

Decreasing Primary Care Providers' Stigma of Mental Illness

Nicole Hoogasian

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Abstract

A recent study has indicated that primary care providers hold comparable and possibly more negative attitudes towards persons with mental illness than the general public (Mittal et al., 2016b). Because of their regular interactions with patients with mental illness, providers stigmatizing attitudes has been implicated as a primary factor behind healthcare disparities for this population (Flanagan et al., 2016; Lebowitz & Ahn, 2016). Effective interventions at decreasing mental health stigma needs to be researched, evaluated, and implemented in primary care settings (Beaulieu et al., 2017). An analysis of the literature was done to answer the question, “What interventions are effective in decreasing the stigma of mental illness among primary care providers?” Hildegard Peplau’s theory of interpersonal relations was used as a framework in this review to describe how provider’s interactions with patients can have a significant impact on the patient’s well-being (Peplau, 1992). Studies in this integrative review have identified social contact-based, skills-based, and biologically-based interventions as demonstrating success at reducing stigma among providers (Flanagan et al., 2016; Knaak, Mantler & Szeto, 2017; Lam, Lam, Lam & Sun, 2015). Key ingredients to include in anti-stigma interventions for providers have also been identified in this review (Knaak et al., 2017; Knaak & Patten, 2016). Providers may implement these interventions in their own practices to potentially decrease stigma against persons with mental illness and improve quality of care in the primary care setting.

Keywords: stigma, mental illness, primary care providers, anti-stigma interventions

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Decreasing Primary Care Providers' Stigma of Mental Illness

Decreasing the public's stigma of mental illness has become an increasingly important focus for research, intervention and program development (Knaak, Patten & Ungar, 2015a). Mental illness affects one in four persons, is the leading cause of years lived with disability, and has far reaching effects on an individual's quality of life, social well-being, and physical health (Caplan, Little & Garces-King, 2016). Stigmatizing attitudes by the public can discourage help seeking, diminish self-esteem, and negatively influence psychosocial functioning; which as a result, can cause status loss and social exclusion in persons with mental illness (Mittal et al., 2016b; Ungar, Knaak & Szeto, 2016). A recent study has indicated that health care providers, particularly primary care providers (PCP's), not only share many of these same stigmatizing attitudes, but hold comparable and possibly more negative attitudes towards persons with mental illness than the general public (Mittal et al., 2016b).

According to Knaak and Patten (2016), healthcare providers stigmatize against persons with mental illness because they tend to see the illness ahead of the person, lack confidence and competence in treating psychiatric disorders, hold pessimistic views about the likelihood of recovery (what they do does not matter), and are unaware of their own prejudices about mental illness. Because of their regular interactions with patients with mental illness, the clinical and social harms of providers stigmatizing attitudes has been implicated as a primary factor behind healthcare disparities for this population (Flanagan et al., 2016; Lebowitz & Ahn, 2016). Only 40% of individuals with a mental illness in the United States receive any form of medical or mental health treatment, and those that do receive lower quality of care, fewer treatments, less preventative services, and decreased number of referrals (Smith, Mittal, Chekuri, Han & Sullivan, 2016). Persons with mental illness frequently report barriers to having their physical

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needs met (Knaak et al., 2017). These barriers include providers not taking their symptoms seriously, misattributing their symptoms to their mental illness, and creating delays in diagnosis and treatment options. This significant fragmentation in care ultimately leads to an increase in morbidity and premature mortality for patients with mental illness (Knaak et al., 2017).

Researchers have stated that persons with mental illness die an average of 25 years earlier than those without a mental illness; a statistic that appears to be increasing over time (Flanagan et al., 2016). Compromised patient-provider relationships, early termination of treatment, and delay in help seeking are also significant consequences of provider stigma (Knaak et al., 2017). Though providers may not directly act on their negative attitudes, these attitudes appear to affect decision making which consequently leads to negative health outcomes for these patients (Smith et al., 2016).

Study Purpose

The healthcare system is one of the main environments in which persons with mental illness are stigmatized and discriminated against (Ungar et al., 2016). Despite this, there is limited literature on how to create and deliver successful anti-stigma interventions toward specific audiences such as health care providers. The specific audience for this scholarly project is primary care providers. Smith et al. (2016), found that primary care providers expressed more negative stereotypes and desired more social distance from a person with a mental illness than any other discipline. This is a compelling issue. Recently, there has been a great emphasis on integrating mental health care into primary care (Lam, Lam, Lam & Sun, 2015). In the United States, PCP's are the most commonly contacted healthcare provider; they prescribe between 60-80% of psychotropic medications, and they are often the only providers contacted for mental

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healthcare (Steele et al., 2014). Effective interventions at decreasing mental health stigma needs to be researched, evaluated, and implemented in primary care settings (Beaulieu et al., 2017).

The purpose of this project is to identify articles relevant to the topic of stigma, complete a comprehensive review of the literature, and discuss strategies shown to be effective at reducing provider's stigma of the mentally ill. This topic is relevant to contemporary advanced nursing practice because many nurse practitioners care for patients with mental illnesses in the primary care setting (Beaulieu et al., 2017). Providers need to be aware of their own prejudices, pessimistic views, and potential lack of confidence or comfort in caring for patients with a mental illness. In doing so, they may decrease health disparities in this population by providing the same level of care they would to another patient without a mental illness (Knaak & Patten, 2016). The potential value of this project is to raise awareness for providers, with a focus on primary care providers, on this pressing issue and the detriment stigma is playing in the lives of patients living with mental illness. This project may help primary care providers understand how their stigmatizing attitudes can negatively affect health outcomes, and provide an opportunity to potentially implement some interventions in their own practices.

With an increase in mental health services being offered in primary care settings, use of anti-stigma interventions may decrease stigma and discriminatory behaviors, but may also reduce health disparities and improve quality of care. This project will discuss several interventions and programs that have demonstrated success in reducing providers' stigmatizing and discriminatory attitudes toward patients with a mental illness. An analysis of the literature will be done to answer the question, "What interventions are effective in decreasing the stigma of mental illness among primary care providers?"

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Methodology

This project is an integrative review of the literature. Databases used to find articles relevant to the topic of stigma include: Health Source, Medline, Psych Info, Psychology and Behavioral Science Collection and the Cumulative Index of Nursing and Allied Health Literature. These databases were made available through the online library of MCPHS University. Keywords used during the search process include *stigma, healthcare providers, decreasing provider stigma, mental illness, mental health, and anti-stigma interventions*. Abstracts were read to get an overview of the studies, including the research purpose, sample, methods, results, and recommendations. Articles used for this study were peer-reviewed, in the English language, and published between 2013-2018. Once three relevant articles were obtained, reference lists from these articles were utilized to gain additional sources. During this search, it was noted that one author published several articles on the topic of decreasing provider stigma of mental illness. This authors name was then searched in all databases mentioned previously, to find additional articles.

Included in this paper were qualitative, quantitative, and mixed method primary research studies. Qualitative studies utilized in this integrative review consist of phenomenological, ethnographic, and grounded theory studies (Knaak & Patten, 2016; Flanagan et al., 2016; Mittal, Corrigan, Drummond, Porchia & Sullivan, 2016a). Quantitative studies are quasi-experimental through pre- and post-test designs, experimental through randomized control trials and survey studies through prospective cohort and cross-sectional designs (Beaulieu et al., 2017; Lam et al., 2015; Michaels et al., 2013). Abstracts were used to get an initial overview of the study, and to assess whether the purpose of the studies matched my research question. Studies chosen for this paper are peer-reviewed primary sources that have identified various interventions aimed at

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decreasing stigma in healthcare providers. Articles chosen had to target healthcare providers of some type, whether it be primary care providers, psychiatrists, psychologists, mental health clinicians or nurses (Beaulieu et al., 2017; Flanagan et al., 2016; Fokuo et al., 2017; Mittal et al., 2016b). Each quantitative article was evaluated for rigor, including the validity and reliability of its methods and instruments, and whether statistically significant results were produced (Beaulieu et al., 2017; Fernandez, Tan, Knaak, Chew & Ghazali, 2016; Lam et al., 2015; Michaels et al., 2013). Each qualitative article was evaluated for its credibility, transferability, dependability and confirmability (Flanagan et al., 2016; Fokuo et al., 2017; Knaak & Patten, 2016; Mittal et al., 2016a). Several aspects of these studies were evaluated including: whether the purpose of the study was clearly identified and relevant to decreasing provider stigma, the sample was adequate, representative and demonstrated data saturation, and if the methods, data collection and data analysis demonstrated rigor and matched the purpose of the study and the findings (Coughlin, Cronin & Ryan, 2007). A meta-analysis was also included in this paper because the authors gave a solid overview of various interventions used to decrease provider stigma of mental health (Knaak, Mantler & Szeto, 2017).

Theoretical Framework

Hildegard Peplau's (1992) theory of interpersonal relations will be used as a framework for this scholarly project because it described how provider's interactions with patients have a significant impact on the patient's well-being, and quality and outcome of care. This theory described central features of the nurse-patient relationship which, for this project, will be used to grasp understanding of the healthcare provider-patient relationship in general. A functional working relationship includes a joint effort, in which there is an identification and understanding of the problem, as well as a task in which the healthcare providers appreciates and tests remedial

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measures to produce beneficial outcomes for patients. The effectiveness of this work relies heavily on the relationship of the persons involved. If there is a disruption or dysfunctional component to this relationship, health outcomes may not be optimal (Peplau, 1992).

Peplau (1992) stated that the behavior of the nurse as a person, interacting with the patient as a person, has significant impact on the patient's well-being and the quality of care given. Providers portraying stigmatizing attitudes or discriminating behaviors against a patient with mental illness may negatively affect the patient's health outcomes and overall well-being. Peplau stated that the nurse-patient relationship should be a professional relationship. Clients are human beings that deserve dignity, respect, privacy, confidentiality and ethical care. The purpose of this theory is to encourage providers to be more aware of their behavior, with regards to these aspects of the nurse-patient relationship (Peplau, 1992). Therefore, implementing interventions to decrease mental health stigma may improve both the provider-patient relationship as well as patient's health outcomes.

Critique of the Literature

Qualitative studies included in this review were critiqued for their credibility, transferability, dependability and confirmability because inclusion of these factors establishes a "truth" to the findings, shows that they are consistent, can be repeated, and have an applicability in other contexts (Ryan, Coughlin & Cronin, 2007). Quantitative studies were critiqued on their reliability and validity, for similar reasons mentioned previously and to establish rigor of the research (Coughlin et al., 2007).

Inclusion of an adequate and representative sample was one factor critiqued in both qualitative and quantitative studies. Sample sizes for qualitative studies ranged from 27 to 83, but even with smaller sample sizes, most authors were able to still reach data saturation

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signifying an adequate sample (Flanagan et al., 2016; Fokuo et al., 2017; Knaak & Patten, 2016; Mittal et al., 2016a). Samples functioned as either a strength or weakness to the studies. A strength to these samples was the use of purposive sampling, where “participants are recruited to a study because of their exposure to, or their experience with the phenomenon in question” (Ryan et al., 2007, p.741). Participants recruited to these studies consisted of primary care providers, mental health providers, clinical psychiatrists, social workers, psychologists, mental health nurses and nursing students (Flanagan et al., 2016; Fokuo et al., 2017; Mittal et al., 2016b). Flanagan et al. (2016) further specified the educational level of each participant, ranging from masters-prepared registered advanced practice nurses to medical doctors. The unique experiences and educational level of each healthcare provider adds a richness to the data (Ryan et al., 2007). A weakness to a few of the samples, however, was the lack of diversity among participants. In the sample by Fokuo et al. (2017), 81.6% of participants were African American and 60.8% were female; while participants in Flanagan et al. (2016) were 93% female and 88% white. This lack of diversity among participants decreased the transferability of the findings. Similarly, Mittal et al. (2016b) recruited 83 providers from five Veteran Affairs (VA) hospitals in the Southeastern United States. Though their findings may be useful towards developing an anti-stigma program for providers at VA hospitals, they could not be transferrable toward other types of healthcare systems or other regions of the United States.

For a study to be generalizable, its findings need to be applicable outside the context of the study situation (Ryan et al., 2007). A study is deemed to have met the criteria for generalizability, when its results can be broadly ‘generalized’ to other study settings, samples or populations (Kukull & Ganguli, 2012). Similarly, qualitative studies are critiqued for their transferability (Ryan et al., 2007). When a study has transferability, the results are meaningful to

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individuals not involved in the research study, and the readers can apply findings of the studies to their own experiences (Ryan et al., 2007). Generalizability or transferability increases the external validity of the study (Kukull & Ganguli, 2012).

Sample sizes for quantitative studies ranged from as low as 67 participants to as high as 1616, though most studies sample sizes averaged between 150-200 participants (Beaulieu et al., 2017; Fernandez et al., 2016; Lam et al., 2015). Samples in Fernandez et al. (2016) and Michaels et al. (2014) were ethnically diverse, but largely female. When there is over-representation of a subgroup within a population, sampling error can occur (Coughlin et al., 2007). However, both studies had large sample sizes, averaging around 120 participants, and statistically significant results, which decreased the risk of sampling error. Analyses were run by Michaels et al. (2014) to assess for demographic differences between intervention and control groups. Analyses did not show any significant differences in participants outcome measures from pre- to post-test based on demographic differences. This analysis increases the internal validity of the study, demonstrating that demographic differences did not affect the results (Kukull & Ganguli, 2012). Most quantitative studies included in this review had large and diverse samples, which increases their generalizability, or usefulness in other contexts (Beaulieu et al., 2017; Fernandez et al., 2016; Lam et al., 2015).

Participants in studies by Beaulieu et al. (2017), Fernandez et al. (2016), Lam et al. (2015), and Michaels et al. (2014) were either current healthcare providers or pre-clinical medical students. These studies drew their sample from a population that was reflective of what was being studied, which in this case was decreasing provider stigma of mental illness. This increases the representativeness and adequacy of the study (Coughlin et al., 2007). Including different types of healthcare providers allows the findings to be generalizable to various other

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areas of healthcare (Coughlan et al., 2007). A few of the studies also included persons with lived experience of mental illness as part of their sample to get a different perspective of stigma (Fokuo et al., 2016; Michaels et al., 2014).

Participants in studies were recruited through various methods including promotional letters, recruitment letters, emails, telephone calls from research teams or presentations at primary care conferences (Beaulieu et al., 2017; Fokuo et al., 2017; Knaak & Patten, 2016; Mittal et al., 2016b). Participants in Flanagan et al. (2016) were recruited by the medical director of a local federally qualified community health center and offered \$100 as incentive for their participation. This study had difficulty recruiting primary care providers, even with the large monetary incentive, and ended up with a small sample size of 27. Though this study was qualitative and does not require a large sample size, the authors state that the difficulty in finding participants could have had a substantial impact on the results (Flanagan et al., 2016). Michaels et al. (2014) offered free continuing education credits (CEU) for participation by mental health providers. This may have skewed the results, because these providers may have been more open to learning how to improve the mental health system than other providers (Michaels et al., 2014).

Various ethical considerations were taken by researchers to ensure autonomy, non-maleficence, beneficence and justice. Ethics approval was obtained from local Institutional Review Boards (IRB) for most studies (Beaulieu et al., 2017; Flanagan et al., 2016; Fokuo et al., 2017; Knaak & Patten, 2016; Lam et al., 2015; Mittal et al., 2016b). The role of IRB is to ensure that participants are protected from harm and that ethical principles are being adhered to (Coughlin et al., 2007). Verbal or written consent was obtained in studies before research was undertaken to protect the autonomy of the participants (Flanagan et al., 2016; Lam et al., 2015; Mittal et al., 2016b). Participants in Mittal et al. (2016b) were given an information sheet

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describing all aspects of the informed consent and a brief description of the study. According to Coughlin et al. (2007), every individual should be fully aware of what is being investigated, and have the right to freely participate in a research study without fear of coercion. To ensure confidentiality, Lam et al. (2015) used anonymous questionnaires coded with unique reference numbers to identify each participant. To provide further protection, only one research assistant had access to the codes.

Researchers used various methods to collect data including questionnaires, semi-structured interviews, reviewing of program documents and quantitatively through randomized control trials (Knaak, Modgill & Patten, 2014; Knaak & Patten, 2016; Fernandez et al., 2016; Michaels et al., 2014). Knaak et al. (2014) and Knaak and Patten (2016) used grounded theory methodology to evaluate current anti-stigma programs in Canada. To ensure credibility, techniques such as triangulation and member-checking were used to collect data. Information was collected from multiple sources and through multiple methods, which ensures robust and comprehensive data (Knaak et al., 2014; Knaak & Patten, 2016). Theoretical memoing was also used during data collection (Knaak et al., 2014). Use of these techniques in qualitative data collection increases credibility by giving participants the opportunity to correct errors, volunteer additional information and summarize preliminary findings (Ryan et al., 2007). Analysis of the studies led to the generation of a theoretical model articulating six key ingredients to include in anti-stigma interventions for providers (Knaak & Patten, 2016). In theory, this model will be used to develop and implement anti-stigma programs, however, the authors state its generalizability is limited because of the qualitative nature of the research (Knaak & Patten, 2016). The study by Knaak et al. (2014), however, also included a quantitative component to examine the association between key ingredients and program outcomes. Data from 18

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randomized control studies (RCT's) were included in the quantitative analysis. Beaulieu et al. (2017), Fernandez et al. (2016), and Michaels et al. (2014) also used double-blind randomized control trials. Randomized control trials are considered the “gold standard” of epidemiologic studies because they provide the strongest possible evidence of causation (Misra, 2012).

Studies in this review either initiated their own anti-stigma interventions or examined the effectiveness of previous interventions at decreasing stigma (Beaulieu et al., 2017; Flanagan et al., 2016; Knaak et al., 2014; Michaels et al., 2014). Studies that initiated interventions used validated scales to assess for decreased stigma post-intervention (Beaulieu et al., 2017; Flanagan et al., 2016; Knaak et al., 2014). The most common scale used was the Opening Minds Scale for Health Care Providers (Beaulieu et al., 2017; Fernandez et al., 2016; Knaak et al., 2014; Knaak, Karpa, Robinson & Bradley, 2016). The Opening Minds Scale for Health Care Providers (OMS-HC) is a 15-item validated scale that measures three main aspects of stigma: preference for social distance, negative attitudes and health professional's own willingness to disclose or seek help for a mental illness (Beaulieu et al., 2017). In 2014, a rigorous examination of the psychometric properties and responsiveness of the OMS-HC was conducted (Beaulieu et al., 2017). Results from this evaluation showed internal consistency was acceptable for all versions of the OMS ($\alpha=0.74-0.79$), and corresponding subscales ($\alpha=0.67-0.68$) (Beaulieu et al., 2017). This scale has been widely validated and identified as an accurate and reliable instrument (Beaulieu et al., 2017; Flanagan et al., 2016; Knaak et al., 2014).

Other scales used include the Attribution Questionnaire, which assesses cognitive, affective and behavioral reactions to a vignette about a schizophrenic man using a nine-point Likert scale (Michaels et al., 2014). This questionnaire was administered at pre- and post- test by Michaels et al. (2014) and measured at an internal consistency of 0.71. Persons with mental

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illness completed another scale in this study, the Recovery Assessment Scale (RAS). Internal consistency for the RAS was excellent (0.94), demonstrating the instrument is reliable.

Flanagan et al. (2016) also used various scales for their study, including the Competence Assessment Instrument, Characteristics and Affective Reaction Scale, Attribution Questionnaire, Social Distance Scale and Recovery Knowledge Inventory. The authors note that scales used in their study have high validity and reliability, but do not note specific values.

The self-reporting nature of these scales is a weakness of the studies. Self-reporting scales are highly subjective and may exhibit a self-reporting response bias (Ryan et al., 2007). Many participants may have scored differently based on social desirability, or “the tendency of people to present themselves favorably according to the current cultural norms” (Dodd-McCue & Tartaglia, 2010). Observable behavior change of providers would demonstrate more substantial evidence of actual change (Michaels et al., 2014).

A few qualitative studies used “thick descriptions” when describing their results (Flanagan et al., 2016; Knaak et al., 2016). These studies reported direct quotations from their participants to describe the phenomenon in sufficient detail. Thick descriptions increase the likelihood results can be transferable to another time, person, setting or place (Ryan et al., 2007).

Findings of these studies accurately portray their hypotheses that proposed interventions would decrease stigma among healthcare providers (Beaulieu et al. 2017; Flanagan et al., 2016; Knaak, Ungar & Patten, 2015b; Michaels et al., 2014). Interventions in this review demonstrated results that were statistically significant toward decreasing various aspects of stigma captured on the OMS-HC, including preference for social distance, negative attitudes and willingness to disclose/seek help (Beaulieu et al., 2017; Knaak et al., 2015b; Michaels et al., 2014).

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Synthesis of the Literature

The detrimental impacts of stigma in healthcare have promoted increased calls to action for healthcare organizations to take leadership roles in correcting the problem (Knaak et al., 2017). Several interventions on decreasing public stigma have been published, but the development of interventions specifically designed for healthcare providers is still in its infancy (Mittal et al., 2016a). Recently, studies focused on healthcare providers have tested contact, education, skills, and biologically based interventions, as well as explored key ingredients for anti-stigma programs (Knaak et al., 2017; Knaak & Patten, 2016). Anti-stigma interventions are now targeting medical and nursing students as well, in hopes that it may prevent stigmatizing attitudes from forming at all (Fernandez et al., 2016; Fokuo et al., 2015).

Key Ingredients

Several studies have identified key ingredients to include in anti-stigma interventions (Knaak et al., 2014, Knaak & Patten, 2016, Mittal et al., 2016a). These ingredients include: social contact from a trained speaker, multiple points or forms of social contact, a focus on behavior change by teaching skills on what to do or say, engagement in myth busting, use of a person-centered approach (rather than pathology-first approach), and emphasis on recovery as a key part of the message (Knaak et al., 2014; Knaak & Patten, 2016). The first ingredient, social contact, should be a personal testimony from a qualified speaker who has lived experience with mental illness (Knaak et al., 2014). The overall tone of the story should be inspiring and hopeful, and speakers should emphasize to the audience what providers did well, as well as what they could improve upon (Knaak & Patten, 2016). Stories should include details of a pivotal point in the patient's recovery, and highlight strengths, accomplishments, or plans (Knaak & Patten, 2016). With this type of intervention, persons with mental illness are not seen as patients,

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but as educators (Knaak et al., 2017). Mittal et al. (2016a) collected input from primary care and mental health providers on what elements they thought were important to include in an anti-stigma contact-based intervention. Participants in this study thought the trained speaker should be a local healthcare provider with lived experience of mental illness, but agreed it may be difficult to find providers willing to share their stories. Participants indicated that the content of the message should be narratives of the speakers lives, where they describe ways in which they felt stigmatized or discriminated against, and what they would have liked their provider to have done differently (Mittal et al., 2016a). They also wanted presenters to describe disparities in care they experienced and if there were any negative health outcomes that resulted from it. Face-to-face contact, small groups, and the use of multiple messengers for delivering the intervention over a period of time was favorable to most providers (Mittal et al., 2016a).

Having multiple forms of social contact is also essential, and has been identified as a second key ingredient to include in anti-stigma interventions (Knaak & Patten, 2016). This could include a presentation from a live speaker, use of multiple first-voice speakers, or video presentations (Knaak et al., 2014). The purpose of having multiple forms of social contact is to recognize that different stories resonate with different people, and different people learn in different ways (Knaak & Patten, 2016). Demonstrating recovery is identified as another key ingredient. Providers want to see that recovery is both real and probable. Providers want validation that they are playing a pivotal role in the patient's recovery and that *what they do actually matters*. Teaching practical skills in the form of educating providers on what to do or what to say in certain situations is another ingredient (Knaak et al., 2014). The purpose of this ingredient is to improve the lack of confidence and competence providers express when treating and working with patients with mental illness.

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Programs should also engage in education sessions and myth busting techniques by focusing on correcting false beliefs, increasing awareness of stigma, providing an opportunity for self-reflection, and improving language use (Knaak & Patten, 2016). A participant in the study by Knaak and Patten (2016) self-reflected and stated, “We often forget our words. We do have a powerful impact... it made me realize how I had prejudices about people with mental illnesses I didn’t even realize I had” (p.60). Fernandez et al. (2016) further discusses the usefulness of myth-busting techniques. In this study, a 1-hour educational myth busting lecture was given on schizophrenia. At post-test, results showed significantly lower stigma scores on the Social Distance Questionnaire for the intervention group but not for the control group. Choosing an enthusiastic facilitator who models a person-first approach, rather than a pathology-first approach, is also an important ingredient (Knaak & Patten, 2016). The facilitator sets the tone and guides the program’s message (Knaak et al., 2014).

These studies identified key ingredients to include in an anti-stigma intervention for providers (Knaak et al., 2014; Knaak & Patten, 2016; Mittal et al., 2016a). Mittal et al. (2016a) recommended key ingredients for contact interventions, whereas Knaak et al. (2014) and Knaak and Patten (2016), explored a broader array of strategies and recommended a combination of educational, skill building and contact strategies. Future research is needed to evaluate the efficacy of these identified ingredients on provider attitudes, clinical behaviors and behavioral intentions (Mittal et al., 2016a).

Contact Based Interventions

Contact based interventions have been identified in several studies as a promising strategy to combat stigma in the healthcare setting (Corrigan et al., 2013; Flanagan et al., 2016; Ungar et al., 2016). Social contact has been shown to decrease anxiety, increase empathy,

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disconfirm stereotypes, improve understanding of recovery and form personal connections (Knaak et al., 2017). Contact can be face-to-face or through the use of videos, as both have shown effectiveness at reducing stigma (Fernandez et al., 2016).

A ten-week peer-led program implemented to reduce stigma in primary care providers called “Recovery Speaks,” is a contact based intervention that has demonstrated success in the United States (Flanagan et al., 2016). Primary care providers (PCP) were randomly assigned to attend a one-hour performance. At each performance, eight to ten participants showed pictures of their lives, told their stories of recovery, and described ways in which they now contribute to their communities. This type of face-to-face lecture minimizes the power distance between patient and provider and allows the patient to gain respect from the audience (Fernandez et al., 2016). Providers were asked qualitative questions about the performance, and then answered a post-test questionnaire using several validated anti-stigma scales (Flanagan et al., 2016). This intervention used several of the key ingredients mentioned by Mittal et al. (2016a), and then tested the effectiveness of the intervention. At post-test, providers who attended the performance reported lower negative stereotypes, less fear, less attribution of dangerousness, less desire to coerce people into treatment, more desire to help, less desire for avoidance, less desire to segregate people from the community, and more hope for recovery for people with mental illness than providers in the control group (Flanagan et al., 2016). “Recovery Speaks” decreased numerous aspects of stigma that had not been previously studied, including avoidance, coercion, and segregation from society. This is an important finding because use of this intervention could affect an even wider arrange of elements than discussed in previous anti-stigma intervention studies in the literature (Flanagan et al., 2016). Fernandez et al. (2016) states that this type of

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face-to-face contact intervention may result in longer maintenance of stigma reduction as compared to other types of interventions.

A review of the literature revealed that a combination of contact and educational based interventions can consistently reduce stigmatizing attitudes and social distancing behaviors (Fernandez et al., 2016). The “Anti-Stigma Project workshop” (ASP), a contact and education based intervention developed in Maryland was designed to educate participants in small group settings about mental illness stigma and the negative impact it has on persons with mental illness, their families and providers (Michaels et al., 2014). It is designed to raise awareness about mental illness stigma through various methods: video presentation, interactive discussion, audience analysis and group exercises. Persons with mental illness and providers attend these workshops, and effects of interventions are determined by pre- and post-tests. After the intervention, providers had lower levels of prejudice and were more aware of their stigmatizing attitudes. The authors hypothesized that increasing providers awareness of stigma and improving their attitudes toward persons with mental illness could decrease disparities and promote higher quality delivery of healthcare (Michaels et al., 2014). A program based in Turkey used similar methods of contact to deliver their anti-stigma intervention, including movie-watching, observation, and discussion (Fernandez et al., 2016). The outcome of this study was similar in that it noted favorable changes with the intervention group in relation to decreased stigmatizing attitudes and social distance.

Another promising contact-based intervention implemented in healthcare settings, is a mentoring program between medical students, nursing students and persons with lived experience of mental illness (Fokuo et al., 2015; Knaak et al., 2016). Two recent studies partnered a patient with mental illness and a healthcare student together. The intent of the study

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was for the student to learn what persons with mental illness experience on a daily basis in regard to stigma (Fokuo et al., 2015; Knaak et al., 2016). Participants in the study by Knaak et al. (2016) stated that having prolonged contact with a patient with mental illness allowed them to know the whole story and get a broader perspective of the patient's experience. Many participants expressed satisfaction with the program, stating it was a valuable means by which to change attitudes about people living with significant mental health issues. Participants in Fokuo et al. (2016), found that interacting with persons with mental illness made them want to improve their communication skills, being especially mindful of using stigmatizing language. Mentor based contact-interventions can be used to train future health professionals, with the hope that they will prevent stigmatizing attitudes from forming in the first place (Fokuo et al., 2016; Knaak et al., 2016).

Skill Based Interventions

Skill-based interventions have demonstrated success at reducing stigma among healthcare providers in various research studies (Beaulieu et al., 2017; Knaak et al., 2017; Lam et al., 2015). Evidence suggested that stigmatization among healthcare providers may be connected to a lack of skills to comfortably assess, communicate with, and treat persons with mental illness (Ungar et al., 2016). By improving communication techniques, skills-based training may enhance the quality of interpersonal contact between patients and healthcare providers. This may lead to diminished clinical and social distance, more positive attitudes, better quality of care and improved client experiences (Ungar et al., 2016). It may also improve providers comfort, confidence, and understanding of mental illnesses as being a treatable disease (Knaak et al., 2017).

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One study based in Canada evaluated a skills-based training program, the “British Columbia Adult Mental Health Practice Support Program” (Beaulieu et al., 2017). The authors hypothesized that enhancing primary care providers skills, and increasing their comfort and confidence, would lead to diminished stigmatization and social distance. The program taught self-management cognitive behavioral tools during a 3.5-hour interactive workshop style session over an 8-week period. The program targeted family physicians and focused on treating patients with mild to moderate depression and anxiety (Knaak et al., 2017). The OMS-HC was used to measure stigma levels among providers both pre- and post-intervention. Results demonstrated that providers in the intervention group had increased confidence and reduced stigma towards persons with mental illness, particularly in relation to social distance, as well as decreased reliance on prescribing antidepressant medications (Beaulieu et al., 2017; Knaak et al., 2017).

Lam et al. (2015) evaluated the effects of a 1- year postgraduate skills-training program in mental health. This study found that providers who participated in the mental health training program had more positive attitudes toward persons with mental illness, were more willing to treat depressed patients by themselves, and had a higher job satisfaction. Providers who participated in the program were also less likely to refer a patient with depression to a psychiatrist, compared to providers who did not participate in the program (Lam et al., 2015). This study demonstrated similar findings to Beaulieu et al. (2017) with regards to improving providers competence and confidence in treating depressed patients.

Both studies describe promising strategies to decrease mental health stigma among providers, but they also identify two interesting gaps in the literature (Beaulieu et al., 2017; Lam et al., 2015). A finding in the study by Beaulieu et al. (2017) that was not originally a planned analysis, is that baseline stigma scores decreased more in men than women. This is consistent

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with existing research that suggests attitudes toward mental illness differs between males and females (Beaulieu et al., 2017). Further research needs to be done on whether gender-specific interventions have potential usefulness in decreasing provider stigma of mental illness. Lam et al. (2015), discusses how providers in their study felt more comfortable in dealing with common mental health problems such a depression, but not psychotic conditions such as schizophrenia. This also identifies a gap in the literature because more research should be done to evaluate the effectiveness of disease-specific interventions at reducing stigma (Lam et al., 2015).

Beaulieu et al. (2017) and Lam et al. (2015) discussed skills-based interventions that have demonstrated success at reducing stigma among primary care providers. Though both interventions were skills-based, and attempted to decrease stigma mainly among depressed patients, the aspects of stigma they aimed to improve differed. Beaulieu et al. (2017) aimed to decrease stigma in relation to social distance, as well as increase providers confidence in working with persons with mental illness. Lam et al. (2015) aimed to decrease psychiatric referrals and increase provider attitudes, job satisfaction and confidence in taking care of persons with mental illness. These two studies decreased several aspects of stigma, and may therefore be useful tools to combat stigma among providers (Beaulieu et al., 2017; Lam et al., 2015).

Biologically-Based Interventions

Two recent studies hypothesized that presenting providers with knowledge of the biologic components of mental illness would be an effective strategy to combat stigma (Knaak et al., 2015b; Ungar & Knaak, 2013). Providers are in the business of fixing, managing, and treating biologic disorders; therefore, it is logical to think that applying the same type of medicalized framing to mental illness would decrease stigma (Knaak et al., 2015b). Thinking of a mental illness organically may shift the locus of control and make it less permanent, less

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unpredictable, less fundamentally different, more controllable, and more recoverable in the eyes of the provider (Ungar & Knaak, 2013). An online continuing medical education program in Canada used several of the key ingredients discussed previously, such as personal testimony from persons with mental illness, skill building and myth busting to decrease stigma in providers. This online program, however, also included a unit that described the biological correlations associated with mental illness (Knaak et al., 2015b). Magnetic resonance imaging and positron emission tomography images were used to show functional changes in the brain, hippocampal volume loss, evidence of inflammation and genetic biologic differences. Pre- and post-test scores were evaluated and showed significant score improvements on the three dimensions of stigma: negative attitudes, desire for social distance and willingness to help. When the authors compared data from this study to six other anti-stigma programs using the same stigma scale, theirs was the only one that included a biological component and it was also the best performing (Knaak et al., 2015b). Though positive results from this online program provide initial support to the effectiveness of biologically based interventions at reducing provider stigma, controlled studies are required to confirm his hypothesis.

Implications for Practice

Several provider-specific anti-stigma interventions have been identified in this paper. These interventions may be implemented in healthcare settings, particularly primary care settings, to decrease stigma, improve interactions with patients, and potentially decrease health disparities for persons with mental illness (Ungar et al., 2016). The intent of this paper was to aid primary care providers in understanding how their stigmatizing attitudes can negatively affect health outcomes for persons with mental illness, and then use these interventions to potentially change the way they practice. With an increase in mental health services being offered in

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primary care settings, use of these interventions could not only help decrease stigma and discriminatory behaviors, but also potentially improve quality of care. It is with great hope that the ideas discussed here will provide a launching pad for further investigation and development of anti-stigma interventions for providers, and that these interventions will be effectively utilized in primary care settings (Ungar et al., 2016).

Implications for Future Research

A key limitation to the current evidence is that many anti-stigma interventions are evaluated using provider-based outcomes, typically attitudes and behaviors (Knaak et al., 2017). There is a need for additional research that targets the impact of stigma reduction interventions on patient outcomes, experiences, and specific care practices. Persons with mental illness experience more health disparities than the general public; therefore, additional research is needed to determine whether or not decreasing stigma improves health disparities.

Another limitation to the evidence is that many of these studies were evaluated in the short-term, and there is limited research that evaluates the effectiveness of interventions on provider attitudes in the long-term (Knaak et al., 2014). Other gaps in the literature were discussed previously, and include the need to test for the effectiveness of gender-specific and disease-specific interventions. There is also a need for future studies that observe behavioral change in providers, but this would likely be very costly (Michaels et al., 2014). Last, further research is needed to test the effectiveness of biologically-based interventions; because current studies provide only preliminary support and controlled studies are required to confirm these hypotheses (Knaak et al., 2015b; Ungar & Knaak, 2013).

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Conclusion

Persons with mental illness experience healthcare services at an alarmingly lower rate, receive poorer quality of care and experience higher morbidity and mortality rates than the general public (Smith et al., 2016). Though these reasons may be multifactorial in origin, provider's stigmatizing attitudes have been implicated as a main contributing factor. To confront stigma consequences, several interventions have been created, implemented, and evaluated among providers in diverse healthcare settings (Michaels et al., 2014). Qualitative and mixed-method studies have identified social contact-based, skills-based, and biologically-based interventions as demonstrating success at reducing stigma in providers (Knaak et al., 2017; Knaak & Patten, 2016). Key ingredients for anti-stigma interventions have also been identified in studies (Knaak et al., 2017; Knaak & Patten, 2016).

One intent of this integrative review was to make primary care providers aware of how their attitudes may be affecting health outcomes for patients with mental illness. The main purpose of this paper however, was to research, report on, and educate providers on various interventions that have demonstrated success at reducing stigma in the healthcare setting. Peplau (1992) theorized that providers interactions with patients have a significant impact on the patient's well-being and quality of care given. Therefore, providers may implement these interventions in their own practices to potentially decrease stigma against persons with mental illness and improve quality of care in the primary care setting. It is with great hope that the findings from this paper be used to educate providers, decrease disparities and improve the healthcare system for persons with mental illness.

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