Mental Health Stigma in Ireland: Exploring Occupational Therapists Perspectives

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Abstract

Stigma is considered the main barrier to recovery for people living with a mental illness. The process of stigma can be inconspicuous, operating through individual, systemic, institutional and structural levels and can leave those working in mental health care unsure of their role in the stigma process. Semi-structured interviews explored views of nine occupational therapists working in mental health, focusing on their perspectives of stigma and drawing on experiences of stigma acting as a barrier to their client’s recovery. The purpose of this research was to develop a greater understanding of forces that perpetuate mental health stigma. The results suggest that the invisibility of mental illness is a major element of stigma that warrants attention. working in mental health primarily address stigma at an individual level. The main force perpetuating mental health stigma was identified as structural discrimination. Finally, the findings suggest the need for occupational therapists to reflect on their role in stigma management and to establish a channel in which to inform wider mental health practice of the need to target structural levels of discrimination. This study will be of particular relevance to occupational therapist working in mental health and endeavours to deepen their understanding of the stigma process.

Introduction

Stigma is the most significant challenge facing the field of mental health today (Lam 2008; WHO 2001), acting as a major barrier to recovery (Dillon 2008). It is prevalent throughout local and worldwide communities (Lam 2008; WHO 2005). It has been suggested that individuals with disabilities such as mental illness face stigma in their communities at both an individual-cognitive level and an institutional-structural level (Corrigan 2006). The move of mental health care away from psychiatric hospitals to community based settings created new opportunities to reduce the prevalence of stigma (Mental Health Commission 2008). With this change occupational therapists adapted their core skills to new settings, while throughout staying focused on the evidence to support the importance of occupation in maintaining and promoting health and wellbeing (COT 2011; WFOT 2011). In Ireland, stigma remains a problem, with only 55% of the general public believing a person experiencing a mental health problem should enjoy the same access to employment (Barry et al 2009; National Disability Authority 2002). Additionally, Chambers (2007) documented that one third of Irish people were scared to talk to those diagnosed with a mental illness. These reports demonstrate worrisome public attitudes towards mental illness. However, there is limited discussion
regarding how stigma is understood and managed by occupational therapists as their roles in community mental health care expand (Krupa 2008). Additionally, a need to research direct connections between clinical interventions and stigma processes has been emphasised (Thornicroft et al 2007). This exploratory research will present qualitative findings from nine semi-structured interviews conducted to answer the timely question; what are occupational therapist’s perspectives of stigma in relation to mental health? This research aims to explore occupational therapist’s perceptions and understanding of stigma in relation to mental health. The findings will identify how therapists address stigma, try to counteract it and will develop a greater understanding of the forces that perpetuate mental health stigma.

**Literature Review**

Stigma has been a pervasive force in the mental health field and voluminous literature exists since Goffman (1963, p. 4) developed the construct in his seminal work (Link and Phelan 2001; Corrigan 2005). Stigma has been defined as the application of negative labels and stereotypes to an identified social group, eliciting strong emotional responses (Corrigan and Lam 2007; Link and Phelan 2006). Goffman and other theorists focused on the psychological aspects of stigma. Jones et al (1984) described stigma as a “mark” (attribute) that links a person to undesirable characteristics creating stereotypes. Interestingly, Link & Phelan (1999) added the analysis of power differentials to the description posed by Jones et al (1984) suggesting that stigma exists when a series of interrelated components converge including: labelling, stereotyping, separation, status loss and discrimination.

More recently, Corrigan et al (2004, 2007) stated that discussions have progressed from an understanding of these individual-cognitive models to institutional-structural models. Estroff et al (2004) further reported that these discussions also focussed on advocacy and activism in addressing stigma within communities. Additionally, Sartorius and Schulze (2005) concluded that research has largely been limited to attitude surveys rather than studies establishing an evidence base of effective interventions. However, these processes that sustain stigma and discrimination are complex and often invisible making it a difficult phenomenon to address.

Since the Mental Health Act (2001) was passed in Ireland many incentives were established to review how mental health care services were delivered (Mental Health Commission 2008). This led to a shift from acute to community care services within Ireland. The document ‘A Vision for a Recovery Model in Irish Mental Health Services’ (2006) outlined a requirement to support social inclusion through addressing stigma. Nonetheless,
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stigma is still prevalent within our society employment (Barry et al 2009; Chambers 2007; National Disability Authority 2002). It is well documented that stigma affects an individual’s access to services, occupational potential, health and wellbeing (Sirey et al 1999; Link 1982, 1987; Rosenfield 1997). Stigma has been shown to result in economic consequences for society and so interventions that reduce stigma are economically beneficial (Sharac et al 2010) – an interesting finding at this current time of economic turmoil.

There is a wealth of literature to suggests that health professionals experienced stigma acting as a barrier in their recovery focussed interventions (Jorm and Griffiths 2008; Watson et al 2007). In 2005, the Canadian Association of Occupational Therapy (CAOT) called for its members to participate in a range of efforts to reduce this societal level stigma. Krupa (2008 p. 201) stated “As occupational therapists, and with a focus on occupation, we have a beneficial role to play in enabling community encounters that are stigma busting.” In agreement with this, Creek and Lougher (2008) reported that occupational therapy is well suited to address the negative consequences of stigma and facilitate community participation. However, in order to tackle stigma health professionals must have an understanding of stigma and how to manage it (Lloyd and Williams 2009). To date there is no systematic examination of how occupational therapists are currently addressing stigma in community mental health care. It is timely to address this as mental healthcare moves into the community. To locate studies on the process of mental health stigma, the Medline, CINAHL, AMED and PsycInfo databases were searched using the following key terms: stigma, mental health, occupational therapy. Further terms were searched in relation to themes during the data analysis process such as structural discrimination and service user movement.

Methodology
The study was based on the interpretive paradigm as it focused on the understanding and perception of the participants (Creswell 2009). Qualitative semi-structured interviews were best suited to describing the stigma process from the therapist’s point of view (Vidich and Lyman 1994). Qualitative data was approached from the phenomenology tradition which describes the meaning “of the lived experience about a concept” (Creswell 1998, p. 51). This approach was aligned with the client centred ethic of occupational therapy (Finlay 1998; Hammell 2000). In this study the lived experiences of participants working in mental health were explored.
Participants
Nine occupational therapists, working in mental health, were recruited through the Association of Occupational Therapists Ireland (AOTI) database. The AOTI administrator e-mailed an information sheet to all occupational therapists on their database willing to engage in research. Individuals were able to contacting the researcher by e-mail or telephone. Participants were sent a detailed information sheet and consent form. After consent was returned an interview was scheduled through e-mail/telephone. Participant’s demographics are illustrated in Table 1.

Table 1: Profile of Participants (n = 9)

<table>
<thead>
<tr>
<th>Years of Mental Health Experience</th>
<th>0-9</th>
<th>10-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>6 (66%)</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>Location of Training</td>
<td>Ireland</td>
<td>Elsewhere</td>
</tr>
<tr>
<td>Setting</td>
<td>Community</td>
<td>Acute</td>
</tr>
<tr>
<td></td>
<td>6 (66%)</td>
<td>3 (33%)</td>
</tr>
</tbody>
</table>

Data Collection
Data collection consisted of audio recorded semi-structured interviews, lasting approximately 1 hour. Interviews were guided by a list of questions that became more focused or refined as the interview progressed (see appendix A). This flexibility allowed depth and breadth within the interview (Holloway 2005; Pope and Mays 2000; Richie and Lewis 2003). Open ended questions permitted the researcher to understand how the participants interpreted their experiences. Question probes were used for further clarification (see appendix B). Active listening was implemented during the interviews to enhance the collection process (Corbin and Morse 2003). Member checking increased research validity and provided further clarification that the data collected was interpreted correctly (Creswell 2009; Russell & Gregory 2003).
**Data Analysis**

After the interviews were transcribed, analysis began with a close reading of all transcripts and field-notes to connect emerging ideas with the research question. Transcripts and field-notes were analysed using NVivo, version 9 (QSR 2010). Information relevant to the study aims was organised into specific codes. Constant comparative analysis was conducted so that coding continued to moving back and forth between identifying similarities among and differences between emerging categories (Colaizzi’s 1978). Codes were defined, compared and contrasted across transcripts and categories emerged after reviewing the material numerous times (Mayring 2000). Categories were re-examined to determine how they were linked (Strauss and Corbin 1990). This allowed questions to be raised and give provisional answers about categories and their relationships. Finally, general conclusions were drawn that illuminated the themes (Dillaway et al 2006). During research supervision debriefing encouraged the researcher to critically reflect on interpretation and analysis (Creswell 1998). Research mind maps, action plans, field notes and a reflective journal were used to continuously question and evaluate the research process. Reflective journaling created an introspective record of the researcher’s assumptions and responses during data collection and analysis to understand personal transformation in the research process (Creswell 1998; Emerson et al 2011).

**Ethical Considerations**

Ethical approval was obtained from the Clinical Therapies Research Ethics Committee at the University of Limerick. Participants were provided with an information sheet and a consent form to sign outlining freedom to: withdraw from the study at any time, review the transcript, refuse to respond to a question if they were uncomfortable or allow interviews to be audio recorded. Finally, permission was sought from participants to use specific quotes in publications/presentations. Because occupational therapists in mental health are a small group in Ireland anonymity could not guaranteed however everything possible was done to minimise risk. Upon completion of recorded interviews audio files were immediately transcribed, cleaned, anonymised and sent electronically to supervisor for password protected storage for seven years. Electronic data was permanently deleted from the researcher's computers/data storage systems and all paper documents were shredded.
**Trustworthiness**

In qualitative research the concepts credibility, dependability and transferability have been used to describe aspects of trustworthiness (Lincoln and Guba 1985; Polit and Hungler 1999; Berg and Welander Hansson 2000). Participants with various experience in mental health were included in the study to increase credibility by shedding light on the research question from a variety of aspects (Adler and Adler 1988; Patton 1999). Credibility was approached through the use of quotations from the transcribed text and findings represented in member checks (Graneheim and Lundman 2004). To facilitate transferability, a clear and distinct description of selection and characteristics of participants, data collection and process of analysis was illustrated (Graneheim and Lundman 2004). A detailed reflexive diary was used to guide ongoing self-critique and self-appraisal, including the moral, social and political stance of the researchers (Finlay 1998; Koch and Harrington 1998).

**Results/Findings**

Three main themes, each with two sub-themes, emerged. The first theme concerned occupational therapists’ understanding of stigma; the second related to occupational therapists skills and knowledge when addressing stigma; the third reflected participants understanding of forces perpetuating stigma in mental health.

**Figure 1:** Overview of the main research themes
**Invisibility of Mental Health – A Major Element of Stigma**

Participants identified the invisibility of mental health was a major element stigma. Two main factors appeared to contribute to this; namely coping with an invisible illness and being treated as invisible.

> “I had a lot of clients saying to me: I wish I had something that people could see. That’s something they really struggle with.”

Therapists report that clients found it hard to accept their illness, as one client called it “living a life of secrecy” and one participant described a particular client she worked with in a vocational rehabilitation programme;

> “He used to come in everyday in a smart three-piece suit. It came out after a few weeks he was actually telling his family that he was going to work each day. I think there were about four other people at home and they all believed he was going into work every day.”

Many participants reported that clients felt invisible within their friendships and report being actively avoided but it would be different if they had a visible illness.

> “It wouldn’t have happened if I had a condition you could see, like a broken leg.”

Families with the best intentions treated their loved ones as invisible by answering questions on their behalf. A mother of a young man attended all of her sons appointments frequently commented in his presence;

> “Ah sure he’s not able, you know. I have to do everything for him.”

Most frequently stigma imposed a barrier to accessing professional roles, with employers suggesting roles that were invisible to the public;

> “One of the places we went to was a local cinema and the employer we spoke with said ‘absolutely I’d love to have people with mental health difficulties work for me, that’s really important. You’d have diversity and you know they could clean the cinemas after the movies’. And we said, yeah or they might work behind the counters and sell tickets or food and he said no, no, we’d want to keep them out of the way.”

Participants reported that there is a lot more work to be done to change public attitudes towards mental illness.
**Structural Forces**
Participants felt that mental health care is in an exciting transition from a medical to social model of care. However, concerns about “stigma within the service itself” were expressed.

“We provide housing, social care, mental health care, even general health needs. They’re tied into a system, so we have a lot of houses which creates stigma in itself.”

The warned that the health care system is “encouraging over-reliance on services” and having a negative effect on client’s self-advocacy and motivation;

“The system becomes the client’s family, friend, provider, educator and they don’t need to move outside the system for anything.”

Participants felt they spent a lot of their time explaining their role to other healthcare professionals in order to receive correct referrals to give them the opportunity to address stigma with their clients through intervention;

“I’ve had the issue of health professionals thinking oh so and so wants to go back to work, I’ll refer to Occupation Therapy because that’s what they do.... I have that role misunderstanding a bit.... and clients say; the doctor said you can help me find a job.”

Participant’s expressed frustration accessing information to support their clients decision making in relation to disclosure; “it’s huge but there isn’t the information there in Ireland, and stated that “you really have to go looking for information. ”Participants all agreed that information in relation to legal rights such as disclosure in the workplace “need to be more available to people.”

Service user involvement was reported by all participants as a movement “every mental health service should have access to.” However, only two participants reported service user involvement in their current place of work. Limitations with the success of service user involvement within the Irish mental health system were reported. Lack of funding and limited resources for service users were identified as barriers.

“I think that’s probably one of the biggest barriers for services to be totally recovery orientated-having people paid to give their expert opinion and advice on committees.”
Existing hierarchical structures resisting change, has led to the development of “a kind of hierarchy.” The service users on the committees are often “far removed from the clients and don’t represent the needs of the people on the ground.” Additionally, participants felt motives for setting up a service user group within a service aren’t always clear. One participant reported that a fellow committee member suggested including service users as it “looks good, it’s good for getting funding”. The current system appears to promote tokenism rather than creating real partnerships.

**Addressing the Problem**

The majority of participants gained an understanding of stigma through work experience rather than university. Therapists felt they addressed stigma indirectly on a daily basis through conventional interventions and staying true to core occupational therapy philosophies (see table 2 for examples of how participants address stigma).

> “I think it’s something that you’re aware that’s there but it’s more subconscious like that you’re addressing it.”

**Table 2:** Occupational therapists understanding of stigma and how they address it

<table>
<thead>
<tr>
<th>What are OTs understanding of the stigma process?</th>
<th>What are OTs doing to address this?</th>
<th>How are they doing it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Invisibility of mental health makes it difficult for clients to understand</td>
<td>• Doing - Increasing awareness of occupational potential</td>
<td>• Grading, activity analysis, goal setting, setting the just right challenge, education</td>
</tr>
<tr>
<td>• MH Stigma makes it difficult for clients to accept their identity</td>
<td>• Being - Restoring occupational identity and preventing occupational alienation</td>
<td>• Coping skills, motivational interviewing</td>
</tr>
<tr>
<td>• Community attitudes act as a barrier to tackling stigma</td>
<td>• Becoming - Exploring occupational identity and decreasing occupational alienation</td>
<td>• Vocational rehabilitation, community integration initiatives, home intervention, recreational exploration</td>
</tr>
<tr>
<td>• Stigma results in social exclusion</td>
<td>• Belonging - Building sustainable communities.</td>
<td>• Promoting social inclusion and making mental health visible</td>
</tr>
</tbody>
</table>

• Targeting stigma through navigating occupational alienation transition belonging social inclusion.

Only one participant had run a direct group intervention to address stigma.
Many therapists reported that they did not consciously attend to stigma within their intervention plans “I never really thought about that [a communication skills intervention] as addressing stigma but it is kind of in what you are doing” and others recognised that stigma did not feature in their decision making “It isn’t something that factors in to your reasoning when you’re working with a client.” Reflecting on the process of stigma as part of continuous professional development was not common practice for therapists; “it’s opportunities like this [the interview] that you actually start thinking there isn’t a whole lot of research on stigma out there. We need to probably be doing more.”

Participants recognised the need to reflect about their role in stigma management “I’ll be thinking of this going home this evening, thinking what can we do?” and also recognised the importance of increasing research and knowledge in the area; “it would be interesting if there was more research in terms of how we could do this [tackle stigma] because it’s a hugely valid question you’re asking, something that we should be thinking about more but it’s something that would need research on.”

**Discussion**

This study explored how therapists address stigma, try to change it or counteract it and it developed a greater understanding of the forces that perpetuate mental health stigma. Participants identified the invisibility of mental health as a major element of stigma. They reported that, clients they work with were treated as invisible by others, family members and potential employers. These findings were reported by Wahl (1999) thirteen years ago. In Wahl’s study (n=1301) participants claimed the most common experiences of stigmatisation included being treated as less competent by others once their illness was known, being shunned or avoided, and being advised to lower their expectations in life. Hinshaw and Stier (2008) researched the impact of this on individuals and recorded “the pain engendered by mental illness is searing enough, but the devastation of being invisible can make the situation practically unbearable.” Krupa (2008) argued that the process of stigma is particularly powerful because it can be unintended and invisible making it difficult to identify how to address it.
It was confirmed that occupational therapists are equipped with the skills to address stigma at an individual level. Participants reported that they did not engage in stigma-specific interventions, an interesting finding. They were addressing stigma indirectly through conventional interventions and stigma rarely featured in their clinical reasoning process. Only one participant out of nine discussed running a group intervention specifically aimed at addressing stigma. Therapists felt they’re role in integrating people into the community and in individual life skills interventions had a positive effect on reducing stigma (See table 2 for detailed examples of interventions). Participants reported using interventions that are well aligned with the theoretical foundation of the profession described by Wilcock (1998) and Yerxa (1998) – that human participation in occupations is fundamental to survival, health and the optimisation of potential. Wilcock (1998) linked occupation to the process of becoming, through which humans achieve identity and authenticity. Participants interventions focussed on targeting occupational deprivation with their clients through vocational rehabilitation, coping skills and community incentives. Pettican and Bryant (2007) support their reasoning and state it is undeniable that people with mental health problems frequently experience occupational deprivation. Townsend and Wilcock (2004) emphasise addressing these individual needs assists communities to overcome occupational deprivation, imbalance and alienation.

A review of the literature supports the findings that occupational therapists are well-situated to disrupt stigma. Rebeiro-Gruhl (2005) maintained that core occupational therapy beliefs are strikingly similar to factors associated with recovery. Similarly, Lloyd & Williams (2009) argued that occupational therapists can apply these skills to support the aims of the World Health Organisation to address stigma through health promotion, social inclusion and supported employment (WHO Europe 2005). Krupa (2008) claimed that as a profession therapists are in a position to take a leadership role in ‘stigma-busting’ interventions and should politicise the power of occupations for achieving anti-stigma goals. Participants described running creative group interventions that were graded into community exhibitions. Community based interventions have been shown to promote inclusion and de-stigmatisation because occupation gives people an opportunity to mix with other members of the community sharing a common interest (Milligan et al 2004; Fieldhouse 2003). Kronenberg and Pollard (2005) build on these claims suggesting that interventions, like those reported by participants, have the potential to combat stigma, health inequalities and occupational deprivation. These results address a gap in the literature highlighted by Thornicroft et al.
(2007) who emphasised a need to directly connect clinical practices to stigma processes to document how clinicians are addressing stigma.

Some participants identified a need to reflect on their role in stigma prevention. Lloyd and Williams (2009) strongly advise that health professionals must have a full understanding of stigma and how to manage it in order to prevent its harmful consequences. This is consistent with Strong et al (2003) who report the need to provide an education that is responsive to the changing practice of mental health. This raised questions about therapists understanding of higher level stigma processes without having received any formal education/training.

Structural discrimination was biggest challenge facing occupational therapists. Interestingly, Corrigan et al (2004) investigated aspects of mental health discrimination and found that researchers have focused on individual levels of stigma lending a need to investigate higher levels of discrimination. This finding comes at an interesting time in mental health when structural influences, such as the mental health strategy, recommend that “a recovery orientation should inform every aspect of service delivery” (Department of Health and Children 2006 p9). This strategy suggests a shift away from treatment towards a social model of treatment with a focus on recovery. Participants described situations where they felt structural forces perpetuated the presence of mental health stigma; ultimately a source of occupational injustice and apartheid (Kronenberg and Pollard 2005). This finding reflects the work of Shulze et al (2003) who report stigma is experienced through structural imbalances built into political and legal regulations. This lends further support to Link and Phelan’s (2001) conceptual discussion that stigma depends on social, economic and political power. Corrigan et al (2007) argue that affirmative action influences structural discrimination differences by providing service users with supports and resources increasing visibility of mental health in general. Service user involvement in service delivery and planning is a good example. In the current study participants reported limited service user involvement and felt the current system supports tokenism and not partnership. Rutter et al (2004) argue that organisations that support tokenism are characterised by inequalities of power, typical features of a medical model of care. Insufficient resources available to clients in relation to disclosure was highlighted and described as an obstacle to vocational rehabilitation. Thornicroft et al (2007) echoed that disclosure discourse is an area of urgent concern. Recent legislation addressing disclosure of mental health issues in the workplace is a promising step toward a recovery model (Equality Authority 2011).
Participants reported that rudiments of a medical model are still in place and are slow to change. The role of the occupational therapist was often misunderstood even though, the Mental Health Commission (2008) recognised occupational therapists as one of the key professional roles of a mental health multidisciplinary team. This not just an Irish concern, Simpson et al (2005) highlighted this concern within the National Health Service. Sumption and Smyth (2001) argued that the Irish mental health system is embedded historically in a medical model of practice. Even though multidisciplinary care was encouraged by the Department of Health (2001) a recent report of community mental health staffing highlighted a clear underrepresentation of allied health care professionals (Mental Health Commission 2009). This indicates a lack of transparency between policy and implementation.

Kleinman (1978) argued medical systems are both social and cultural. Within his explanatory model of care he acknowledged the existence of professional culturism. Different professions form a group apart with their own concepts, rules and social organisation. Powell and DiMaggio (1991) advised developing a capacity to change a medical system involves organisation restructuring through new policy; designing jobs; assigning authority and responsibility; establishing accountability. However, Corrigan et al (2007) claimed without providing supports and adequate training to educate staff in new knowledge, skills and approaches necessary structural discrimination prevails and is not likely to readily change because strategies currently focus on in individual psychological level. Krupa (2008) recommended occupational therapists should continue disrupting stigma at an individual level but must attend to higher levels of discrimination or risk a consequence of being part of the problem and not the solution. However, Townsend (1998) testified that these initiatives are subject to predominant biomedical institutional forces. It is time to embrace a recovery model of care more than ever.

In a systematic review, Warner (2010) identified a component of the recovery model that has a direct effect on reducing stigma; empowerment. This suggests an urgent need to address structural discrimination by supporting the service user movement empowering clients to make mental health visible in our communities and reduce stigma.

**Implications for Occupational Therapy Clinical Practice**

Occupational therapists working in the field of mental health in Ireland may use this information to reflect on whether their practice is in line with current stigma prevention concepts. It is essential that occupational therapists have a clear understanding of the stigma process. The findings also encourage occupational therapists to include political reasoning
into their clinical reasoning framework and develop initiatives to address higher level structural forces that perpetuate stigma (Van der Eijk 2001). There is a need for occupational therapists to ensure that service users are better represented in mental health settings in Ireland. Finally, this research highlights that it is essential that occupational therapists are aware of how they are addressing stigma. Articulating their skills in stigma management, to the healthcare service, will highlight the contribution that the profession can make to mental healthcare.

Limitations and Recommendations for Future Research

Although this study takes an important step towards understanding how stigma acts as a barrier to recovery it is acknowledged that several limitations restrict conclusions that may be drawn.

A small sample size was chosen given the timeframe and resources available. This limits the transferability of the study. A larger sample size of community and acute occupational therapists is recommended. This will allow an in-depth analysis of how stigma presents in both settings. It would be interesting to compare the results from both settings.

The sample contained mainly basic grade occupational therapist. Their career stage trajectory may have limited their knowledge and understanding of stigma. There is a potential for further research to investigate senior occupational therapists perspectives of how service user involvement is currently being managed in mental health settings in Ireland.

The researcher’s relative inexperience in conducting this type of research must also be considered. The inclusion of a second person to review the data to ensure the themes selected were accurate would have enhanced the reliability of the study.

Conclusion

This study indicated that occupational therapists are equipped with the skills to address stigma at an individual level. It emerged that therapists were primarily addressing occupational deprivation, imbalance and marginalisation (Townsend and Wilcock 2004, Kronenberg and Pollard 2005). In doing so participants realised their interventions had a positive effect on stigma reduction. The results illustrated structural challenges faced by occupational therapists as they further their role in community mental health care. Results support previous findings to suggest that the occupational therapists are working in a system which is slow to adapt to change; the dominance of a medical model was evident.
Additionally, service user involvement in the current system promotes tokenism rather than creating real partnerships.

The research findings revealed a link between clinical practice and the process of stigma questioned in the literature. Different levels of discrimination (individual versus structural) were highlighted posing questions for future areas of research and practice in mental health care, in particular structural discrimination. Clinical practice focussed primarily on individual discrimination concluding that there was a lot more work to be done in order to close the gap between individual and structural discrimination. Efforts designed to address structural discrimination rested on the therapist’s ability to understand stigma processes, the factors that produce and sustain such processes, and the mechanisms that lead from stigmatisation to harmful consequences.

Occupational therapists need to reflect on their role in stigma management and politise they’re contribution to addressing the problem. Ensuring political reasoning is incorporated in the clinical reasoning framework, will support therapists to connect practice and research to current anti-stigma agenda’s, initiatives and policy.

This is an exciting time with many challenges ahead, but it is important for the growth and development of occupational therapy in mental health that occupational therapists take a lead in defining their role and as a result seizing opportunities to expand the profession. Occupational therapists have a powerful role to play in combatting mental health stigma within communities. This suggests a need for health care management to recognise this strength, further develop the profession in the area of community mental health, paying particular attention to the long term cost effectiveness of doing so.

**Acknowledgements**

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References


Appendix A: Interview Guide

Research Interview Guide

Key: Highlighted areas are prompts for the interviewer to produce visual aids during the interview.

Section One: Demographics

1. Can you tell me a little about yourself first of all; Professionals name, location of professional training and experience date working as an occupational therapist in mental health care?
2. Can you briefly describe the current setting that you are working in and the client profile?

Section Two: Background knowledge of stigma

3. How have you learned what stigma means?
4. What aspects of your professional training have influenced your knowledge of stigma?
5. I am interested to know what stigma means to people and I came across research carried out by the National Disability Authority highlighting the negative attitudes to people with mental health problems. The NDA research showed that:
   - Only 55% of respondents thought that people with mental health problems should have the same access to employment as everyone else compared to 82% in the area of physical disability.
   - 33% thought that they should not have the same opportunities as everyone else.
   - Only 55% of respondents felt that people with mental health difficulties should have the right to the same fulfilment through relationships and sexuality compared to 83% in the area of physical disability.

Have you ever experienced attitudes like these whilst working with your clients, whether the belief stems from the client themselves or from other sources?

Section Three: Professionals experiences of stigma affecting their clients

6. I would like you to think of a specific example when stigma presented as a barrier to one of your clients. Can you tell me as much as you can about this event?

Now I am going to give you this diagram to help you to think of the event in a broader context also.

7. I came across an interesting situation whilst on my mental health placement and I would be interested to know what you think about it. When one of the clients was first diagnosed with a mental illness his general practitioner advised him not to disclose to anyone only immediate family members. The GP also provided him with a long term sick note from work due to a gastro-intestinal related disorder and told him strictly never to disclose the truth to his employer.
   - What do you think about this situation? Do you have any similar examples?
   - As you know OT’s support clients in their return to work. What would you do to help the client in this situation?
Section Four: Perceptions of client’s abilities

8. Have you ever used any initiatives to educate support your clients in tackling stigma for themselves?
   Whilst I was on placement the clients were asked to work in small groups to produce a PowerPoint presentation about stigma to educate a different group in Ireland. In the past the site has also involved the clients in a debate on stigma.
   - Have you ever done anything like that with your clients?
   - Would it be possible to do anything like that with your clients?
   - What would you do to develop this idea further or would you do anything differently?

Section Five: Approaches used by the interviewee to tackle stigma.

9. Do you use any specific strategies or supports when clients tell you about stigmatizing experiences?
   PROMPT: Groups on self advocacy, assertiveness, NAT strategies, stress management, diaries

10. Are there any policies in place to reduce stigma experienced by clients as a long term goal in your workplace?

11. I would like you to think about how you address stigma in a broader context in your daily practice. Again, I am going to give you this diagram to help you to think about the question in a broader context.

12. I have a few examples I’d like you to think about.
   PROMPT:
   - Mental health service user movement and service users involved in research; A Vision for Change recommends user (and carer) involvement at every level of the mental health services and initiatives to develop user-run services, education programmes to enable service users to represent themselves and others, and establishment of a National Service User Executive. For example, Boyle, J and Walsh, J (2009) Improving Acute Psychiatric Hospital Services According to Inpatient Experiences. A user-led piece of research as means to empowerment.
   - Laing House peer support model; A youth driven, community based organisation in Canada.
   - What is being done to initiate change in stigma in Ireland; Produce the magazine ‘Speak your mind’ Spring 2011 Vol 3.

13. What do you think about the examples above? Would something like this make sense with your client group? At your workplace? If so, why? If not, why not?

14. Do you think healthcare professionals are adequately equipped to address stigma in Ireland? If so, provide examples. If not, what would help us become better able to address this issue?

15. Do you see any opportunities for occupational therapists to work with any other professionals, organizations or agencies to tackle stigma? PROMPT: To develop strategies in stigma management through advocacy work, write policy briefs etc.

16. We are coming to the end of the interview now. Is there anything else you would like to share that may benefit this area of research further?

Thank you very much for your time and support today. Your professional experience and participation in my research is extremely valuable and very much appreciated.
Appendix B: Interview Question Prompts

**Image 1:** Prompt used to explore occupational therapists experiences of stigma in depth.

**Image 2:** National Disability Authority Research Findings used to explore therapists experience of attitudes towards mental illness.

**Image 3:** Media Image
Appendix C – Theme Map

Stigma Process and how it is understood

Invisible

Not understood fully/clearly (L&P)- understood as a complex process
- Segregation
- Isolation
- Discrimination... employers

Creating a transition

No policy or structure change
Instit without walls

Awareness of structural influences

Interventions at microlevel but not direct stigma intervention

MH remains invisible

Identity loss:
Self & family

SU involvement

Invisible

Reflection and incorporate into clinical reasoning – skills and knowledge

OT unable to address the gap between micro and macro level intervention

Change theory: think global act local, start at bottom and work up to make MH visible. resistance theory, MI, but need support from policy and structural supports to encourage change without resistance

No change motivators

- Lack of communication
- Role uncertainty

Stigma

norms

MDT

Power (L&P)
APPENDIX D – ASSOCIATION OF OCCUPATIONAL THERAPIST IRELAND DATABASE ACCESS
APPLICATION FORM

1. Research Plan

The study will evaluate occupational therapists perspectives of stigma in mental health and how they counteract this, work with it or try to change it.

2. Research Purpose

To explore what assessment tools and outcomes occupational therapist use to address the possible negative effects of stigma experienced by clients. Considerations for future developments in the occupational therapy profession will also be investigated.

3. Research Methodology

Ten occupational therapists will be recruited for one to one interviews up to sixty minutes long. Interviews will be audio recorded. Data will be transcribed verbatim by the researcher. Data collected will be transcribed and analysed thematically using NVivo.

Proof of ethics committee approval: University of Limerick Education and Health Sciences Ethics Committee approval.

Participant information sheet

You are invited to take part in a study evaluating occupational therapists experiences of stigma management in mental health care settings. The interviews will explore tools occupational therapist use to address the possible negative effects of stigma experienced by clients. Considerations for future developments in the occupational therapy profession will also be investigated.

Taking part in this study means engaging in a one to one private interview for up to 60 minutes. The interviews will be conducted in the occupational therapists place of work or study in a quiet, private space. A brief summary (up to 300 words) will be sent to the participants via email as a member check within 7-10 days of the interview.

All of the information you provide as part of the research study will be kept confidential at all times. Direct quotations from the answers to the interview questions may be used in publications or presentations based on this study. However, your name or identifying information about you will not be reported in any publications arising from this research.

Please contact Louise Hanby if you have any questions about this study

Primary Investigator Contact Details
Louise Hanby

Supervisor Contact Details
Dr Nancy Salmon
APPENDIX E – Email Script

Email script for point of first contact between Louise Hanby and interested potential participants.

Dear [insert name of participant],

Thank you for contacting me and showing your interest in participating in the research study.

The interviews will be conducted summer 2011. They can be arranged to facilitate your working schedule and can be conducted in your place of work or in a suitable interview environment out of working hours. The one to one interview will last up to 60 minutes.

Description of the study:

This study will evaluate occupational therapists perspectives of stigma in mental health care settings and how they counteract this, work with it or try to change it. Considerations for future developments in the occupational therapy profession will also be investigated. Up to ten occupational therapists will be recruited through the Association of Occupational Therapists of Ireland (AOTI) database. Participants must be registered occupational therapists or occupational therapy students who have completed a mental health placement of more than 8 weeks in length.

If you are interested in finding out more details about the research study I can forward the research information letter to you by post or email. This letter explains in detail what the study is about and how you can be involved. If you are interested in finding out more about the study, please let me and I’ll email it onto you. Alternatively, please let me know your postal address and I can send out the information sheet.

If you have any questions in relation to the research studies please do not hesitate to ask me. Thank you for your interest in the study and I look forward to hearing from you,

Louise Hanby, 10000507@studentmail.ul.ie
APPENDIX F- INFORMATION LETTER

You are invited to take part in a study evaluating occupational therapists perspectives of stigma in mental health care settings and how they counteract this, work with it or try to change it. The interviews will explore what assessment tools and outcomes occupational therapist use to address the possible negative effects of stigma experienced by clients. Considerations for future developments in the occupational therapy profession will also be investigated. Participants must be registered occupational therapists, or occupational therapy students that have completed a minimum eight week placement in a mental health setting.

Taking part in this study means engaging in a one to one private interview for up to 60 minutes. The interviews will be conducted in the occupational therapists place of work or study in a quiet, private space. The interviews will be audio recorded and a brief summary (up to 300 words) will be sent to the participants via email as a member check process, within 7-10 days of the interview.

There are no risks associated with taking part in this study. All of the information you provide as part of the research study will be kept confidential at all times. Direct quotations from your answers to the interview questions may be used in publications or presentations based on this study. However, your name or identifying information about you will not be reported in any publications arising from this research.

Taking part in this study is completely voluntary and everyone is completely free to refuse to participate. Participants can withdraw or stop the study at any time without any consequences. You can simply contact Louise Hanby via email or if you no longer want to continue with the research study. No questions will be asked.

Please contact Louise Hanby or her research supervisor, Dr. Nancy Salmon if you have any questions about this study.

Louise Hanby
10000507@studentmail.ul.ie

Dr Nancy Salmon
nancy.salmon@ul.ie

If you have any concerns about this study please contact:
Chairman Education and Health Sciences Research Ethics Committee
Mental Health Stigma in Ireland: Exploring Occupational Therapists Perspectives

University of Limerick

Tel (061) 234101
APPENDIX G– CONSENT FORM

Consent Section:

I, the undersigned, declare that I am willing to take part in research for the project entitled “Crossing Borders in Mental Health Care”.

- I declare that I have been fully briefed on the nature of this study and my role in it and have been given the opportunity to ask questions before agreeing to participate.
- The nature of my participation has been explained to me and I have full knowledge of how the information collected will be used.
- I am also aware that my participation in this study may be recorded (audio) and I agree to this. However, should I feel uncomfortable at any time I can request that the recording equipment be switched off. I am aware that I will receive an interview summary for review 7-10 days after the interview.
- I fully understand that there is no obligation on me to participate in this study
- I fully understand that I am free to withdraw my participation at any time without having to explain or give a reason
- I am also entitled to full confidentiality in terms of my participation and personal details
- I am aware that direct quotations from the answers to the interview questions may be used in publications or presentations based on this study. I understand that I will not be identifiable in the publications or presentations.

_____________________________         __________________________
Signature of participant                                               Date

_____________________________         __________________________
Signature of researcher                                               Date