‘IN PRINCIPLE, YES, IN APPLICATION, NO’: RWANDAN NURSES’ SUPPORT FOR INTEGRATION OF MENTAL HEALTH SERVICES

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ABSTRACT

Mental ill-health contributes significantly to the global burden of disease as the fourth leading cause of global disability. To reduce this burden, by aiming at reduction of the treatment gap, the World Health Organization recommended integration of mental health care into general health care structures, and de-institutionalisation coupled with community re-integration. Given the distribution of mental health professionals in sub-Saharan Africa, the implementation of such integration is largely the work of nurses, specifically non-mental health specialist nurses. Previous African studies report nurses’ difficulties with this integration, and their lack of preparation, knowledge, expertise, and time. Mental illness stigma is suggested to underscore a large portion of these difficulties. This quantitative study used a cross sectional survey approach to gather mental illness stigma-related data from nurses (n=102) working within in a district hospital in Rwanda. A

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self-report questionnaire used to achieve the aims of the study included personal variables (age, gender, nursing experience, nursing qualification and category of nurse) and two scales: Level of Contact Scale (LOC) and Community Attitudes towards Mental Illness Scale – Swedish version (CAMI-S). All nurses within the selected district hospital were invited to participate and a response rate of 98% (N=104) was achieved. Results support previous research regarding the type and extent of mental illness stigma, and mediating effects of familiarity. Significant associations between mental illness stereotypes and younger, less experienced nurses were also reported. However, the extent of contradiction within participant responses on the CAMI-S, across all demographics variables, suggests significant tension between nurses' desire to subscribe to a nursing and the national ideology of non-discrimination, a cherished value within the Rwandan context, and their fears associated with their stereotypical beliefs. In addition to the continued use of contact within health care worker training programmes and clinical placements, it is recommended that supportive interventions be implemented that are narrative in nature and facilitate the resolution of tension between 'what I should believe' and 'what I do believe'.

Keywords: mental illness stigma, community-based care, nurse, Rwanda

INTRODUCTION AND BACKGROUND

Mental illness affects hundreds of millions of people globally, impacting on individuals, their families and communities, and resulting in disability and economic loss (WHO, 2013:4; 2015:1). Epidemiological studies indicate that mental illness, one of the four leading causes of global disability, represent 13% of the global burden of disease (WHO, 2013:4). In response to mental health care needs, and in an attempt to reduce their burden, integration of mental health care into general health care facilities was recommended by the WHO (2001:11) and continues to be recommended both internationally (WHO, 2013:1; 2015:1) and locally (Rwandan Ministry of Health, 2014:23). Such integration is particularly pertinent to the Rwandan context of limited mental health specialist human resources and a post-genocide population. The events of the 1994 genocide within Rwanda had, and some would argue continue to have, a considerable impact on the mental health of the population, the resultant mental trauma creating a huge burden on Rwandan mental health services (Munyandamutsa, Nkubamugisha, Gex-Fabry *et al*., 2012:1755; Rwandan Ministry of Health, 2011:4). Prior to the genocide, mental health services were centralised and provided by a single specialist psychiatric hospital. In response to the urgent need for mental health care, the Rwandan Ministry of Health began in 2005 upscaling and integrating mental health services into district hospitals settings, the second level of health care within the Rwandan decentralised health care system (Rwandan Ministry of Health, 2014:23). In keeping with other authors (Petersen, Bhana, Campbell-Hall *et al*., 2009:7; Rwandan Ministry of Health, 2011:4; 2014:15)

within Africa, the ministry recognised that the success of mental health integration is largely dependent on nurses. Current international (Arvaniti, Samakouri, Kalamara *et al*., 2009:661; Corrigan, Mittal, Reaves *et al*., 2014:35; Corrigan, Powell, Fokuo *et al*., 2014:6; Dovidio & Fiske, 2012:946; Ewalds-Kvist, Hogberg & Lutzen, 2012:166) and African (James, Omoaregba & Okogbenin, 2012:32; Ssebunnya, Kigozi, Kizza *et al*., 2010:7) literature report that health care providers, including nurses, are not immune to social prejudices and have the same stigmatising attitudes as the general public regarding mental illness. Anti-stigma initiatives suggested to positively impact these negative steretypes generally include education, information sharing about mental illness, and familiarity through increased contact (Arvaniti *et al*. 2009:662; Corrigan *et al*. 2014:35; James *et al*. 2012:32; Corrigan, Powell *et al*. 2014:6). Despite the integration of Rwandan mental health services into general health care at the beginning of 2005, there is no local mental illness stigma research, specifically among nurses tasked with implementing integrated care (Rwandan Ministry of Health, 2014:23).

THE PURPOSE

The purpose of this study was to explore nurses' mental illness stigmatising attitudes in a selected district hospital in Rwanda in order to inform initiatives aimed at improving integrated services and mental health care outcomes. The research objectives were two-fold, firstly, to explore mental illness stigmatising attitudes among nurses, and secondly, to explore possible mediation of nurses socio-demographic factors (age, gender, qualification, years of nursing experience, and specifically familiarity) on mental illness stigmatising attitudes.

OPERATIONAL DEFINITION OF KEYWORDS

Familiarity: The Oxford English Dictionary defines 'familiarity-n' as 'The close acquaintance with, or knowledge of something' (OED online, 2015). Within this study familiarity is defined according to Corrigan's conceptualisation and refers to the level of personal contact with a person with mental illness, and is expressed within the level of contact (LOC) scale (Corrigan, Edwards, Qreen *et al*., 2001:223).

Mental illness: Within this study mental illness included participants' perceptions of 'mental illness', defined by the Oxford English dictionary as 'A condition which causes serious disorder in a person's behavior or thinking' (OED online, 2015).

Nurse: For the purpose of this study, the term nurse included nurses of all categories who have completed a course in nursing that is recognised by the National Council of Nurses in Rwanda (Rwandan National Council of Nurses and Midwifes, 2008:4).

RESEARCH METHODOLOGY

This study adopted a quantitative, non-experimental, descriptive cross-sectional survey design to facilitate an audit of nurses' mental illness stereotypical attitudes to map the extent of mental illness stigma, and possible mediating effects of familiarity.

RESEARCH SETTING AND PARTICIPANTS

The purposefully sampled selected district hospital is a referral hospital for 26 health centres within a specific health care district. There is no specific unit set aside for persons with mental illness; all nurses are likely to encounter mentally ill persons in any number of treatment settings within the hospital. To access the target population, an all-inclusive sampling technique was used to invite all the nurses working in the district hospital (N=104) to participate. Due to unplanned leave one hundred and two nurses (n=102) participated, yielding a response rate of 98%.

DATA COLLECTION INSTRUMENT

A self-report questionnaire was divided into three sections and contained two data collection scales. The first section of the self-report questionnaire established demographic data (age, gender, nursing experience, qualification and category of nurse) selected in keeping with the extent that these variables appeared within current stigma studies (Morris, Scott, Cocoman *et al*., 2012:464; Mårtensson, Jacobsson & Engström, 2014:783).

The second section contained the Level of Contact (LOC) scale (Corrigan *et al*, 2001:223). The LOC, developed by Corrigan *et al.* (2001), measures the extent of participants' familiarity with persons with a mental illness, and familiarity defined as the level of intimate contact with a person with a mental illness. Table 1 presents the LOC's 11 item statements. Each statement contains a brief description of familiarity, intimacy of contact, with a person with a mental illness. Statements vary from least familiar, 'I have never observed a person that I was aware had a mental disorder' to most familiar, 'I have a mental disorder'; greater levels of familiarity achieving greater scores. Participants are asked to answer yes or no regarding all 11 statements, only the highest score, the greatest level of familiarity, recorded, each respondent generates one score, ranging 1–11, for the LOC. Use of the LOC scale is supported by an inter-rater reliability of 0.83 (Holmes, Corrigan, Williams *et al*., 1999:452) and current literature supports the measurement of familiarity (Mårtensson *et al*., 2014:783).

The third section of the self-report questionnaire contained the Swedish version of the Community Attitudes towards Mental Illness (CAMI-S) instrument (Hogberg, Magnusson, Ewertzon *et al*., 2008:3). The original Community Attitudes towards Mental Illness scale (CAMI) was designed as a population survey tool by Taylor, Dear, and Hall (1979) and Taylor and Dear (1981) to assess the attitudes of the general public

towards persons with mental illness. The Swedish version contains 20 item statements, and has three subscales: open minded or pro-integration (Factor 1, items 1–9), fear and avoidance (Factor 2, items 10–15), and community mental health ideology (Factor 3, items 16–20). Participants rate each of the 20 item statements on a five option Likert type scale – 'strongly agree', 'agree', 'I am neutral', 'disagree', 'strongly disagree'. Response choices are scored from one to five, producing an overall CAMI-S score and three subscale scores, the greater the score indicative of greater mental illness stigma. The original CAMI has been used extensively, and validity and reliability of its reduction to a three factor scale supported, in Europe (Morris *et al*., 2011:466–467); in Asia (Song, Chang,Yi *et al*., 2005:1); and Africa (Ukpong & Abasiubong, 2010:58; Barke, Nyarko & Klecha, 2011:1195).

The self-report questionnaire was translated into French by a French-English linguist. A test re-test of the French translation of the CAMI-S achieved a Cronbach's alpha reliability coefficient suggesting good reliability for the total scale (0.900) and for subscales (open minded and pro-integration (0.811); fear and avoidance (0.702); and community mental health ideology (0.757). The LOC scale was reviewed for coherence of each of the statements within the French version by the French-English linguist and the researchers. Within the LOC scale, and item 7 within the CAMI-S, 'illness' was replaced with 'disorder' in keeping with local linguistic expression.

Informed implied consent was used to reduce participants' perceived risk to anonymity and confidentiality, and reduce social desirability bias influencing participants' responses. The expression of discrimination is specifically sensitive in Rwanda, the 1994 genocide, fuelled by discrimination of one group against another, is a source of national shame.

DATA COLLECTION

Data collection took place from 18th February, 2013 until 26th February, 2013, and following ethical approval from the University of KwaZulu-Natal (HSS/1280/012M) and the Kigali Health Institute Institutional Review Board (KHIIRB) on behalf of the National Ethical Committee (NEC) (KHI/IRB/19/2013). In addition, hospital, specifically nursing, management permission was obtained. The implemented data collection schedule extended over seven consecutive days. Data was collected per unit via three data collection sessions to accommodate all shifts. Information sheets were distributed to all units by the Rwandan researcher three days prior to the first day of data collection.

DATA ANALYSIS

Using a codebook data was entered into the statistical computer package SPSS, Version 21. Although the level of familiarity (LOC) was viewed as a demographic variable,

it was treated as an independent variable and the results of the scale are described separately from other demographic data.

Within the CAMI-S reverse scoring was applied to items 4, 5, 6, 10, 11, 12, 13, 17 and 20 (Hogberg *et al*., 2008:3), resulting in higher scores indicating greater mental illness stigma. For each item and subscale a score was calculated and converted to a percentage (%). The total CAMI-S score represents a percentage already (20x5). Descriptive statistics computed included frequency counts, measures of central tendency, and non-parametric tests of association. Strongly agree and agree, and strongly disagree and disagree, were conflated to one code, agree and disagree, respectively. Non-parametric tests included the Mann Whitney U test of association between CAMI-S scores, subscales and total, and gender, the Kruskal Wallis H test to compute associations of CAMI-S scores, subscales and total, and age, years of nursing experience, nursing qualification and category of nurse. Lastly, Spearman's rho correlation coefficient test was used to compute correlations between CAMI-S scores, item, subscales and total, and participants LOC score.

RESULTS

Table 1 displays the LOC scale's descriptions of levels of familiarity in ascending order, the allocated score in the first column, familiarity statement in the second column and frequency of specific levels of familiarity (n (%)) in the last column. The majority of participants reported high levels of familiarity. Level 7, 'my job involves providing services or treatment to person with a mental disorder', was the most commonly occurring score (38.2%, n=39), supporting the assumption that nurses within the Rwandan district hospital would likely have contact with persons with mental illness within their work environment. In addition to this group, more than half the participants (56.8%, n=58) scored even higher levels of familiarity, from a score of 8, 'A friend of my family has a mental disorder', to 11, 'I have a mental disorder'. Familiarity, LOC scale score, negatively correlated with mental illness stigma as reflected in the total CAMI-S score (rho= -.379, n=102, p∠0.001), indicating that greater familiarity, contact, with a person with mental illness reduces mental illness stigma.

Table 1: Participants level of familiarity LOC

score	Contact experience in ascending levels of familiarity	n (%)
1	I have never observed a person that I was aware had a mental disorder	0
2	I have observed in passing a person I believed may have had a mental disorder	1 (1)
3	I have watched a movie or television show in which a character depicted a person with a mental disorder	0

4	I have watched a documentary on television about mental disorder	0
5	I have observed a person with a mental disorder on a frequent basis	1 (1)
6	I have worked with a person who had a mental disorder at my place of employment	3 (2.9)
7	My job involves providing services or treatment to persons with a mental disorder	39 (38.2)
8	A friend of my family has a mental disorder	15 (14.7)
9	I have a relative who has a severe mental disorder	24 (23.5)
10	I live with a person who has mental disorder	15 (14.7)
11	I have a mental disorder	4 (3.9)

Table 2 displays CAMI-S item descriptors and participant responses. Results indicate some tension associated with integration of mental health services, and persons with mental illness, within local communities. The substantive number of participants that indicated agreement with items 1, 7, 8, 9, 14, 16, 17, 18 and 19 contradicted these agreement responses by the substantive levels of agreement with items 4, 6, 10, 11, 13 and 20. Agreement that we need to be more tolerant (item 8) and accept community integration of mental health services (item 1) as mentally illness is the same as other illnesses (item 7) and the mentally ill are not more dangerous than other persons (item 9) and we need not fear them (item 14) were contradicted by the substantive agreement that it is best to avoid persons with mental problems (item10), keep these persons separate from the community (item 20) and locked away (item13). Responses to items 16, 17 and 18 are directly contradicted by responses to item 20. In addition, researchers noted participants' increased neutral stance to specific items. The number of participants who took a neutral stance to perceived risk (item 5) and the need for public protection (item 15) may reflect discomfort with 'owning' negative stereotypes. The substantive agreement, and limited neutral positions taken, in response to item 19 is argued to reflect a degree of social desirability bias.

Table 2: CAMI-S individual Item scores

Item descriptive statements	**Frequency of participant responses**		
	Agree n (%)	**Neutral n (%)**	**Disagree n (%)**
1. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community	73 (71.6)	17 (16.7)	11 (11.7)
2. Most persons who were once patients in a mental hospital can be trusted as babysitters	60 (58.9)	12 (11.8)	30 (29.4)

3. Locating mental health services in residential neighbourhoods does not endanger local residents	63 (61.8)	18 (17.6)	21 (23.4)
4. Mental health facilities should be kept out of residential neighbourhoods	58 (56.8)	8 (7.8)	36 (35.3)
5. Having mental patients living within residential neighbourhoods might be a good therapy, but the risks to the residents are too great	14 (13.7)	46 (45.1)	42 (41.2)
6. Local residents have good reason to resist the location of mental health services in their neighbourhood	46 (45.1)	23 (22.5)	33 (32.4)
7. Mental disorder is an illness like any other	77 (75.5)	6 (5.9)	18 (17.6)
8. We need to adopt a far more tolerant attitude towards the mentally ill in our society	83 (81.4)	18 (17.6)	1 (1)
9. The mentally ill are far less of a danger than most persons suppose	70 (68.7)	12 (11.8)	20 (19.6)
10. It is best to avoid anyone who has mental problems	71 (69.6)	17 (16.7)	14 (13.7)
11. I would not want to live next door to someone who has been mentally ill	61 (59.9)	16 (15.7)	25 (24.5)
12. It is frightening to think of persons with mental problems living in residential neighbourhoods	41 (40.2)	7 (6.9)	54 (53)
13. The best way to handle the mentally ill is to keep them behind locked doors	71 (69.7)	15 (14.7)	16 (15.6)
14. Residents have nothing to fear from persons coming into their neighbourhood to obtain mental health services	64 (62.7)	21 (20.6)	17 (16.7)
15. Less emphasis should be placed on protecting the public from the mentally ill	43 (42.2)	30 (29.4)	29 (28.4)
16. The best therapy for many mental patients is to be part of a normal community	81 (79.5)	17 (16.7)	4 (3.9)
17. The mentally ill should not be treated as outcasts of society	80 (78.5)	12 (11.8)	10 (9.8)
18. As far as possible, mental health services should be provided through community facilities	72 (70.6)	19 (18.6)	11 (10.8)
19. No one has the right to exclude the mentally ill from their neighbourhood	86 (84.3)	10 (9.8)	6 (5.9)
20. The mentally ill should be isolated from the rest of the community	74 (72.5)	13 (12.7)	15 (14.7)

As displayed in table 3, subscales results within the CAMI-S continued to reflect tension and contradiction. Measures of central tendency and distribution indicated less mental illness stigma on subscale 3, 'community mental health ideology', (Md= 36; Mo= 20; 25th percentile= 24%: 75th percentile= 52%) than subscale 1, 'open minded and pro integration', (Md= 47; Mo= 42; 25th percentile= 38%; 75th percentile= 58%) and subscale 2, 'fear and avoidance', (Md= 47; Mo= 47; 25th percentile= 40% ;75th percentile= 60%). Results indicate that the extent of negative stereotypes between the 'open minded' and 'pro integration' subscale and 'fear and avoidance' subscale is similar. However, percentile results indicate slightly higher negative stereotypes on the 'fear and avoidance' subscale than the 'open minded and pro integration' subscale. Total scores for the CAMI-S suggest a slightly skewed distribution. The skew is largely influenced by the 'community mental health ideology' subscale.

Table 3: CAMI-S subscales results

		Open minded and pro integration	Fear and avoidance	Community mental health ideology	Total score
N	Valid	102	102	102	102
	Missing	0	0	0	0
Median		47.00	47.00	36.00	44.00
Mode		42	47	20	40
Skewness		.302	.451	.379	.528
Std. Error of Skewness		.239	.239	.239	.239
Minimum		22	23	20	25
Maximum		82	80	68	77
Percentiles	25	38.00	40.00	24.00	37.75
	50	47.00	47.00	36.00	44.00
	75	58.00	60.00	52.00	54.00

Statistically significant age associations with specific CAMI-S items and the subscale 'open minded and pro integration', presented in table 4, indicated greater mental illness stigma among the younger age group (21–30 years). Years of nursing experience and mental illness stigma were also significantly associated with specific CAMI-S items, the 'open minded pro integration' subscale, and the participants' total CAMI-S score indicating that participants with less nursing experiences (0–8 years) expressed greater mental illness stigma.

Table 4: Significant associations between demographic variables and CAMI-S item, and subscale scores

CAMI-S item or Subscale	Age group 21-30 years	Years of nursing experience
Item 1: Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community	((3, =102) =9.554, p=.023)	((3, =102) =12.117, p=.007)
Item 2: Most persons who were once patients in a mental hospital can be trusted as babysitters		((3, =102) =12.064, p=.007)
Item 3: Locating mental health services in residential neighbourhoods does not endanger local residents	((3, =102) =8.055, p=.045)	((3, =102) =9.853, p=.020)
Item 4: Mental health facilities should be kept out of residential neighbourhoods	((3, =102) =13.266, p=.004)	((3, =102) =8.871, p=.031)
Item 6: Local residents have good reason to resist the location of mental health services in their neighbourhood		((3,=102)=9.530, P=.023)
Item 8: We need to adopt a far more tolerant attitude towards the mentally ill in our society		((3,=102)=11.439,p=.010)
Item 9: The mentally ill are far less of a danger than most persons suppose	(3, =102) =9.385, p=.025)	((3,=102)=14.686, P=.002)
Item 10: It is best to avoid anyone who has mental problems		((3, =102) =9.974, p=.019)
Item 20: The mentally ill are far less of a danger than most persons suppose	(3,=102) =10.694, p=.014)	((3,=102)=11.309, p=.010)
Subscale: open minded and pro integration	((3, =102) =10.557, p=.014)	((3,=102)=17.071, p=.001)
total CAMI-S score		((3,=102)=12.056, p=.007)

DISCUSSION OF RESULTS

The extent of mental illness stigma and the mediating effects of familiarity are in keeping with previous African (Adewayu & Oguntade, 2007:4; Barke, *et al*, 2011:1195; Ukpong & Abasiubong, 2010:58) and international studies (Bjorkman, Angelman & Jonsson, 2008:172; Mårtensson *et al*., 2014:784; Morris *et al*., 2011:466). Mental illness stigmatising attitudes are present within Rwandan nurses. However, the extent of contradiction evident in participants' responses, while unexpected, is argued to illustrate that current research and or anti-stigma initiatives focus on knowledge of, and programmes aimed at reinforcing, professional values with little focus on resolving discordant personal-professional values and beliefs (Dovidio & Fiske, 2012;949; Nelson & Franks, 2008:167–168). Although participants' responses reflected an understanding of the prescribed mental health integration ideology, and behaviour, they also expressed a personal desire for social distance from persons with mental illness. The extent of contradictory responses is argued to reflect a conflict, possibly unconscious, between professional and personal values and beliefs that influences practitioner agency (Dovidio & Fiske, 2012:945; Nelson & Franks, 2008:174).

CONCLUSION AND RECOMMENDATIONS

Participants' understanding the professional point of view, expected behavioural responses, did not prevent their personal point of view 'leaking' into the dialogue in the form of contradiction or the adoption of a neutral position. Additional qualitative research is recommended that encourages dialogue related to discordant professional and personal values and beliefs to facilitate nurses' effective promotion of community integration of mental health care services (Dovidio & Fiske, 2012:949; Nelson & Franks, 2008:168). Initiatives that are narrative in nature offering general health care practitioners, specifically nurses, space for reflexivity and reduction of tensions between discordant professional and personal beliefs are required (Dovidio & Fiske, 2012:945; Nelson & Franks, 2008:167). More specifically, intervention studies are required to obtain empirical data related to the effectiveness of the introduction of this narrative and if such interventions facilitate the progression and effectiveness of community integration of mental health care services.

LIMITATIONS OF THE STUDY

The study was conducted in only one district hospital in Rwanda and findings may not be generalised to other Rwandan district hospitals.

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