# Stigma Related to Mental Illness Among Primary Care Nurses in Barbados

## INTRODUCTION

Originating from the ancient Greek verb which translates "to carve, to mark as a sign of shame, punishment or disgrace” (Economou et al, 2020) stigma related to mental illness confers on persons living with mental disorder an undue burden and its adverse impacts can at times be worse than the effects of the illnesses for which persons are stigmatised. The disparate treatment of persons based on the presence of mental disorder, in other words, discrimination, is prevalent worldwide (Economou et al, 2020). Link & Phelan (2001) described stigma as a concept that is applicable when its elements “labelling, stereotyping, separation, status loss and discrimination co-occur” in situations where there is a power differential. It is well recognised that only groups that have a measure of power can stigmatise others (Link & Phelan, 2001).

### Stigma: definition and effects

Stigma can be categorised as intrapersonal (self-stigma), interpersonal (public stigma) and structural (stigmatising policies, laws, systems) (Knaack et al, 2017). Public stigma, the negative views held by the general public about mental illness have been shown to be prevalent across cultures, and is a cause of shame and isolation for patients and their families (Ahad et al, 2023). After years of ill-treatment and discrimination, some persons living with mental illness may internalise the negative beliefs and live with shame and feelings of hopelessness (Corrigan & Watson, 2002). This self-stigma, as it is called, can prevent persons from seeking healthcare, employment and social opportunities, resulting in a reduced quality of life (Corrigan & Watson, 2002; Corrigan & Rao, 2012). Institutional stigma can be equally destructive, when organisational culture and policies prevent fair approaches to mental health issues. Early work by Corrigan et al, 2004 demonstrated that decision makers were less likely to allocate resources to mental health despite supporting needs assessments due to the existence of stigmatising beliefs.

Sadly, all components of stigma are present in healthcare settings, even among mental health professionals (Henderson et al, 2014). Many persons with lived experience with mental illness report dehumanising and dismissive treatment during healthcare encounters (Barney et al, 2009; Hamilton et al, 2017). Acting as a barrier to help-seeking, it increases morbidity and mortality related to mental disorder (Ahad et al, 2023). When present among healthcare professionals, stigma can create barriers that prevent the development of effective therapeutic relationships, impeding care provision and reducing the quality of life for patients in need (Corrigan, 2004; Sartorius, 2007; Corrigan et al, 2014).

Many reasons for the presence of stigma related to mental illness in healthcare have been posited, including negative attitudes and behaviours, a pessimistic or defeatist approach to care provision, poor organisational culture, and insufficient mental health and stigma awareness and training (Knaack et al, 2017).

### Causes of stigma and discrimination in healthcare settings

**Negative beliefs and attitudes** - using a qualitative methodology, Knaack and Patten (2017) identified a tendency among healthcare workers to see the disorder before or instead of the patient, an attitude that can have dismissive, disrespectful or demeaning treatment as its consequence. The difference in power between patients who are in need of help and their healthcare providers who control access to help is evident in this context. Henderson et al (2014) also highlighted burnout and compassion fatigue as possible underpinnings for the stigmatising attitudes and behaviours present among healthcare workers.

**Approach to treatment** - beliefs and attitudes influence a healthcare provider’s approach to the treatment of persons with mental health problems. Some healthcare providers have been shown to have pessimistic or fatalistic views of the effectiveness of mental health interventions (Knaack et al, 2017). Some providers hold the belief that persons who live with mental disorder are less likely to adhere to treatment protocols for general medical interventions, making them less likely to refer them for specialist care or offer treatment for certain conditions, failing to adhere to best-practice guidelines (Corrigan et al, 2014). Jones et al (2008) described “diagnostic overshadowing” where the symptoms of physical disorder are attributed to the mental disorder with which a patient lives, causing genuine physical health problems to be ignored. This aberrant decision-making can increase morbidity and mortality among persons living with mental disorder and may be a contributing factor to the lower life expectancy in this vulnerable group.

**Stigmatising organisational culture** - in organisations where speaking openly about mental health needs and care is discouraged or construed as weakness, fears of being stigmatised or perceived as unfit to work impact healthcare workers themselves. Healthcare professionals may themselves need mental health support and care, and the help-seeking barriers that adversely impact patients can also prevent care providers from seeking help (Knaak et al, 2017), a potential source of functional impairment among workers.

**Inadequate mental health education and training** - stigma can be subtle, and it has been shown that many healthcare providers have stigmatising beliefs but lack awareness that this is the case (Knaack et al, 2017). This unconscious bias, shown to be due in part to a perception of dangerousness associated with mental disorder, (Sukhera & Chahine, 2016) can result in perpetuation of care tainted by discrimination. Healthcare professionals who may believe that they are sufficiently enlightened and tolerant are unlikely to further educate themselves and take action to improve the quality of care that they provide.

### Eradication of stigma in clinical settings

Based on the fact that stigma among healthcare workers is not due solely to a lack of education and training in mental health, such training though valuable, is likely insufficient to eradicate stigma related to mental illness among healthcare professionals. This thinking is reinforced by the fact that stigma is present in both specialist mental health and non-specialist healthcare settings (Schulze, 2007; Henderson et al, 2014). Sukhera and Chahine (2016) showed that specific stigma awareness and anti-stigma training were effective for the reduction of stigma among healthcare professionals. Henderson et al, 2014 found that contact with patients improves beliefs about rights to care but does not reduce stigma as effectively as does contact with friends or relatives who live with mental disorder. Not all healthcare workers have such exposures, but Phelan et al (2023) recently demonstrated that integrated behavioural health approaches such as exist in the primary care setting in Barbados, where mental and behavioural health services are available in the primary care setting, reduce stigma among healthcare professionals while improving the acceptability of care that persons living with mental disorder receive. These authors further recommended open communication with patients, promotion of professional self-disclosure and use of patient-centred language by healthcare professionals as other means of reducing stigma in healthcare settings. Interaction with and training by persons with lived experience and their families has also been shown to be an effective way of reducing stigma in healthcare settings (Khort et al, 2015; Thornicroft et al, 2022).

**mhGAP** - the WHO’s Mental Health Gap Action Programme, first launched in 2008, was developed to scale-up identification and treatment of priority mental, neurological and substance use disorders in low and middle income countries (WHO, 2023), and assist such countries with the implementation of their specific comprehensive mental health action plans. It targets non-specialist healthcare workers with the goal of helping them to deliver integrated services especially at the primary care level (WHO, 2023). The intervention guide provides non-specialist healthcare workers with clear pathways for the identification and treatment of common mental disorders. In addition to providing information, some authors have reported a positive impact of mhGAP implementation on the reduction of stigma. Keynejad et al (2021) in their meta-review of papers on its use in various low and middle-income countries stated that improved attitudes, confidence and training post-implementation of mhGAP were consistently documented. Mutiso et al (2018) demonstrated a reduction in stigma in a cohort of healthcare workers in rural Kenya. Findings in a Sri Lankan cohort of primary care workers were similar (Doherty et al, 2024). Of note, mhGAP training for primary care workers in Barbados is a part of the country’s comprehensive mental health action plan.

## METHODS

In the public healthcare system in Barbados primary health care is delivered through 9 polyclinics and 2 outpatient clinics across the island. As a part of the island’s mental health action plan, the integration of mental health into maternal and child health services, especially in the primary care setting where the bulk of service is provided, has been mandated with the aim of improving outcomes for women and their children. Training in the use of mhGAP for primary care nurses is a part of the development of the perinatal mental health programme. Stigma related to mental disorder among healthcare workers has been shown to be a barrier to receiving adequate mental health care for women in the perinatal period (Xiao et al, 2023; Sambrook-Smith et al, 2019; Afulani et al, 2019). Assessing levels of stigma related to mental disorder among these workers, and examining the effect of training on stigma would be useful to inform improvements in mental health service delivery.

### Design

The study will be interventional. Levels of stigma in the cohort of primary care nurses prior to the commencement of training will be assessed using two screening tools, the mental Illness: Clinicians’ Attitudes scale, version 4, (MICA-4) and the Opening Minds Stigma scale for Healthcare Providers (OMS-HC). All primary care nurses will receive training in the use of mhGAP, but a randomly selected sub-group will receive face-to-face exposure to persons with lived experience through attendance at mental health clinics. The instruments will be distributed to participants prior to the commencement of training which is to be conducted in person.

**Instruments** - The Mental Illness: Clinicians’ Attitudes scale, version 4, (MICA-4) was developed from the original and intended for use with health care professionals other than medical students (Gabbidon et al, 2013). The 16-item self-administered scale was found to have good internal consistency (α=0.72) and item-total correlations when compared with the original (Gabbidon et al, 2013). The scale, which requires less than 5 minutes for completion was also found to have good face validity, easy readability, low rates of missing data (Gabbidon et al, 2013).

The Opening Minds Stigma Scale for Healthcare Providers was developed by Kassam et al (2012) to assess levels of stigma among healthcare providers as many sales available at the time did not have items that were specific to this group. Initial testing showed good internal consistency, Cronbach’s alpha = 0.82 and satisfactory test-retest reliability, intraclass correlation = 0.66 (95% CI 0.54 to 0.75). The scale was revised by Modgill et al (2014) using a larger and more diverse cohort of healthcare professionals than the developers, and demoacceptable internal consistency, construct validity, responsiveness to change, and a meaningful factorial structure. Their study favoured the use of the 15-item version over the original 20-item version, and the 15-item version will be used in this study. The scale is a self-report, and responses are graded on a Likert-type scale.

### Aim

The study aims to

1) Assess the level of stigma among primary care nurses in Barbados

2) Determine the effect of mhGAP training on levels of stigma among primary care nurses in Barbados

3) Determine if face-to-face exposure to persons with lived experience affects levels of stigma differently to mhGAP training alone

### Participants

All primary care nurses (N=136) as well as midwifery students are to be trained in mhGAP and are the population under study. Nurses who present for training will be provided prospective participant information and invited to take part.

Demographic information??? (I vote no, but you tell me).

Random selection?????

### Data Collection

Data Collection will begin in October, 2024 once approval the Institutional Review Board and the Ministry of Health and Wellness are obtained. Instruments will be distributed via a peer-based format on the first day of the training session before the start of training, and collected prior to teaching session. Responses will be entered into an excel spreadsheet by research assistants.

### Data Analysis

### Ethical Considerations

No signed consent forms???

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