaluated to measure stigma and could the approaches be applied to gambling?
 - d. What are the key lessons learned for planning and executing anti-stigma programmes?

The review was conducted in two stages to allow early findings from stage one to feed into the delivery of a specific campaign, whilst stage two was broadened to help the wider programme of work. Stage one took place in August 2022 and aimed to respond to RQ1 and Stage two took place from September to November 2022 and aimed to respond to RQ2.

Although the RQs refer to 'programmes' and 'campaigns', the report uses the term 'intervention' when referring to programmes and campaigns collectively.

4 Methodology

Methodology overview

This study used a scoping review approach. Scoping reviews map the body of literature on a topic and present an overview of potentially large and diverse bodies of literature (Arksey and O'Malley, 2005). This allowed for data collation, review and synthesis to be carried out in the most efficient way. The methodological approach set out below was applied at both Stage one and two. Stage two built on the data collated during Stage one to cover wider stigma reduction programmes.

Evidence identification

The study involved a systematic search of both academic and grey literature. Academic literature was located using search strings in Scopus, an academic database, and from additional sources (e.g. papers referenced in the ITT “Stigma programme best practice literature review: Request for proposal”). The search strings (see Appendix 8.2) were developed in relation to the inclusion and exclusion criteria and are set out in Appendix 8.1. The search strings for Stage one aimed to identify anti-stigma campaigns and key recommendations across gambling and adjacent sectors. The search terms were modified at Stage two to cover a broader range of stigma reduction programmes including (not limited to) behavioural change interventions and educational programmes. After searches were conducted for Stage two, inclusion and exclusion criteria were adjusted in order to focus on the most relevant evidence. Papers and/or programmes that specifically focused on school and university settings, children and young people, and papers published before 2017 were excluded. Furthermore, grey literature searches were conducted using a list of relevant websites. The research team used a set of core search terms to find documents on these websites. The list of websites is provided in Appendix 8.3.

Where studies were found to be particularly relevant, citation tracking was conducted. This involved looking through the list of references in the chosen paper and/or viewing all the papers that cite the chosen paper.

Evidence screening and selection

Academic and grey literature at Stage one and Stage two was screened for inclusion at two stages: title and abstract, and full text. Following full-text screening, studies that met the inclusion criteria were systematically prioritised based on relevance (e.g. topic area, inclusion of evidence about evaluation, geographic location). Figures 2 and 3 in Appendix 8.4 illustrate the search and screening processes undertaken, and the total number of studies included and excluded. Overall, 44 papers were included for data extraction across both stages¹. Four of these papers related to gambling, 25 to mental health, six to drug and alcohol misuse, and the remaining to HIV/AIDS (two), dementia (three), diabetes (two), stuttering (one) and abortion (one). Of the 44 papers included, six were evidence reviews which included information on multiple interventions (ranging from six to 21 interventions). For example, Bascu et al. (2022) reviewed 21 interventions which aimed to reduce stigma related to dementia. The remaining papers focussed on one programme or campaign and included academic papers as well as grey literature such as evaluation reports.

Narrative synthesis and data integration

¹ Papers refer to academic papers, grey literature reports and articles, and campaign websites.

At both Stage one and Stage two, based on an initial read of a subset of the prioritised studies, a data extraction sheet was developed to carry out a narrative synthesis. Members of the research team read the papers closely and extracted relevant information into the corresponding cells of the extraction framework. Data was organised into key descriptive and conceptual themes including programme aims and execution, evaluation methods, and key lessons learned. For both Stage one and Stage two, the extraction sheet was piloted with up to three papers to ensure that it successfully captured data and any required adjustments were made. Following data extraction, the evidence was narratively synthesised by research question.

5 Anti-stigma interventions

The following sections set out how interventions to tackle stigma have been set up, delivered and evaluated and best practice recommendations. They aim to answer the following research questions:

- What were the aims of campaigns and programmes?
- How were campaigns and programmes executed?
- How have campaigns and programmes been evaluated?

The term 'anti-stigma intervention' is used in this report to refer to both anti-stigma programmes and campaigns. Anti-stigma programmes include any measures or activities designed to reduce stigma, for example the delivery of training. Anti-stigma campaigns include public-facing or targeted outreach and communication aiming to reduce stigma. Campaigns can involve mass media promotion to reach a large audience or be targeted to a smaller audience. Figure 1 below shows the types of anti-stigma interventions which have been identified in this review. The review identified overlaps between anti-stigma programmes and campaigns and many interventions used multiple methods, such as education programmes using contact approaches or campaigns focusing on education.

Figure 1: Types of anti-stigma interventions identified in the review



Whilst the review identified a wide range of anti-stigma interventions, the key campaigns and programmes identified are listed below:

- **Time to Change** (2007-2021) – a national programme in England which aimed to challenge mental health stigma and change the way people think and act about mental health in the workplace, local community, and schools. The programme included awareness days and campaigns, Employer pledges, training, and *Community Hubs*.
- **Time to Change Wales** (2019-Present) – the first national programme in Wales which aims to overcome mental health stigma through improving knowledge and understanding of mental illness and encouraging people to talk about mental health. Programme activities include campaigns (e.g. Talking is a Lifeline) and *Young People's Champions* in schools.
- **See Me** (2016-Present) – a programme in Scotland which aims to end mental health stigma and discrimination. A key intended outcome of the programme is for people to recognise and challenge mental health stigma and for people experiencing mental ill health to feel confident talking about their experiences. The programme consists of knowledge sharing, campaigns (e.g. FeelsFM) and events.
- **Blue Light Programme** (2015-Present) – a programme run by Mind to provide mental health support to emergency workers. A core aim of the programme is to reduce stigma within workplaces. The programme provides information and advice, (including guides on how to talk about mental health in the workplace), and the *Blue Light Time to Change Organisational Pledge*.
- **Stigma Kills** (2022-Present) – a campaign run by the NHS Addictions Provider Alliance which aims to highlight the effects of stigmatising language and attitudes towards those who experience addiction, and challenge misconceptions around addiction. The campaign is grounded in the understanding that stigmatisation can be a driver of exclusion (i.e. not accessing treatment) and can cause or contribute to harms such as suicide. The campaign includes case studies, resources on stigmatisation, and digital tools such as supporter badges and social media graphics.

5.1 Intervention set-up

The following section outlines how anti-stigma interventions were set up. Campaigns and programmes identified in this review used various set-up methods and strategies, including evidence-based and theory-informed approaches to understand issues related to stigma, and to inform the design and delivery of campaigns and programmes. Interventions also took place in collaboration with specialists (e.g. media specialists), and used co-production with individuals with lived experience. Some interventions piloted the programme or campaign before implementation.

The majority of interventions were informed by research on the impact of stigma and discrimination. During the set-up phase, many organisations adopted an evidence-based approach through conducting or commissioning research to inform design and delivery of interventions and understand issues related to stigma in greater depth (Magpie 2022; NHS Inform, n.d.; See Me 2022; Time to Change 2021a; Time to Change 2022; Yang and Mackert 2021). The 'See Me' programme, which is Scotland's national programme to end mental health stigma and discrimination, used surveys and focus groups to establish key issues around stigma and mental health (See Me, 2022). Some organisations also adopted a theory-informed approach (e.g. use of behaviour change theories) in the design and development of their interventions. For example, 'See Change', a programme based in Ireland which aims to tackle mental health stigma, was informed by social contact theory. The theory suggests that under certain conditions, contact between two groups (those with lived experience and those without) can promote tolerance and acceptance. The programme used personal narratives of

people with lived experiences of mental health challenges with the aim of overcoming attitudinal and behavioural barriers (Stuart et al., 2019). Likewise, stigma theory and empirical literature framed the intervention approach adopted by the 'CHHANGE' project to address stigma about HIV/AIDS (Frye et al., 2017).

Interventions also used research to establish existing evidence on best practice for campaign messaging (NHS inform, n.d.), and lessons from previous anti-stigma campaigns. The 'Time to Change' campaign used learning from Scotland's 'See Me' and New Zealand's 'Like Minds Like Mine' campaigns to inform their design (Time to Change, 2022). Organisations have also used research to inform their campaign approach. The Centre for Disease Control and Prevention (CDC)'s 'Rx Awareness' campaign (2017-present) in the USA aims to increase awareness of prescription opioid risks, increase awareness about treatment and reduce stigma. A literature review, social media assessment, focus groups, in-depth interviews and secondary data analysis were conducted to inform the design of the campaign, including the age range the campaign should target. The 'Time to Change' campaign (2007-2021) similarly used insights from both qualitative and quantitative research to design a campaign approach that could better reach the campaign's target groups (Time to Change, 2021a).²

Organisations developed partnerships and collaborations in the set-up phase of interventions, both with those with lived experience of stigma and specialists (e.g. media specialists) to support intervention delivery. The 'Beat the Odds' campaign (2017-present), commissioned by Leeds City Council, aims to reduce the stigma of gambling harms. During the campaign set-up, Leeds City Council sub-contracted a specialist media campaign agency called Magpie to deliver the campaign (Magpie, 2022). Similarly, 'Time to Change Wales' worked with a design agency to develop the concept and design for their 'Talking is a Lifeline' campaign (Time to Change Wales, 2022).

Many interventions integrated elements of co-production during their set-up phase. Scotland's 'See Me' programme identified co-production as a core element of their anti-stigma approach and campaigns such as the 'FeelsFM' campaign were co-designed with young people (See Me, 2019). Programmes such as 'Time to Change', asked people with experiences of mental health problems what they thought the campaign should seek to address (Time to Change, 2022). They collected views through a survey before the programme began, and then subsequent surveys throughout the programme to account for and reflect changing priorities (Time to Change, 2021b). 'Time to Change' also worked with **Lived Experience Advisors** who offered suggestions on the set-up strategy, scrutinised progress, and supported the leadership team (Time to Change, 2022). Similarly, the 'Challenge HIV Stigma and Homophobia and Gain Empowerment (CHHANGE)' project, a community level intervention which aimed to reduce HIV stigma in New York City, conducted formative participatory research to inform the intervention's set-up and approach. The project facilitated five focus groups with 54 people from key groups (i.e. gay men and people with HIV) and organisations, to understand how they conceptualised HIV stigma. A steering committee made up of key community stakeholders then reviewed the evidence from the focus groups and offered advice as to how the intervention should be designed and executed (Frye et al., 2017).

Prior to roll out, some anti-stigma interventions implemented a **pilot stage**. The 'Time to Change' campaign was piloted in Norwich and Northern Ireland (Time to Change, 2022) and the 'Beat the Odds' campaign obtained feedback from target audiences via focus groups, an online questionnaire and on the street research. This ensured that

² The campaign's target groups changed at various points in the campaign's history but have included those aged between mid-twenties and mid-forties, middle-low income groups, and men.

initial campaign concepts could be refined to be as engaging as possible (Magpie, 2022).

5.2 Intervention delivery methods

The following section aims to answer the research questions ‘What were the aims of campaigns and programmes?’, and ‘How were campaigns and programmes executed?’. The section describes different types of interventions that have aimed to reduce stigma. This includes campaigns, education interventions, advocacy programmes and contact-based interventions. Many programmes have included multiple methods. This has included multi-component interventions or interventions combining methods such as education programmes using a contact approach. Each type of intervention will be discussed in turn in the following sections.

5.2.1 Campaigns

Across a variety of sectors, public facing and targeted campaigns, either on a national or local scale, have been used to reduce stigma.

Anti-stigma campaigns identified in this review have been delivered through a broad range of activities and outputs. Campaigns have ranged from **digital outputs** (e.g. adverts on Twitter, Facebook and Instagram or email footers for emails), **out-of-home advertising** (e.g. information on billboards), **print media** (e.g. leaflets or newspaper adverts) and **television** and **radio adverts**. Most campaigns have combined a variety of methods. For example, the ‘It’s Okay’ campaign (delivered by Scotland’s ‘See Me’ programme), which aimed to tackle mental health stigma among young people, used online videos, website banners, and images for Twitter, Instagram and Facebook (See Me, 2020a). Many campaigns have used targeted online content to reach different target audiences. The ‘Talking is a Lifeline’ campaign run by ‘Time to Change Wales’ (2019-present) used tailored social marketing to reach men living in Wales (Time to Change Wales, 2022).

Anti-stigma campaigns have used **social media hashtags** in combination with other media (e.g. videos and images) to expand their reach. Scotland’s ‘See Me’ programme ran a campaign called the ‘Power of Okay’ which focussed on reducing the stigma of mental health in the workplace. The campaign used the hashtag ‘#powerofokay’ and featured the hashtag on digital campaign posters for Twitter, Instagram and Facebook.³ Other hashtags used in anti-stigma campaigns include the #shoutyourabortion Twitter hashtag, which was used in a campaign aiming to combat the stigma associated with abortion (Ahmed, 2018) and the #WeAllKnowSomeone and #SeeThePersonHearTheirStory hashtags used as part of the NHS Addictions Provider Alliance’s ‘Stigma Kills’ campaign. The campaign aimed to highlight the damaging effects that stigmatising language and attitudes can have towards those who experience addiction (NHS Addictions Provider Alliance, 2022).

Campaigns have used homepages as a platform to share campaign tools and materials, allow people to engage with digital campaign tools and get involved in the campaign and signpost to support. NHS Inform Scotland’s ‘Challenge Drug and Alcohol Stigma’ website includes information about what stigma is, how it applies to drug and alcohol use and why tackling stigma is important. The homepage also acts as an education resource by providing practical information about ways to tackle stigma and signposting users to further information and support (NHS Inform, n.d.). Other campaign homepages, such as the ‘Rx Awareness’ homepage, have acted as a

³ Examples of posters featuring the hashtags can be accessed on the ‘See Me’ website: <https://www.seemescotland.org/seeus/campaigns/power-of-okay/>

repository for social media graphics and campaign materials that users can download (Yang and Mackert, 2021).⁴

The 'Language Matters' campaign run by NHS England (2018-present) aims to reduce stigma about diabetes by changing the language that healthcare professionals use when interacting with patients diagnosed with diabetes. The campaign advocated a 'person first' approach by using the phrase 'person with diabetes' and respecting the preferences of those living with diabetes as to how they wish to self-identify. The campaign encouraged healthcare professionals to avoid language referring to the idea of diabetes 'control' and instead discuss how diabetes is affecting the person's life in general. The campaign also advocated for collaborative language which doesn't judge, blame or shame people with diabetes, for example avoiding terminology such as 'compliant/non-compliant' when discussing how patients approach their diabetes treatment. The campaign took a more targeted approach to campaign delivery and produced a leaflet for healthcare professionals which set out good practice for language about diabetes. This leaflet approach ensured that the campaign material could be distributed easily in healthcare settings (NHS England, 2018).

5.2.2 Digital tools and platforms

Although most anti-stigma campaigns identified by the review focussed on mass digital or print methods, anti-stigma campaigns identified have also designed personalised **digital tools** which aimed to reduce stigma. These personalised tools have allowed better interaction with specific target audiences. For example, the 'Pass the Badge' campaign which was delivered as part of the 'See Me' programme in Scotland created an online tool which added a **badge** to photographs that users upload of themselves.⁵ This photograph could then be shared by users on social media and they could 'tag' friends and colleagues to ask them to share their own badge (See Me, 2020a). Another digital tool developed by the 'See Me' campaign was an **online platform** called 'FeelsFM' which aims to promote music as a way for young people to express how they are feeling and talk openly about mental health.⁶ The platform allows users to pick an emoji to represent how they are currently feeling and produces a playlist which reflects that feeling (See Me, 2020a). A different interactive approach developed by the 'Time to Change' campaign was an **online chat box** called 'Charlie3000' which gave men tips on how to chat to friends experiencing a mental health problem (Time to Change, 2022).

5.2.3 Contact-based interventions

Contact-based interventions involve contact with people who have lived experience of a stigmatised behaviour or condition. A number of contact-based programmes identified in the review used **Champions** as a key component of delivery. **Champions** are people, often volunteers, who may have relevant lived experience and work to tackle stigma and raise awareness in their local community or workplace. 'See Me', a multi-component programme aiming to challenge mental health stigma in Scotland, trained 57 people between November 2016 and November 2019 to be *Community Champions* (See Me, 2020a). The *Community Champions* underwent practical training sessions to help them run effective campaigns and events in their communities such as coffee mornings, street parties, arts and crafts groups, and football matches (Time to Change, 2021b). **Champions** have also been embedded into workplaces. The 'Blue Light Programme', which has been run by Mind since from 2015, aims to reduce mental health stigma amongst emergency service workers. In the first year of the programme, 441 individuals were recruited from across different emergency services

⁴ The Rx campaign website can be accessed at: <https://www.cdc.gov/rxawareness/index.html>

⁵ The 'Pass the Badge' platform can be accessed at: <https://passthebadge.co.uk/>

⁶ The 'FeelsFM' platform can be accessed at: <https://feelsfm.co.uk/>

into the role of *Blue Light Champions* (Future Thinking and Mind, 2016). The role of the champions is to challenge stigma and increase understanding of mental health in order to create more positive workplace cultures that promote mental wellbeing. Whilst many of the champions have their own lived experience of mental health, this is not a requirement of the programme (Future Thinking and Mind, 2016).

Community and place-based interventions have also involved elements of contact-based delivery. Place-based interventions involve the delivery of services or programmes in a community setting, and help to reduce stigma by delivering services in a non-judgemental environment. A core component of the 'CHHANGE' project involved the promotion of a neighbourhood space in New York which promoted the visibility of people living with HIV/AIDS (Frye et al., 2017). **Workshops and training** were delivered in barbershops and beauty salons in the neighbourhood space, alongside pop-up events and street outreach in the wider community to increase local residents' contact with those living with HIV/AIDS. The workshops involved a presentation of the 'CHHANGE' curriculum which explored definitions and examples of stigma, its consequences, and the skills needed to overcome stigmatising practices (Frye et al., 2017). This community empowerment model used contact with people with lived experience to decrease the stigma pertaining to HIV/AIDS. In the UK context, 'Time to Change' established *Hubs* across 50 local communities in England, which were local networks of **Champions**, public bodies (i.e. councils, public health boards, and clinical commissioning groups), and voluntary sector organisations which worked together in partnership to challenge stigma and discrimination in their local area (Time to Change, 2021e). The *Hubs* helped to increase the reach and sustainability of the programme in local organisations (i.e. schools) and allowed best practice and knowledge sharing between different *Hubs* (Time to Change, 2021e; Time to Change, 2021b).

5.2.4 Education interventions

Education interventions use factual information to address stigma by confronting negative beliefs and incorrect information. The review identified that *training* is a key method used in education interventions to tackle stigma, for example in schools or workplaces. Many programmes adopted **cascade training**, which involves training staff within organisations to deliver anti-stigma training themselves. This 'train the trainer' approach works by giving individuals the skills and confidence to deliver anti-stigma training and workshops and can therefore improve the longevity of a programme (Time to Change, 2021b). For example, 'See Me' delivered *Scottish Mental Health First Aid Training* by training teachers and pupils to deliver the training themselves in schools. *Youth Champions*⁷ supported the development and delivery of the training and contributed to shared learning events (See Me, 2020a). Likewise, 'Prevail', a programme designed to reduce mental health stigma across the Driver and Vehicle Licensing Agency (DVLA), involved 6 employees being trained by the research team in a one-day programme to deliver the training to other staff members (Gray et al., 2020). The training included themes such as mental health literacy and self-stigma.

Intervention methods have often been combined to deliver multi-component programmes. Education and contact-based interventions are often used simultaneously to tackle stigma. For example, 'See Me' used 'proxy social contact'⁸ to deliver training for the national 'Distress Brief Intervention' programme. This consisted of sharing stories from 'See Me's' *Community Champions* in the training (See Me, 2020a). Similarly, 'See Me's' workplace programme implemented an **e-Learning resource**

⁷ 'See Me' Youth Champions are young people between the ages 16-25, many of whom have lived experience of mental ill health (See Me, 2020b, pg. 31).

⁸ Proxy social contact involves distant contact (i.e. hearing or watching stories) from a person with lived experience of stigma, rather than face-to-face contact.

which consisted of scenario-based videos describing how stigma may occur and stories of people who have struggled with mental health problems at work. The **e-Learning course** was also complemented by events in workplace settings where people with lived experience of mental health stigma were invited to share their stories (See Me, 2020a).

Arts-based interventions such as plays, and films have also been used as education interventions to overcome negative and stigmatising assumptions. The Bournemouth University Dementia Institute (BUDI) Orchestra used music as a way to share knowledge and improve awareness of dementia. The performance was made up of people with dementia, as well as family, carers, volunteers and symphony members. Similarly, a play called *Cracked: A New Light on Dementia* narrates the story of two families who experience stigma associated with dementia. Both interventions aimed to 'shift perceptions and challenge stereotypes' surrounding dementia stigma (Bacsu et al., 2022). In a similar vein, 'See Me's' *Community Champions* led podcasts and community choirs as alternative ways to educate and reduce mental health-related stigma (See Me, 2020a).

5.2.5 Advocacy

Advocacy interventions involve the formal objection to negative portrayals of people experiencing stigma. Advocacy interventions within workplace settings are a common element of anti-stigma programmes. **Employer pledges** have used both advocacy and education to facilitate work cultures where mental health can be discussed. 'Time to Change' and 'Time to Change Wales' developed an *Employer pledge* programme where organisations publicly announced their commitment to tackle mental health discrimination in their workplace(s). At the end of the programme, 1500 organisations had signed up to the pledge⁹. Organisations who had signed up to the pledge were provided with practical resources, toolkits and training. Due to the COVID-19 pandemic, **digital resources** were developed by 'Time to Change Wales' as part of action plans and strategies to tackle stigma in the workplace. These included Champion podcasts, refresher training, cuppa & chat sessions, pre-recorded anti-stigma presentations, and virtual networking events between pledged organisations (Time to Change Wales, 2022). Furthermore, as part of the 'Blue Light Programme', organisations were encouraged to sign the *Blue Light Time to Change Organisational Pledge*. Pledge action plan activities included staff training, signposting staff to support services, and setting up 'support and peer group networks' (Future Thinking & Mind, 2016).

Interventions have also involved implementation of annual awareness days and events to advocate against stigma. For example, *Time to Talk Day* is an annual event organised by Mind and Rethink Mental Illness, with support from Co-op, Time to Change Wales, See ME, and Change Your Mind. The annual event was originally launched in 2014 by Time to Change and the UK Alliance¹⁰ (Time to Change Wales, 2022). *Time to Talk Day* is an annual day in which people are invited to discuss mental health and stigma through local events (e.g. a tea morning, talk in a community centre), putting up posters on a notice board, events in the workplace (e.g. lunch and learn, walk and talk), and sharing on social media via the hashtag #TimetoTalk¹¹.

⁹ Further information about the 'Employer Pledge' and case studies of pledged employers can be found on the Time to Change Website: <https://www.time-to-change.org.uk/take-action/resources-your-workplace/employer-pledge/pledged-employers>

¹⁰ The UK Alliance was a forum made up of representatives from the UK and Ireland's national anti-stigma campaigns.

¹¹ The Time to Talk Day website can be accessed here: <https://timetotalkday.co.uk/>

5.3 Intervention evaluation and measurement

The following section aims to answer the research question ‘How have campaigns and programmes been evaluated?’. The section describes intervention evaluation approaches and how campaigns and programmes have measured impact, including how they have measured stigma.

5.3.1 Intervention evaluation

Most of the stigma interventions identified in the review included some form of evaluation, with a range of different methods used, including: randomised controlled trials (RCTs); quasi-experimental design; surveys; secondary data analysis; thematic analysis of social media engagement (e.g. analysis of Twitter posts); qualitative interviews and focus groups.

A number of organisations built **impact evaluation** into their intervention design. This involved collecting baseline data and then collecting data in the same way after the completion of the intervention, with the comparison between the two allowing the effectiveness of the intervention to be assessed. For example, an online intervention aiming to reduce HIV stigma was evaluated using a pre-and post-intervention questionnaire. The questionnaire measured attitudes toward HIV to assess how effective the programme was in improving perceptions of those who are HIV-positive among people accessing a gay content website (National Aids Trust, 2016). Similar methods were used in randomised controlled trial evaluation approaches (Gray et al., 2020), where data were also collected on a control group (who did not receive the intervention) to assess whether changes in the data between the timepoints were attributable to the intervention. These evaluation approaches have often used established scales designed to measure the phenomenon in question and assess the impact of interventions. These measures are explored further in section 5.3.2.

Some interventions also built **process evaluation** into their design. For example, the ‘See Me’ (2020a) campaign in Scotland was evaluated by an external partner – Mental Health Foundation Scotland – to ensure independence from programme delivery. The process evaluation, alongside impact evaluation activities, aimed to “provide insight into the processes and mechanisms of change that have contributed to the impact” of the campaign (See Me, 2020a). A mixed methods approach was taken, consisting of focus groups with stakeholders and surveys relating to training and community feedback at multiple time points. This ongoing evaluation approach allowed assessment of delivery successes and challenges while the campaign was being delivered.

Furthermore, other evaluation approaches have involved **ongoing data collection** during intervention delivery in order to assess impact and make improvements to programme design or methodology. For example, ‘Beat the Odds’ – a media campaign designed to reduce the stigma of gambling-related harm – collected data on their social media performance throughout delivery. This allowed them to adjust the tone and timing of the campaign messaging to increase their reach and engagement (Magpie, 2022).

Intervention evaluators also considered the participant population when designing evaluation approaches. In some cases, data was collected only on the target population of the intervention, while in other instances data on those delivering the intervention or on the wider population were analysed. In the case of the ‘Time to Change Wales’ programme, several different groups were surveyed, including the *Champions* who helped deliver the workplace interventions and the employers who pledged to help staff with their mental health. Survey questions focussed on

perceptions of the programme, including whether the programme had made staff feel safer discussing mental health at work and whether they were more aware of mental health support (Time to Change Wales, 2022). The ‘Blue Light’ campaign took a similar broad approach and surveyed family and friends of the *Champions* involved in the workplace interventions in order to examine the wider impact of the programme in reducing mental health stigma in the emergency service workforce (Future Thinking and Mind, 2016). While most of the evaluations included in this review measured impact on specific target populations, the ‘Time to Change’ campaign also used national data to assess impact. The programme analysed secondary data from a pre-existing national survey to examine whether mental health stigma in UK society had decreased in the time the campaign had been running (Time to Change, 2021d).

5.3.2 Measuring impact

Outcome measures have been used to measure the impact of anti-stigma interventions. These measures work by asking respondents to complete a questionnaire – consisting of certain items that measure the phenomenon in question – before and after the intervention. By comparing the two sets of results they can measure how effective the intervention has been. Table 5:1 below details several established measures which were highlighted by one or more papers included in this review.

Table 5:1 Anti-stigma measures

Name of measure/scale	What it is designed to measure	How it has been used in anti-stigma intervention(s)
Attitudes to Mental Illness (AMI)	This measure was developed specifically for use in ‘Time to Change’ surveys and is based on the Community Attitudes to Mental Illness (CAMI) scale. Respondents are asked to rank 27 statements on a 5-point scale (from “strongly agree” to “strongly disagree”). The questions cover a range of issues, from attitudes towards people with mental illness, to opinions on services provided for people with mental health problems (Time to Change, 2015).	‘Time to Change’ (2022) used AMI to collect data on changes in national attitudes towards mental illness, surveying the general population every other year while the programme was running.
Community Attitudes to Mental Illness (CAMI)	CAMI was developed to assess community attitudes toward people with mental illness. The original version has four subscales, each with 10 items, relating to: authoritarianism, benevolence, social restrictiveness, and community mental health ideology.	An evaluation of ‘Time to Change’ (Sampogna et al., 2017) measured whether attitudes towards people with mental illness had changed as a result of project delivery. Respondents recruited through an online market research panel were given a modified version of the CAMI scale, consisting of 12 items (along with MAKs and RIBS, discussed below).

<p>Dementia Knowledge Assessment Scale (DKAS)</p>	<p>DKAS is a 27-item measure of understanding of dementia that asks respondents to rank statements about dementia based on how true they think they are to measure knowledge of dementia.</p>	<p>DAKS has been used by a number of interventions included in the review by Bascu et al (2022) on dementia stigma. For example, the scale was administered to college students who were the subject of an art-based intergenerational program to improve students' attitudes towards people with dementia. The students completed a survey at the beginning and end of the semester to measure changes in attitudes (Lokon et al., 2017 in Bascu et al., 2022).</p>
<p>Mental Health Knowledge Scale (MAKS)</p>	<p>MAKS consists of two sections. The first assesses how accurately the public recognises psychiatric conditions, and the second evaluates how far the public agrees that professional help can support recovery. The scale is built on the theory that an individual's responses to the question correspond to levels of prejudice and discrimination (Walsh and Foster, 2021).</p>	<p>Part A of the scale was used in the 'Blue Light' evaluation in surveys of employees and their friends and family. Findings enabled comparisons between the two different respondent groups. (Future Thinking and Mind, 2016). Part A comprised six items covering stigma-related mental health knowledge areas (help-seeking, recognition, support, employment, treatment and recovery).</p>
<p>Mental Illness Stigma Scale</p>	<p>This scale was developed to measure 7 factors of attitudes toward people with mental illness: interpersonal anxiety, relationship disruption, poor hygiene, visibility, treatability, professional efficacy, and recovery. Respondents are asked to rank statements on a 5-point scale (from "strongly agree" to "strongly disagree").</p>	<p>The scale was used by an intervention discussed in Carrara et al (2021) to measure the impact of a one-woman theatrical performance on attitudes towards bipolar disorder (BD) among a sample of people with BD and their friends and family, healthcare providers and members of the general public, immediately after the performance and over time (Michalak et al., 2014 in Carrara et al., 2021).</p>
<p>Opening Minds Scale for Health Care Providers (OMS-HC)</p>	<p>The OMS-HC was developed in Canada to measure mental illness-related stigma among health care providers. Questions ask respondents whether they agree or disagree with a series of statements about mental illness (with five answer options ranging from "strongly agree" to "strongly disagree").</p>	<p>Used in interventions reviewed by Carrara et al (2021) including one that administered OMS-HC to primary care nurses before and after undertaking a short video-based contact intervention (VBCI) to evaluate its effectiveness in improving their attitudes towards people with mental illness (Ping et al., 2017 in Carrara et al., 2021)</p>
<p>Reported and Intended</p>	<p>The RIBS asks respondents about their experiences and intended behaviour within four different</p>	<p>The scale has been used in an RCT cited in Carrara et al (2021) to evaluate the impact of a training</p>

Behaviour Scale (RIBS)	contexts: (1) living with, (2) working with, (3) living nearby and (4) continuing a relationship with someone with a mental health problem.	course for community mental health staff which aimed to reduce their stigma toward people with mental illness. The treatment of staff who received the course, and control groups who did not, were surveyed before and 6- and 12-months post intervention (Li et al., 2015 in Carrara et al., 2021).
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The most commonly used impact measures in the papers included in this review were MAKS and CAMI. This reflects the fact that most of the anti-stigma literature included in this study focused on stigma surrounding mental health.

Although not used in intervention evaluations explored in this review, two relevant scales have been identified for stigma related to gambling. The *Gambling Perceived Stigma Scale* (GPSS) measures the perception of gambling stigma at a societal level and the *Gambling Experienced Stigma Scale* (GESS) measures how much those who gamble feel stigmatised (Andrà et al., 2022). The GPSS has 36 items adapted from existing stigma scales, with six items assessing each of six perceived dimensions of stigma: concealability, course, disruptiveness, aesthetics, origin, and peril (Barney et al., 2010; Jones et al., 1984 in Donaldson, 2015). Within each of these dimensions, three items measure perceived stigma related to recreational gambling and three focus on stigma associated with those experiencing gambling problems. The GESS consists of 18 items measuring respondents' experiences of stigma, with three items measuring each of the six dimensions of stigma mentioned above (Donaldson, 2015).

Scales from other sectors have also been applied to gambling stigma. These scales measure generic concepts of dangerousness and risk rather than gambling specific concepts. For example, Brown and Russell (2020), when evaluating the success of different types of interventions in addressing gambling stigma, measured disruptiveness, peril and origin (three of the dimensions measured in the GPSS and GESS) using the *Key Informants Questionnaire*, *Perceived Dangerousness Item* and *Perceived Causes Scale* respectively (Brown and Russell, 2020).

The evaluation and impact data identified in this review are varied and interventions have taken a variety of evaluation and measurement approaches. Additionally, some interventions have collected broad impact data across a whole programme whereas other impact data are specific to each strand or component (e.g. data focussed on the impact of a campaign or a specific training programme). Due to this variation, it is difficult to assess the extent to which different intervention approaches have had more or less of an impact on reducing stigma.

5.4 Best practice for the set-up and delivery of interventions

The following section aims to answer the research question 'What are the key lessons learned for planning and executing anti-stigma campaigns and programmes?'. This section draws on the findings from both Stage one and Stage two of the review, outlining best practise for the set-up, delivery, messaging, design and implementation of both campaigns and programmes. The review found that evidence on best practice for designing and delivering anti-stigma campaigns and programmes was largely similar across sectors (e.g. mental health, HIV, diabetes), and consistent with the literature on best practice for delivering interventions more broadly.

5.4.1 Best practice for anti-stigma intervention set-up

- **Set clear objectives for the intervention prior to design and launch** – this includes clearly defining the aims as well as the target audience(s) of the intervention (Cuadrado et al., 2021). Scotland’s ‘See Me’ campaign set out a number of clear outcomes for their programme, for example ‘people in the populations we target feel confident to talk openly about their mental health and their experience of stigma and discrimination’ and ‘leaders in key settings and organisations create inclusive culture and take action to tackle mental health stigma and discrimination’ (See Me, 2023).
- **Incorporate theory into the design of the intervention** – the ‘Time to Change’ campaign was a national mental health anti-stigma campaign in England which ran from 2007-2021. The campaign used behavioural change models (the COM-B model and the Stages of Change model) to help gain an in-depth understanding of their target audience and maximise behaviour change (Time to Change, 2021a).
- **Consider the broader socioeconomic context and intersectional nature of gambling stigma** – evidence from mental health anti-stigma campaigns suggests that campaigns are more effective when they consider the physical, cultural, economic and political contexts that situate stigma (Walsh and Foster, 2021). Campaigns should also take into account the intersectional nature of gambling stigma, as it often co-occurs with stigma relating to identity (e.g. age, gender, race, socioeconomic status), other existing health conditions (e.g. mental ill health, chronic illness), and behaviours (e.g. drug and alcohol use) (Pliakas et al., 2022). It is also important to consider the local context in which an intervention is delivered. The ‘Like Minds, Like Mine’ mental health programme combined community level action targeted to the local area with national media messaging in order to address localised stigmatising beliefs as well as attitudes held at a societal level (Stuart et al., 2019).¹²
- **Collaborate with other anti-stigma campaigns and programmes throughout campaign set-up and delivery** – this will ensure that learning can be shared (Time to Change Wales, 2022). NHS England set up a working group for their ‘Language Matters’ campaign (2018-present) which aimed to reduce stigma related to diabetes. The working group included experts such as NHS staff and academics, those working for diabetes charities and those with lived experience of diabetes (NHS England, 2018). Collaboration can also increase reach and capacity within the intervention delivery team, particularly where other organisations have pre-existing relationships with the target population or the resources to support intervention delivery (See Me, 2020a).
- **Involve people with lived experience from the set-up phase** - this will ensure a better understanding of the priorities of beneficiaries and improve the relevance of the intervention activities (Pliakas et al., 2022). Interventions should allow people with lived experiences to guide strategy and inform the design and development of interventions. For example, the ‘Time to Change’ programme set-up the *Lived Experience Advisory Panel* (LEAP) to provide strategic advice and support and contribute to the evaluation steering group (Time to Change, 2022).
- **Determine whether there is a need to make intervention activities compulsory** - evidence from a school-based programme designed to reduce mental health stigma found that making training programmes compulsory for pupils from specific schools prevented low participation rates (See Me, 2020a). Similarly, ‘Opening Minds’, a workplace-based programme, found that staff

¹² The ‘Like Minds, Like Mine’ programme website can be accessed at: <https://www.likeminds.org.nz/>

were less likely to attend intervention activities if attendance was voluntary and attendees reflected those with an interest in understanding mental health stigma (Szeto et al., 2019).¹³

5.4.2 Best practice for anti-stigma intervention delivery

Best practice for programme delivery

- **Combine different types of approaches to increase exposure to intervention messages and avoid digital exclusion** - 'Deserve', a dementia stigma reduction programme found that using written materials alongside a form of virtual social contact, such as videos, was most effective in reducing stigma (Kim et al., 2021). This is also the case for HIV stigma reduction interventions which have used a combination of media in order to increase public exposure to their message (National Aids Trust, 2016). While the internet provides a good opportunity to disseminate tools and information, it is important to consider if an online component could exclude access to some groups (Carrera et al., 2021).
- **Provide ways for people to continue to engage with the programme once it finishes** - mental health stigma reduction programmes have identified the need to provide opportunities or materials for participants to refresh their learning once the programme is over (Szeto et al., 2019). Other programmes have achieved this by signposting to similar local or community level programmes (National Aids Trust, 2016).
- **Ensure the intervention can be easily replicated and adapted for different audiences over time** – this can be achieved by creating clear records on set-up and delivery methods and guidance for others (See Me, 2022). 'Time to Change' adapted their programmes to different demographic audiences based on factors such as age, gender and ethnicity. These changes were based on evaluation findings from the first phase of the programme (Stuart et al., 2019).
- **Use testimonies from people with lived experiences in programme materials** – this has been found to elicit empathy and initiate conversation about stigma as it can allow people to understand the true impact of a problem and disconfirm negative stereotypes (Boyle et al., 2017; See Me, 2022). The 'Life in my Shoes' HIV stigma reduction programme developed a film based on the personal experiences of young people living with HIV (National Aids Trust, 2016). Similarly, dementia stigma interventions have showcased the achievements of people with dementia through live musical performances in front of an audience (Bacsu et al., 2022).
- **Share programme content through people with lived experiences** - previous stigma reduction programmes have delivered programme content through volunteers with lived experiences to bring messages to life (See Me, 2020a). Evidence from HIV anti-stigma programmes show that people are less likely to hold stigmatising views when they perceive they know someone who is affected (National Aids Trust, 2016).

Best practice for campaign messaging

Language and messaging to use:

- **Use person-first language to show that gambling disorder is a mental disorder and not an identity** – using 'person with a gambling disorder' or 'person who struggles with gambling' instead of 'addict' or 'problem gambler'

¹³ The 'Opening Minds' programme website can be accessed at: <https://mentalhealthcommission.ca/opening-minds/>

can avoid increasing individual blame which contributes to stigmatisation (Pliakas et al., 2022; NHS England, 2018). The ‘Stigma Kills’ campaign (2022) aims to highlight the damaging effects of stigmatising language and attitudes towards those who experience addiction. The campaign messaging is person-first and describes addiction in terms of a condition a person ‘has’ rather than something a person ‘is’ (e.g. it avoids using the term ‘addict’)¹⁴.

- **Use positive framed (‘competence based’) messages which emphasise that people have their own unique identities, personalities and capabilities** – this type of messaging has been found to be effective at reducing stigma in mental health, Alzheimer’s disease and drug and alcohol stigma campaigns (Cuadrado et al., 2021; Kroska and Harkness, 2021; NHS Inform, n.d.). Scotland’s ‘See Me’ campaign (2001 – present) focussed on what people with mental ill health can do rather than the negative impacts or causes of mental ill health.¹⁵
- **Use the word ‘stigma’ in messaging and describe its harmful consequences** (Pliakas et al., 2022) – successful campaigns which have taken this approach include NHS Scotland’s ‘Challenging Drug and Alcohol Stigma’ campaign (2021-present), the NHS Addictions Provider Alliance’s ‘Stigma Kills’ campaign (2022) and the ‘Talking is a Lifeline’ campaign (2019-present), run by ‘Time to Change Wales’, which won a Wales Online Digital Award for ‘Best Use of Digital Marketing’.
- **Include guidance about language to use when discussing gambling** – changing the language that people use can reduce stigma by promoting positive images of people or groups (NHS Inform, n.d.; NHS England, 2018). This language-centred approach has been taken in the ‘Language Matters’ campaign run by NHS England (2018-present) which aims to reduce stigma about diabetes by changing the language that healthcare professionals use (NHS England, 2018).¹⁶
- **Use metaphors (linguistic or visual) in messaging** – this has been shown to be successful when communicating about complex health topics related to stigma and has been found to attract the attention of audiences (Lazard et al., 2016). Metaphors are linguistic or visual expressions involving two concepts in which the features of one concept are applied to the other. For example, when communicating about the impacts of depression, Lazard et al (2016) give the example of campaign messaging which compares getting out of bed to a workout: ‘Getting out of bed shouldn’t feel like a workout’.

Language and messaging to avoid:

- **Avoid language which places shame or blame on people who gamble** – this can contribute to stigmatisation (Pliakas et al., 2022).
- **Avoid language with may instil fear about gambling** – for example, language or imagery which aims to stop people engaging in a behaviour by making them fear it through emphasis on danger or risk (Pliakas et al., 2022; Cuadrado et al., 2021).
- **Avoid messaging which focusses on the causes of conditions or behaviours** – mental health anti-stigma campaigns which have focussed on the causes of mental health (e.g. biogenetic or neurogenetic explanations) have

¹⁴ Campaign outputs for the ‘Stigma Kills’ campaign can be accessed here:

<https://www.nhsapa.org/post/stigmakills-campaign-resources>

¹⁵ Campaign outputs for the various ‘See Me’ campaigns can be accessed here:

<https://www.seemescotland.org/seeus/campaigns/>

¹⁶ The leaflet produced by the ‘Language Matters’ campaign can be accessed at:

<https://www.england.nhs.uk/wp-content/uploads/2018/06/language-matters.pdf>

been found to change stigma rather than eliminate it – for example changing the perception that people with mental ill health are dangerous to the perception that they are weak (Walsh and Foster, 2021; Kroska and Harkness, 2021).

- **Avoid linking gambling with other stigmatised conditions or behaviours** – for example describing people with gambling problems as neglecting their families or being unable to pay bills. This can increase stigma by increasing separation between ‘us’ and ‘them’ (Pliakas et al., 2022).

Best practice for campaign design and implementation

- **Use storytelling approaches to feature those with lived experience of stigma** – previous anti-stigma campaigns about mental health and drug use have found that featuring those who are impacted by the stigma is more effective than purely education-based campaigns (Lazard et al., 2016; Time to Change, 2021a). The Centre for Disease Control and Prevention (CDC)’s ‘Rx awareness’ campaign (2017-present) in the USA aims to increase awareness of prescription opioid risks, increase awareness about treatment and reduce stigma. The campaign features ‘testimonial’ videos with those who have experience with prescription opioids (Yang and Mackert, 2021)¹⁷.
- **Use image and video content to engage viewers** – the ‘Time to Change’ campaign (2007-2021) identified video content as a key driver of behaviour change (Time to Change, 2021a). Scotland’s ‘See Me’ programme developed an image-focussed campaign called ‘It’s Okay’ (2016-2019).¹⁸
- **Use an interactive homepage / personalised approach for the campaign** – the #Passthebadge campaign (run by Scotland’s ‘See Me’ programme in 2017) found that an interactive homepage allowed people to engage digitally with the campaign (create their own digital ‘badge’) and find out more information (See Me, 2020a).¹⁹
- **Use multiple digital channels (or print advertising methods) to reach different demographics** – impactful anti-stigma campaigns identified in the review used several channels to reach audiences and selected channels based on their target demographics (Time to Change Wales, 2022; Sampogna et al., 2017). These included social media content (e.g. Facebook, Twitter or Instagram), leaflets, posters and billboards, TV and newspaper adverts, online search adverts, bespoke online platforms, radio adverts and campaign websites. The ‘Beat the Odds’ campaign (2017-present), commissioned by Leeds City Council, aims to reduce the stigma of problem gambling and encourage people to discuss gambling-related harm. The campaign took a varied approach, combining digital media and ‘out-of-home’ media such as bus shelter advertising (Magpie, 2022).
- **Create social media content which is shareable** – an evaluation of the ‘Time to Change’ campaign (2007-2021) found that shareable social media content was important for creating impact (Time to Change, 2021a). Twitter hashtags, as one example, can have global reach. This has been seen with the #Shoutyourabortion campaign, which aimed to reduce stigma about abortion. However, it has been noted that simple hashtags risk creating misunderstanding about the purpose and messaging of campaigns and can also be used by those with opposing views to the campaign (Ahmed, 2018).

¹⁷ Campaign outputs for the ‘RX Awareness’ campaign can be accessed here: <https://www.cdc.gov/rxawareness/resources/index.html>

¹⁸ Campaign outputs for the ‘It’s Okay’ campaign can be accessed here: <https://www.seemescotland.org/seeus/campaigns/its-okay/>

¹⁹ The ‘Pass the Badge’ platform can be accessed at: <https://passthebadge.co.uk/>

- **Include information about where to access support on campaign materials** – this could include direct links to support services or advice, or signposting to a campaign website with further information (NHS Inform, n.d.).
- **Use ‘opinion leaders’ to deliver messages** – these are people who exert significant influence within their network and can affect the opinions of others. Sharing campaign messages and outputs through opinion leaders (e.g. local or national celebrities, religious leaders, employers or healthcare workers) can help campaigns to reach more people and increase impact (Pliakas et al., 2022). The ‘One of Us’ programme, a mental health stigma reduction programme in Denmark recruited celebrity ambassadors to support their programme and share messages (Stuart et al., 2019)²⁰.
- **Use partnerships with other organisations and brands to reach relevant audiences** – organisations or brands who already have a large following of relevant audiences can increase the reach and impact of anti-stigma campaigns. In 2019, the ‘Time to Change’ campaign partnered with JOE Media which helped them to reach an additional 1.7 million people. They also partnered with *Real Radio* to promote the ‘It’s time to talk’ campaign across radio stations in the north of England (Time to Change, 2021a).

Best practice for intervention evaluation

- **Build in independent evaluation from the beginning of the intervention** – this will ensure that objective and relevant process and impact data can be obtained. A review of anti-stigma interventions identified that this could be achieved by collaborating with academics who have the knowledge and resources to share best practice findings and contribute to the peer-reviewed literature base (Stuart et al., 2019).
- **Develop a Theory of Change as part of the intervention** – this will ensure that there are clear mechanisms and outcomes upon which to base process and impact evaluation data collection (Stuart et al., 2019).
- **Use validated measures for stigma across evaluation activities** – as described in section 5.3, anti-stigma interventions have previously used established outcome measures for the relevant stigma they are aiming to reduce (See Me, 2020a; Time to Change, 2021a). There are two relevant scales which have been identified for stigma related to gambling which are the *Gambling Perceived Stigma* scale, which measures the perceived stigma of those with gambling problems in society and the *Gambling Experienced Stigma* scale which measures how much those who gamble feel stigmatised (Andrà et al, 2022).
- **Include a range of participant populations in data collection** – considering a range of groups can help assess the impact of interventions on different groups and different types of stigma, and allow process data to be collected from those who have been involved in delivery. Groups who have been included in data collection in previous interventions include those who have experienced stigma, their friends or family, those delivering the intervention (e.g. programme staff or *Champions*), those who received an intervention (e.g. employees who took part in workplace training) or the general public to assess population-level changes in perceptions (Time to Change Wales, 2022; Future Thinking and Mind, 2016; Time to Change, 2021d).

²⁰ The ‘One of Us’ programme website can be accessed at: <http://en-af-os.dk/english>

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- **Consider the timing of evaluation activities** – during their evaluation of the ‘Blue Light Programme’, Mind and Future Thinking found that conducting evaluation activities before the intervention had been fully rolled out reduced participation rates in evaluation activities (Future Thinking and Mind, 2016). However, conducting some ongoing data collection during intervention delivery can help assess impact and mark improvements to programme design or methodology (Magpie, 2022)
 - **Collect follow-up data at multiple time points** – evidence from a range of stigma reduction programmes has also emphasised the need to collect follow-up data for more than a couple of months after the programme has ended to ensure longer-term impact is assessed (Kim et al., 2021; Walsh and Foster, 2021; Quigley, 2022). Programmes have found that using a single follow-up point immediately after the intervention had finished were more likely to capture reflexive negative responses (Brown and Russell, 2020).

6 Conclusion

Research on reducing gambling-related stigma is currently limited and there was a need for us to examine strategies or methods used in other parallel (and sometimes intersecting) stigmatised conditions to understand the generalisable principles and features associated with effective measures in reducing stigma. In this scoping review, we summarised and synthesised evidence from 44 individual papers on best practice for designing, setting up, delivering and evaluating anti-stigma campaigns and wider programmes in gambling and across adjacent sectors such as mental health, HIV and dementia.

The results highlight that interventions often include multiple components to address the complex nature of stigma – campaigns, education, advocacy, contact-based and digital tools. Although the review has identified evidence across intervention set-up, delivery and evaluation, the evidence landscape on campaign and programme set-up is somewhat limited. Future programme evaluation would therefore benefit from the further detailing and outlining of the steps involved in programme set-up. Future interventions should also include detailed descriptions of all intervention components such as duration, sequence, frequency of delivery, materials or tools used for the delivery of the intervention as well as the context in which the intervention was set up and delivered. This will allow individuals to replicate and/or adapt the interventions more effectively.

As a result of this review, we were able to develop a comprehensive and practical overview of evidence-based best practice and recommendations that will be useful for organisations and/or individuals who wish to set up, implement and deliver campaigns and programmes to tackle stigma. However, this review has also highlighted that evaluation and impact data about interventions to reduce stigma is varied and interventions have taken a variety of evaluation and measurement approaches. Due to this variation, it is difficult to assess the extent to which different intervention approaches have had more or less impact on reducing stigma. Additionally, because gambling disorder is unique and less well understood, further research is needed to ascertain to what extent/ how the effectiveness of these interventions may differ within the context of gambling stigma.

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8 Appendix

8.1 Inclusion and exclusion criteria

Stage one exclusion and inclusion criteria

Criterion	Inclusion criteria	Exclusion criteria
Content	<ul style="list-style-type: none"> • Research includes descriptive examples of anti-stigma campaigns (including above the line and below the line media campaigns) including aims and objectives and execution (including how campaigns have been set up and delivered and details of outputs e.g. images/videos). • Research details the impact of campaigns. The research must describe an approach for determining impact/success of the campaign (although inclusion will be considered if paper contains very relevant evidence on delivery or evaluation methods). 	<ul style="list-style-type: none"> • Campaigns or not specifically targeting stigma. • Campaigns and which target stigma but no do have any indication of impact or process assessment (although inclusion will be considered if paper contains very relevant evidence on delivery or evaluation methods). • Campaigns which are only targeted at children/young people.
Evidence type	<ul style="list-style-type: none"> • All types of evaluative studies (where available): systematic literature reviews (including scoping reviews, rapid evidence assessments, meta-analyses, narrative analyses), randomised controlled trials, quasi-experimental studies (including cohort and pragmatic trials, case and observational studies. Grey literature (those publications or policies not published in peer reviewed journals). • Campaign delivery materials. 	<ul style="list-style-type: none"> • Protocols, opinion pieces, popular media (e.g., blogs, social media feeds and/ or newspaper articles).
Methods	<ul style="list-style-type: none"> • All paradigms (i.e., quantitative, qualitative, mixed methods). 	<ul style="list-style-type: none"> • Where methods are unclear, do not respond to the research questions and/ or are of low-quality (excluding grey literature).
Year	<ul style="list-style-type: none"> • January 2012 – June 2022. 	<ul style="list-style-type: none"> • Standalone research over 10 years old. • Evidence published between 2012-2022 but reporting on

		campaigns delivered before 2012.
Geography	<ul style="list-style-type: none"> • Prioritising UK evidence but will draw on comparable international evidence if relevant to research questions. 	<ul style="list-style-type: none"> • Those papers/ grey literature that report decision-making and/ or interventions outside of the OECD.
Language	<ul style="list-style-type: none"> • English 	<ul style="list-style-type: none"> • Those papers/ grey literature not in English.

Stage two exclusion and inclusion criteria

Criterion	Inclusion criteria	Exclusion criteria
Content	<ul style="list-style-type: none"> • Research includes descriptive examples of anti-stigma programmes including aims and objectives and execution (including how programmes have been set up, delivered and evaluated and details of outputs e.g. images/videos). • Research details the impact of campaigns or programmes. The research must describe an approach for determining impact/success of the programme (although inclusion will be considered if paper contains very relevant evidence on delivery or evaluation methods). 	<ul style="list-style-type: none"> • Programmes not specifically targeting stigma. • Programmes which target stigma but no do have any indication of impact or process assessment (although inclusion will be considered if paper contains very relevant evidence on delivery or evaluation methods). • Programmes only targeted at children and young people.
Evidence type	<ul style="list-style-type: none"> • All types of evaluative studies (where available): systematic literature reviews (including scoping reviews, rapid evidence assessments, meta-analyses, narrative analyses), randomised controlled trials, quasi-experimental studies (including cohort and pragmatic trials, case and observational studies. Grey literature (those publications or policies not published in peer reviewed journals). • Programme delivery materials (e.g. programme plans) 	<ul style="list-style-type: none"> • Protocols, opinion pieces, popular media (e.g., blogs, social media feeds and/ or newspaper articles).
Methods	<ul style="list-style-type: none"> • All paradigms (i.e., quantitative, qualitative, mixed methods). 	<ul style="list-style-type: none"> • Where methods are unclear, do not respond to the research questions and/ or are of low-quality (excluding grey literature).

Year	<ul style="list-style-type: none"> January 2017 – June 2022. 	<ul style="list-style-type: none"> Standalone research over 5 years old. Evidence reporting on campaigns delivered before 2012.
Geography	<ul style="list-style-type: none"> Prioritising UK evidence but will draw on comparable international evidence if relevant to research questions 	<ul style="list-style-type: none"> Those papers/ grey literature that report decision-making and/ or interventions outside of the OECD.
Language	<ul style="list-style-type: none"> English 	<ul style="list-style-type: none"> Those papers/ grey literature not in English.

For Stage two, additional prioritisation criteria were agreed with GambleAware to finalise the inclusion list. The papers with the following criteria were prioritised:

- Evidence about stigma related to gambling;
- UK evidence and evidence which is more applicable to the broader UK context (e.g. programmes with a very specific geographic setting or target group were deprioritised);
- Evidence about programme evaluation methodology (including how stigma has been measured).

8.2 Scopus search strings

Stage one search strings

(TITLE-ABS-KEY (stigma) OR TITLE-ABS-KEY (anti-stigma) AND TITLE-ABS-KEY (campaign)) AND PUBYEAR > 2011 AND PUBYEAR > 2011

Stage two search strings

TITLE-ABS-KEY (stigma OR anti-stigma AND programme) AND (LIMIT-TO (AFFILCOUNTRY , "United States") OR LIMIT-TO (AFFILCOUNTRY , "United Kingdom") OR LIMIT-TO (AFFILCOUNTRY , "Canada") OR LIMIT-TO (AFFILCOUNTRY , "Australia") OR LIMIT-TO (AFFILCOUNTRY , "Netherlands") OR LIMIT-TO (AFFILCOUNTRY , "Spain") OR LIMIT-TO (AFFILCOUNTRY , "France") OR LIMIT-TO (AFFILCOUNTRY , "Italy") OR LIMIT-

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TO ( AFFILCOUNTRY , "Belgium" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Sweden" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Norway" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Denmark" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Austria" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Turkey" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Finland" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Czech Republic" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Poland" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Croatia" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Greece" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Ukraine" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Romania" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Serbia" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Hungary" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Cyprus" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Luxembourg" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Lithuania" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Malta" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Estonia" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Iceland" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Albania" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Bulgaria" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Belarus" ) OR LIMIT-
TO ( AFFILCOUNTRY , "Latvia" ) ) AND ( LIMIT-
TO ( PUBYEAR , 2023 ) OR LIMIT-
TO ( PUBYEAR , 2022 ) OR LIMIT-
TO ( PUBYEAR , 2021 ) OR LIMIT-
TO ( PUBYEAR , 2020 ) OR LIMIT-
TO ( PUBYEAR , 2019 ) OR LIMIT-
TO ( PUBYEAR , 2018 ) OR LIMIT-
TO ( PUBYEAR , 2017 ) ) AND ( LIMIT-
TO ( LANGUAGE , "English" ) )
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8.3 List of grey literature websites

The following websites were searched as part of the grey literature search:

- NHS England
- NHS Scotland
- Health in Wales
- National AIDS Trust
- Mind
- Gambling Commission

- Global Anti-Stigma Alliance
- NHS Addictions Provider Alliance
- Mental Health Europe
- Dean Street Sexual Health Clinic
- Stonewall
- Young Minds
- Time to Change
- See Me
- Stamp Out Stigma
- Campaign Against Living Miserably (CALM)

8.4 Overview of included papers

Figure 2: Flowchart of evidence identification, screening and selection for Stage one

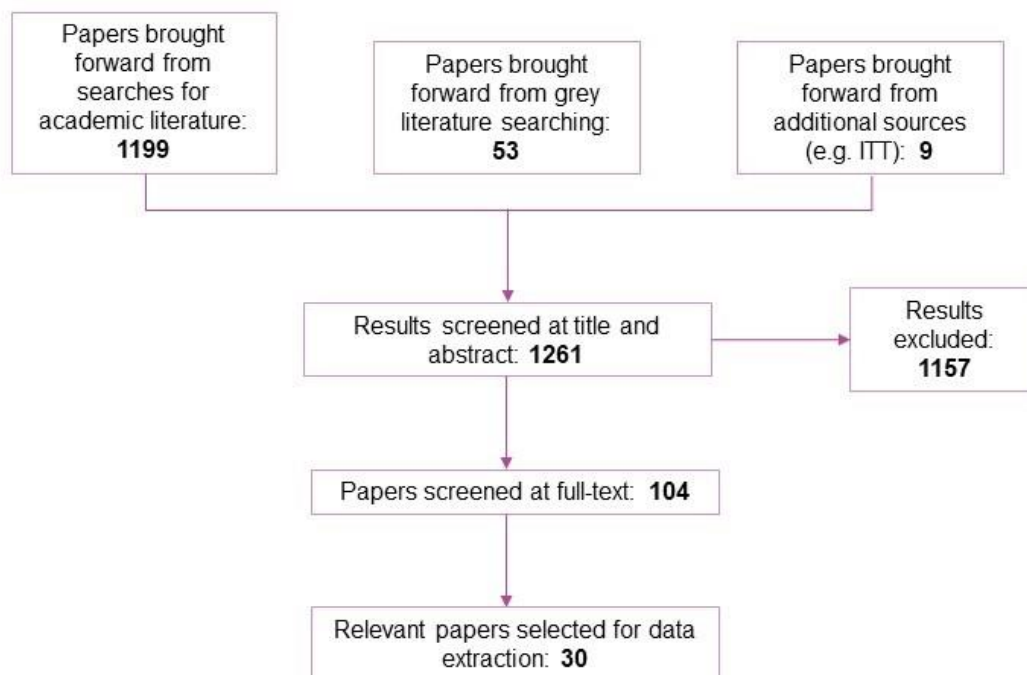
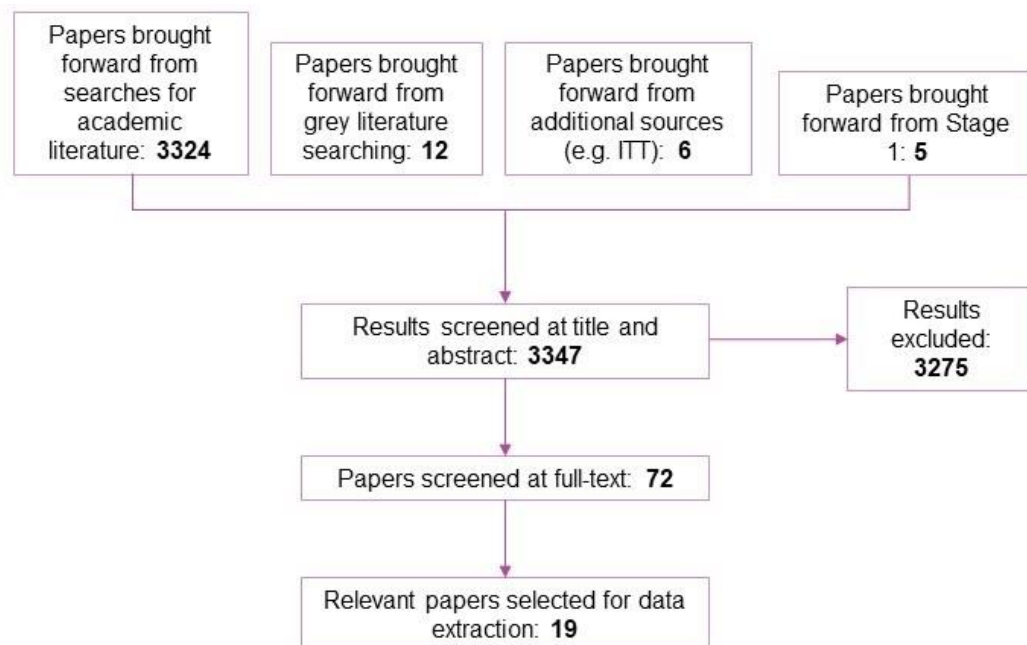


Figure 3: Flowchart of evidence identification, screening and selection for Stage two



30 papers met the inclusion criteria and were selected for data extraction at Stage one, whilst 19 papers were included for data extraction at Stage two. This included five papers brought forward from Stage one, and therefore 44 papers in total were selected across both stages as relevant for inclusion. The term 'papers' is used here to refer to academic articles, grey literature reports and articles, and campaign/programme websites.