Q1. Has the mindline been evaluated? If so, could you share the results?

Sharing some publications about mindline.sg below:

- Journal of Medical Internet Research - Mental Wellness Self-Care in Singapore With mindline.sg: A Tutorial on the Development of a Digital Mental Health Platform for Behavior Change
- JMIR Human Factors - Perceptions of a Digital Mental Health Platform Among Participants With Depressive Disorder, Anxiety Disorder, and Other Clinically Diagnosed Mental Disorders in Singapore: Usability and Acceptability Study
- User perceptions and utilisation of features of an AI-enabled workplace digital mental wellness platform 'mindline at work' | BMJ Health & Care Informatics
- Frontiers | Examining a brief web and longitudinal app-based intervention [Wysa] for mental health support in Singapore during the COVID-19 pandemic: mixed-methods retrospective observational study

Q2. Are there differences in level/mechanism of stigma towards interventions implemented in different settings e.g. public institutions/services like IMH or NUHS, vs private services; perhaps in relation to perceived anonymity or trust in government, etc.?

Providing mental health services within settings such as primary care or digitally allows people to avoid feeling vulnerable to stigma as a result of attending a mental health service. Anecdotally, people paying for private care feel less stigmatised than by public services that are free at the point of services. Private providers are not in a position to do some of the things people find stigmatising such as involuntary treatment; and they can give longer appointments. When there is a short appointment focusing on symptoms and risk to self/others people can feel stigmatised as there appears a lack of interest in them as a person.

Q3. Hi, just to clarify, when Caleb referred to young people in the context of the mental health services being provided, what age range was he referring to?

I understand that in Singapore, young people can sometimes refer to those aged 18 to 35, but I'm also wondering how adolescents and teens (e.g. ages 12–18) are considered within this framing. The experience of stigma may differ across these age groups too, and for the even younger groups, there may be additional considerations around parental consent and involvement (and their internalised/experienced stigma), especially when accessing mental health services in school or community in Singapore.

Could you help clarify the intended age group and how these distinctions are addressed in the design or delivery of services?

Youth mindline targets users between 17-35. There is more independence in this age groups so our content is designed to feel relevant and non-patronising - covering topics like identity & purpose, relationships, and adulting stress. In terms of delivery. We emphasize autonomy and privacy, leveraging features like anonymous forums (let's talk) and AI chatbots to reduce barriers to engagement.

For adolescents and teens, I think interventions often require partnerships with schools and educators (while also considering parental literacy and stigma)

In short, younger adolescents need scaffolding and trusted adults, while older youths need independence and peer-informed support. This distinction shapes how content is designed, how outreach is done, and where users are likely to first encounter the service.

Q4. Can stigma be perceived differently people to people or if stigma can be perceived differently like how mental disorder/stress can be perceived differently, and how would that affect how we design a solution/strategy to tackle no stigma society in Singapore?

As for any public health intervention one needs to consider target groups with specific experiences which relate to their stigma, for example certain occupational groups. Similarly, within the general population the different levels of stigma suggest that strategies need to be based on population segmentation e.g. by age, gender, and socioeconomic status.

Q5. Caleb, I'm wondering if you could share some broad themes of questions that you have received from young people on the various digital platforms? This might help us to know the barriers that still exist.

Users on let's talk typically ask questions around:

- seeking help & guidance
- academic & career pressures
- navigating relationships and social dynamics
- understanding mental health conditions

Q6. Mental health is often misrepresented in media (e.g., having violent and/or psychopathic tendencies, assuming they have multiple dangerous personalities or "forgot to take their medicine") which can perpetuate stereotypes and stigma. What are some interventions that have been implemented to target media to reduce this perpetuation of stigma?

Contact based education for journalists; this is more effective if it includes guidelines that their editors also sign up to. Speaker bureaus of people with lived experience that journalists can contact for lived experience testimonies and perspectives; likewise, professionals willing to speak with journalists to try and provide them with context, e.g. to understand that compared to the prevalence of psychosis homicides are very rare and that homicides by such people account for only single figure percentages of all homicides.

Q7. Can stigma be reduced by integrating mental healthcare with medical care? I.e. approach to healthcare should be holistic (bio-psycho-social approach). People should not have to go to a mental health institution for mental healthcare, and transferred to a non-mental health hospital for medical care.

This can help people avoid feeling stigmatised (not the same as actual stigma reduction). It may also increase access to physical health care for people with mental illness. There is a risk that the budget for mental health care shrinks when it is part of the whole budget for a health service.

Q8. What should be the approach to screening be for youth mental health? If young people are asked to fill in a validated questionnaire like PHQ -9, K-10, would stigma prevent the young person from seeking help? Is there evidence to show that accessing help is more forthcoming when the approach is more relational, more socialised, and less medicalised?

There is a large literature on help seeking and the many factors which influence it.

Q9. I think this is a very big topic. Reducing stigma in one country or a few countries do not solve the problem or lessen the impact. Nowadays, people travel around the globe for work and have international collaborators. For example, if we soften stigma in Singapore, people talk about this openly in Singapore, but when things travel to an international collaborator or work partner, this person will still be judged and deemed less competent or suitable as a potential work partner for international collaboration.

On the other hand, the openness of the Singaporean who is clearly performing well may positively influence the people from another country. The timing of disclosure is worth considering here, i.e. waiting until one has proved oneself and had made a working relationship.

On another note, there are a number of countries which have had large scale stigma reduction programmes, and a Global Anti Stigma Alliance which allows them to share learning.

Q10. Do you think targeting friends/relatives/communities in attempts to reduce stigma of mental health would be preferable than individuals? Lots of the actions taken, anonymity etc. centre the burden on the individual but shouldn't we be looking beyond them?

Yes, anonymity allows one to avoid stigma but does little or anything to reduce it at the population level.

Q11. In terms of policymaking and resource allocation (manpower/training more clinicians, funding), how does stigma affect the implementation of a mental health intervention?

In various ways leading to less accessible, poorer quality and less effective services: I recommend

Mental health-related structural stigma and discrimination in health and social policies in Nepal: A scoping review and synthesis. Gurung D, Neupane M, Bhattarai K, Acharya B, Gautam NC, Gautam K, Koirala S, Marahatta K, Gurung P, Khadka KB, Kohrt BA, Thornicroft G, Gronholm PC.Epidemiol Psychiatr Sci. 2023 Dec 13;32:e70. doi: 10.1017/S2045796023000823.