Mental health stigma and primary health care decisions

Patrick W. Corrigan\textsuperscript{d,*}, Dinesh Mittal\textsuperscript{a,c}, Christina M. Reaves\textsuperscript{a,c}, Tiffany F. Haynes\textsuperscript{a,c}, Xiaotong Han\textsuperscript{c}, Scott Morris\textsuperscript{d}, Greer Sullivan\textsuperscript{a,b,c}

\textsuperscript{a} VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center, Central Arkansas Veterans Healthcare System (CAVHS), North Little Rock, AR, USA
\textsuperscript{b} Translational Research Institute, University of Arkansas for Medical Sciences, Little Rock, AR, USA
\textsuperscript{c} Department of Psychiatry Division of Health Services Research, University of Arkansas for Medical Sciences, Little Rock, AR, USA
\textsuperscript{d} Illinois Institute of Technology, Chicago, IL, USA

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A B S T R A C T

People with serious mental illness have higher rates of mortality and morbidity due to physical illness. In part, this occurs because primary care and other health providers sometimes make decisions contrary to typical care standards. This might occur because providers endorse mental illness stigma, which seems inversely related to prior personal experience with mental illness and mental health care. In this study, 166 health care providers (42.2% primary care, 57.8% mental health practice) from the Veteran’s Affairs (VA) medical system completed measures of stigma characteristics, expected adherence, and subsequent health decisions (referral to a specialist and refill pain prescription) about a male patient with schizophrenia who was seeking help for low back pain due to arthritis. Research participants reported comfort with previous mental health interventions. Path analyses showed participants who endorsed stigmatizing characteristics of the patient were more likely to believe he would not adhere to treatment and hence, less likely to refer to a specialist or refill his prescription. Endorsement of stigmatizing characteristics was inversely related to comfort with one’s previous mental health care. Implications of these findings will inform a program meant to enhance VA provider attitudes about people with mental illness, as well as their health decisions.

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1. Introduction

People with serious mental illness experience health challenges yielding alarming morbidity rates (\textit{Mai et al., 2011}; \textit{WHO, 2005}) and die, on average, 15–30 years younger than their cohort (\textit{Saha et al., 2007}). In part, this occurs because of health system failures: e.g., absence of integrated care services (\textit{Lutterman, 2010}) or insufficient insurance coverage (\textit{Druss and Mauer, 2010}). However, research also suggests that some provider decisions may worsen health outcomes. Compared to patients not identified with mental illness, research has shown health providers are less likely to refer patients with mental illness for mammography (\textit{Koroukian et al., 2012}), inpatient hospitalization after diabetic crisis (\textit{Sullivan et al., 2006}), or cardiac catheterization (\textit{Druss et al., 2000}). Provider endorsement of stigma might be one influence on these health care decisions for people with mental illness (\textit{Jones et al., 2008}; \textit{Thornicroft et al., 2007}). It is possible that perceptions about adherence to treatment mediate the connection between provider stigma and health care decisions. Namely, those with stigmatizing attitudes may believe people with mental illness are less likely to adhere to treatment recommendations. If this is the case, providers may be less likely to offer some types of health care options to people with serious mental illness. In this paper we examine two treatment options that might be offered to a patient presenting with significant pain related to arthritis: refer for specialist consult or refill the patient’s prescription for Naproxen. The hypothetical relationship between stigma and health decisions is summarized in the right paths of Fig. 1.

Two other variables are likely influential here. First, familiarity with mental illness is inversely associated with endorsing the stigma of mental illness (\textit{Corrigan et al., 2001a, 2001b}). One proxy for familiarity is the degree to which a person is comfortable seeking mental health care themselves. We expect to show that health care providers who are comfortable seeking mental health treatment are less stigmatizing. Second, we hypothesize that health care provider discipline might be expected to moderate stigma’s effects on treatment response. It seems reasonable to think nurses and physicians with mental health training are less likely to hold stigmatizing views compared to primary care colleagues; hence, being a mental health professional might be associated with endorsing stigmatizing characteristics. However, research suggests mental health providers may endorse stigma equal...
to or greater than many other professions (Lauber et al., 2006; Schulze, 2007). To learn more about this relationship, we include discipline (mental health versus primary care) as an additional variable in our path model without hypothesis about expected relationship.

2. Methods

2.1. Participants

Nurses, physicians, and psychologists from mental health and primary care clinics were recruited from five VA hospitals in the southeast and southwest areas of the US in 2011 and 2012. The study was approved by the VA Central Institutional Review Board. Providers who were fully informed to the study and consented to participate were given a hardcopy survey and self-addressed, postage paid envelope to return information anonymously. Research participants completed one of two vignettes of a patient (described more fully below) who varied based on presence or absence of a diagnosis of schizophrenia. Results reported here are responses from research participants solely randomized to the patient “X” with schizophrenia (N = 166). The sample was 62.4% female. In terms of ethnicity, participants were 15.9% American Indian/Alaskan Native, 13.6% Asian/Asian American, 15.8% Native Hawaiian/Pacific Islander, 14.8% African/African American, and 67.8% European/European American; 6.9% reported themselves as Hispanic. In terms of professional discipline, 42.2% reported they worked in primary care, and 57.8% in mental health. Participants reported 16.1 years (S.D. = 13.6) to d.f. ratio far less than 2 (ratio = 2.92, p < .05, chi-squared = 3.28, p > .95, chi-squared to d.f. ratio far less than 2 (ratio = 0.36), and RMSEA below 0.06 (RMSEA = 0.000). Additional indicators also supported goodness of fit (i.e., indicator is greater than 0.90): normed fit index = 0.93 and comparative fit index = 1.00. Fig. 1 also includes Betas representing relationships between adjacent constructs in the path model as well as t-tests indicating significance of these relationships. Hypotheses about relationships between stigma and the two proxies of health decisions were supported. Providers who endorsed stigmatizing characteristics were more likely to believe patients would not adhere to treatment. Comfort with previous mental health service experiences was inversely associated with stigma. Those who believed the patient would adhere to treatment recommendations were more likely to refer patient X to a specialist and more likely to refill prescriptions; in other words, they were more likely to take clinical actions to address the patient’s complaints of back pain. Fig. 1 also shows no significant relationship between discipline and expectations about treatment response; mental health providers seemed to endorse elements of the path similar to primary care.

4. Discussion

This paper helps to explain the relationship between mental illness stigma and health care decisions. In particular, health care providers who endorse more stigmatizing attitudes about mental
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