STIGMA AS A BARRIER TO EARLY RECOGNITION AND DIAGNOSIS OF DEPRESSION IN PRIMARY HEALTH CARE SYSTEM

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Psychiatric problems – major health issue

- In the United States, neuropsychiatric disorders have now surpassed other disorders such as cardiovascular diseases and malignant neoplasms as the **number one cause of disability** as expressed as disability-adjusted life years. (WHO, 2008)
- **Mental health expenditures** in the United States, expressed as a percentage of total health care expenditures, were more than 6%. For the year, that amounted to a cost approaching $100 billion. (SAMHSA, 2008)
- **Suicide** remains a significant cause of death and lost productive lives, with the most recent U.S. data (from 2007) showing that almost 35,000 people died that year from all forms of suicide. (Kessler et al, 2005)

Mental illness stigma

- Three out of four people with a mental illness report that they have experienced **stigma**.
- Stigma is a **mark of disgrace** that sets a person apart. When a person is labelled by their illness they are seen as part of a stereotyped group.
- **Negative attitudes** create prejudice which leads to negative actions and discrimination.
- Stigma brings **experiences and feelings** of:
  - shame
  - blame
  - hopelessness
  - distress
  - misrepresentation in the media
  - reluctance to seek and/or accept necessary help

Mental illness stigma

- People with mental health issues recognize and internalize this stigma to develop a strong **"self-stigma"** who will often undermine self-efficacy. (Watson et al, 2007)
- As people begin to experience symptoms of their mental health conditions, stigma may cause some people to try to **avoid, separate from or suppress** these feelings. (Haves et al, 1996)
- Stigma and embarrassment were the **top reasons** why people with mental illness did not engage in **medication adherence**.
- Due to stigma, mental health conditions are **not typically screened** in most health care settings, losing an important opportunity for care. (Gulliver et al, 2010)

Mental illness stigma and healthcare professionals

- Majority of people hold **negative attitudes** and **stereotypes** towards people with mental illness. (Crisp et al, 2000)
- Often the negative stereotypes involve perceptions that people with mental illness are **dangerous**. This perception is fueled by **media stories** that paint violent perpetrators as "mentally ill" without providing the context of the broad spectrum of mental illness. (Link et al, 1999)
- **Health care providers** and even some **mental health professionals** hold these very same stereotypes. (Thornicroft et al, 2007, Nordt et al, 2006)

Mental illness stigma and mental health professionals

- Mental health professionals' attitudes toward someone with a mental illness can both **perpetuate stigma and create new barriers** to receiving treatment.
- Most well-trained professionals in the mental health disciplines subscribe to the **same stereotypes** about mental illness as the general public (Corrigan, 2002).
- Patients are often thought to be **incompetent**. This attitude is similar to historical attitudes about psychiatric patients (Crawford & Brown, 2002).
- The general public held **more optimistic opinions** about treatment outcomes for people with mental illnesses than were held by mental health professionals. (Cook, Jonikas, and Razzano, 1995)

Mental illness stigma and mental health professionals

- That attitudes held by mental health professionals were influenced by the professionals' **personal work experiences** with clients and by prevailing attitudes of the profession and the professionals with whom they worked. (Jorm et al. 1999)
- **Professional contact** may improve general attitudes about mental illness, but such contact was not helpful in changing negative attitudes about predicting prognosis and long-term outcomes (Cook et al., 1995).
- These negative attitudes may be conveyed to clients and their families and have an **influence on their expectations** of outcomes (Hugo, 2001).
- **Fear** is the most prevalent emotion reported by mental health professionals regarding this population. Some other secondary emotions include **dislike, neglect, and anger** (Penn & Martin, 1998).

Depressive disorder – epidemiological data

- Among adults, **depression** ranks as a significant cause of disease and disability, with a lifetime prevalence of over 16%21 and a 12 month prevalence at any time of 6% to 7%. (Kessler et al, 2005)
- 12 month prevalence of depression averages about **8% to 9% for women and 4% to 5% for men.**(SAMHSA, 2008)
- **Lifetime prevalence** of depression is 70% greater for women than men. (Kessler et al, 2005)
- When depression is broken down into various **degrees of severity**, more than 30% of U.S. adult cases identified in 2007 are listed as being in a "severe" category. (Kessler et al, 2005)
- Approximately 52% of those adults received some form of treatment, with 38% receiving what was considered **adequate treatment**. (Kessler et al, 2005)

Primary healthcare role in mental health

- GPs typically **manage multiple symptoms and problems**. (Callahan, 1998)
- A visit to a psychiatric professional typically lasts at **least 30 minutes** and is focused on a clearly defined issue. Primary care visits last an **average of 13 minutes** and include an average of six patient problems. (Eisenberg, 1992)
- **Detecting and managing mental health problems** must compete with other priorities such as treating an acute physical illness, monitoring chronic illness, providing preventive health services, and assessing compliance to standards of care. (Eisenberg, 1992, Rost et al, 2000)

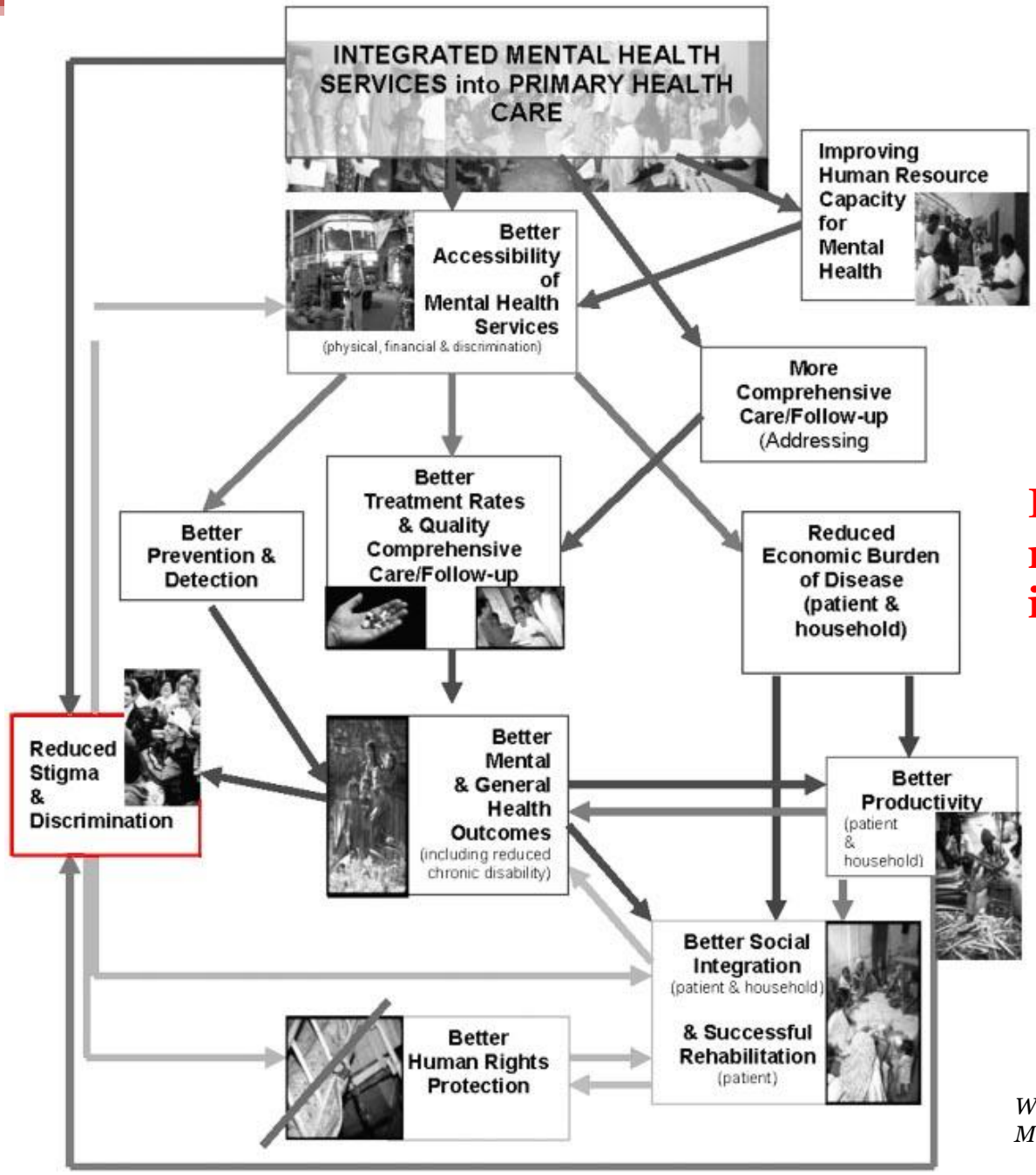
Primary healthcare role in mental health

- **The general reluctance** of patients to seek care for mental health problems complicates the diagnosis of mental illness. 40% of patients with major depression do not want or perceive the need for treatment. (Williams, 1998, Wells et al, 2000)
- Patients consistently **underreport emotional issues** to their physicians. Only 20% to 30% of patients with emotional/ psychologic issues reported these to their GP. (Eisenberg, 1992)
- Many patients **somatize their psychologic issues**. One in three patients who go to the emergency department with acute chest pain is suffering from either panic disorder or depression, and 80% of patients with depression present initially with physical symptoms. (APA, 1998, Katon et al, 1997)

Primary healthcare role in mental health

- **Better physical accessibility** – primary healthcare is 'the first level of contact (the closest and the easiest to access) of individuals, the family and community with the national health system'
- **Better financial accessibility** – when consulting in hospitals, indirect health expenditures (transportation, loss of productivity related to the time spent in accompanying the patient to hospital, etc) add to the cost of consultation and medications. If mental health services are integrated into primary healthcare, healthcare costs are greatly reduced/minimal
- **Better acceptability** – linked to reduced stigma and easier communication with healthcare providers (e.g. reduced language and cultural barriers, better knowledge of the user's personality and personal and familial background/history).

(WHO, 2008)



Rationale for integrating mental health services into primary healthcare

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Depressive disorder in primary healthcare

- Only **20% of individuals** with serious mental illnesses were treated in general medical settings (Wang et al., 2002).
- The **low rates** in general medical settings were ascribed to lack of provider knowledge about mental health treatments and of clinic-level supports for providing high-quality care.
- Development of simple, self administered **depression screeners**, made it easier to perform routine screening for depression and other common mental disorders in primary care settings.
- Between 1989 and 2000, the percentage of primary care visits leading to **antidepressant prescriptions** rose from 2.6% (approximately 6 million visits) in 1989 to 7.1% (approximately 20.5 million) in 2000 (Pirraglia, Stafford, & Singer, 2003).

Mental Illness Stigma in South-East Europe The Present and the Future in Terms of Research Priorities

- The objectives of study were:
  - to describe the research context in the five targeted countries (Albania, Bulgaria, Moldova, Romania, and Serbia)
  - to establish research priorities of relevance for key stakeholders from the five targeted countries (Albania, Bulgaria, Moldova, Romania, and Serbia)
  - to inform decisions concerning mental illness stigma research funding in the five targeted countries (Albania, Bulgaria, Moldova, Romania, and Serbia)

Prioritization Exercise

	Researchers	Practitioners	Advocates	Consumers	Policy & decision makers	Total
Albania	2	11	5	2	3	23
Bulgaria	8	13	1	4	3	30
Moldova	7	5	1	3	4	20
Romania	5	9	2	2	2	20
Serbia	7	8	0	0	0	15
Total	28	47	9	11	12	**108**

Prioritization Exercise - Results

- **Does stigma interfere with pathways to mental health care (i.e., delays in referral, delays in access, hospitalization rates, under-diagnoses and under-treatment of mental illnesses, reduced treatment adherence)?**
- Does stigma impact employment opportunities? Why? How? To what extent? To what effect?
- How to increase social inclusion of individuals with mental illness?
- How to reduce stigma and discrimination?
- Do family members stigmatize and discriminate? Why? How? To what effect?

Prioritization Exercise - Results

- Would rehabilitation of those with mental illness reduce stigma and discrimination?
- Does media contribute to increasing or decreasing stigma? Why? How? To what extent? To what effect?
- What are the levels of stigma associated with schizophrenia?
- **Are individuals with mental illness stigmatized and discriminated against? Why? How? To what extent? To what effect?**
- What are the explicit and implicit attitudes of the general population towards individuals with mental illness?

Strategies That Diminish Stigma

- Education provides information so that the public can make more informed decisions about mental illness. Research on education related to mental illness stigma has suggested that participation in these kinds of programs has led to improved attitudes about persons with these problems (Corrigan, River, et al., 2001; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Keane, 1990; Morrison, Cocozza, & Vanderwyst, 1980; Penn et al., 1994).
- Stigma is further diminished when members of the general public have contact with people with mental illness who are able to hold down jobs or live as good neighbors in the community (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan et al., 2002; Pinfold et al., 2003; Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003).
- Interventions that challenge self-stigma and facilitate empowerment are likely to improve adherence (Corrigan & Calabrese, in press; Speer, Jackson, & Peterson, 2001)

Coping with stigma in primary healthcare settings

- Feature contact with people with lived experience of mental illness
- Emphasize skills training
- Have some kind of attached incentive or expected participation
- Focus on a specific illness
- Put the person ahead of the illness
- Demonstrate recovery and competence
- Increase the awareness and knowledge of the nature of mental illnesses and treatment options
- Improve public attitudes to those who have mental illnesses, and their families

Thank you!