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Stigma and discrimination by professionals from Integrated Continuing Care Units

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Resumo

Introdução: O estigma aliado à doença mental (DM) verifica-se como uma grande barreira no acesso ao tratamento e pode estar aliado a cuidados de pior qualidade nos sistemas de saúde. A Rede Nacional de Cuidados Continuados Integrados (RNCCI) presta cuidados continuados integrados a pessoas que, independentemente da idade, se encontrem em situação de dependência, através da intervenção de uma equipa multidisciplinar.

Objetivo: Descrever os níveis de estigma e discriminação relativos à pessoa com DM pelos profissionais que intervêm nas Unidade de Cuidados Continuados Integrados (UCCI) de âmbito geral.

Métodos: Trata-se de um estudo quantitativo, observacional, analítico e transversal com uma amostra de 163 participantes. Procedeu-se à aplicação de um questionário sociodemográfico e dois instrumentos de avaliação estandardizados, o Attribution Questionaire (AQ-27) e o Community Attitudes Toward Mentally (CAMI).

Resultados: No AQ-27 foi possível verificar que o género masculino apresenta maior estigma e discriminação face ao feminino, sendo que este último apresenta mais atitudes de ajuda para com as pessoas com DM (p=0.188). A região do Algarve destaca-se como a mais estigmatizante segundo o instrumento CAMI (p=0.816). Adicionalmente, mais anos de experiência profissional associa-se também a mais atitudes estigmatizantes (p=0.111). Nos profissionais de ECCI observam-se piores resultados (p=0.701). Os terapeutas da fala e auxiliares de ação médica são os profissionais que apresentam mais estigma. Contrariamente destacam-se os psicólogos (p=0.023). Não ter familiar com DM demonstra ter impacto na presença de estigma e discriminação (p=0.280).

Conclusões: Existem baixos níveis de estigma em relação à pessoa com DM pelos profissionais das RNCCI de âmbito geral.

Palavras-chave: Doença Mental; Estigma; Profissionais de UCCI; Serviços de Saúde; Tratamento

Abstract

Introduction: The stigma associated with mental illness (MI) is a major barrier to accessing treatment and can be linked to poorer quality care in health systems. The National Continuing Care Network (NNICC) provides integrated continuing care for people who, regardless of age, are in a situation of dependency, through the intervention of a multidisciplinary team.

Aim: To describe the levels of stigma and discrimination against people with MI among professionals working in the general Integrated Continuing Care Unit (ICCU).

Methods: This is a quantitative, observational, analytical and cross-sectional study with a sample of 163 participants. A sociodemographic questionnaire and two standardised assessment instruments were applied, the Attribution Questionaire (AQ-27) and the Community Attitudes Toward Mental Illness (CAMI).

Results: In the AQ-27 it was possible to see that the male gender shows greater stigma and discrimination than the female gender, with the latter showing more helpful attitudes towards people with MI (p=0.188). The Algarve region stands out as the most stigmatising according to the CAMI instrument (p=0.816). In addition, more years of professional experience is also associated with more stigmatising attitudes (p=0.111). ICCT professionals had worse results (p=0.701). Speech therapists and medical assistants are the professionals with the most stigma. On the other hand, psychologists stand out (p=0.023). Not having a relative with MI has been shown to have an impact on the presence of stigma and discrimination (p=0.280).

Conclusions: There are low levels of stigma towards people with MI among in the general ICCU professionals.

Keywords: Mental Illness; Stigma; ICCU professionals; Health services; Treatment

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1. Introduction

The growing number of studies in the area of mental health has been widespread throughout the world, given its importance for the well-being of the population. According to the World Health Organisation (WHO), mental health is considered an essential part of our health and well-being. In addition, having good mental health is related to a better ability to connect and function (WHO, 2022).

In general, people with mental disorders are often stigmatised, discriminated against and denied essential rights and care. In addition, this is followed by social isolation, influence and limitation in education and unemployment (Corrigan et al., 2000; WHO, 2022).

Thus, the stigma associated with mental illness (MI) is a major barrier to accessing treatment and can have a significant impact on the potential for recovery (Knaak et al., 2017). The concept make of stigma was proposed by Erving Goffman in 1961 as a complex social process of labelling, devaluation and discrimination involving an interconnection of cognitive, emotional and behavioural components (Goffman Erving, 1963; Knaak et al., 2017; Lyon & Mortimer-Jones, 2021; Moreira et al., 2021). According to Corrigan & Penn (1999), stigma can have even more of an impact on a person's life than the symptoms of MI itself (Corrigan & Penn, 1999).

In the health field, stigmatising attitudes, the use of stereotypes and the attribution of characteristics to the patient before assessing their state of health can have an impact, particularly on the professional's involvement in responding to the health episode or condition, poor prognosis, longer waiting times and verbal abuse (Ghuloum et al., 2022; Gras et al., 2015; Lien et al., 2019). In this way, compromising the adequacy of care can contribute to the worsening of the individual's condition. Thus, the stigma related to mental illness in healthcare systems is identified as a barrier to treatment and recovery, as well as poorer quality care for individuals with mental illnesses (Del Olmo-Romero et al., 2019; Lien et al., 2019; Rivera-Segarra et al., 2019). In addition, in many healthcare settings, stigmatisation can cause more harm than the disease itself and can significantly contribute to a decrease in the quality of life of users of a healthcare service (Carrara et al., 2019).

Research shows that health professionals are just as likely to have stigmatising beliefs and behaviours towards people with MI as the general population. They share stigmatising attitudes, regarding people with MI as incompetent, violent and dangerous (Rivera-Segarra et al., 2019). In addition, qualitative studies show that users of general and mental health services complain of

stigmatising and discriminatory attitudes on the part of professionals (Del Olmo-Romero et al., 2019).

It is therefore important for healthcare professionals to be aware of the adverse impact that stigmatising attitudes and discriminatory behaviour can have on healthcare consumers (Carrara et al., 2021).

Schizophrenia and depression are the most common mental disorders to be stigmatised (Jauch et al., 2023; Rivera-Segarra et al., 2019). It should be noted that recent studies have found that professionals stigmatise people with schizophrenia more than those with depression. In addition, they often perceive people with personality disorders as manipulative and less deserving of care. People with suicidal ideation and substance abuse have similarly negative attitudes and emotions (Rivera-Segarra et al., 2019).

According to the study by Eliut Rivera-Segarra et al. (2019), the attitudes and beliefs of health professionals can have a direct impact on their interventions. One example from the same study is that the narratives given by professionals show that they actively ignore their complaints and only refer them to a mental health professional, even though their main complaint is physical (Rivera-Segarra et al., 2019).

Although most of the research carried out on this subject mentions the presence of stigma among health professionals, a study carried out as part of the "Bicho de 7 Cabeças Project" showed that health professionals have better attitudes and behaviours towards people with MI compared to other professionals in the education and social fields. In addition, he justifies the results as being due to greater training and daily contact with people with MI in their jobs (Simões de Almeida et al., 2023).

MI related stigma in health services is an area that has been analysed and identified as a cause for concern. There is therefore a strong impetus to carry out research into this issue (Jauch et al., 2023). Interventions through anti-stigma education have been carried out all over the world as a way of combating this problem (Ghuloum et al., 2022; Lien et al., 2019; Raj, 2022). Thus, there is a need to determine the current state of attitudes towards MI in Portugal, focussing on general Integrative Continuing Care Units (ICCU).

ICCU are a set of services that aim to provide a response to people in situations of dependency and in need of specialised care. They were created in 2005 by Decree-Law no. 101/2006, of 6th June, under the Ministries of Health and Labour and Social Solidarity, and became the National Network for Integrated Continuing Care (NNICC) (Armindo & Dourado, 2022; Monteiro et al.,

2013). The objectives are to provide health care and social support in a continuous and integrated manner to people who, regardless of age, are in a situation of dependency as a result of illness or the need to prevent the worsening of a chronic illness. The main focus is on promoting the overall recovery of the person, promoting their autonomy and maximising their functionality through rehabilitation, readaptation and family reintegration, as well as improving the capacity of families to deal with multimorbidity situations, through the intervention of a multidisciplinary team (Armindo & Dourado, 2022; Monteiro et al., 2013; Unidade de Gestão e Acompanhamento da Rede Nacional de Cuidados Continuados Integrados, 2022). The NNICC is made up more specifically of areas such as medicine, nursing, physiotherapy, occupational therapy, speech therapy, psychology and social work. The ICCU with a general scope are divided into 4 types according to the duration of the support provided: Convalescence Unit (CU), up to 30 days; Medium Duration and Rehabilitation Unit (MDRU), from 30 to 90 days; Long Duration and Maintenance Unit (LDMU), more than 90 days; Integrated Continuous Care Team – Domiciliary (ICCT). In Portugal, as of March 2023, there are a total of 672 institutions (53 – CU; 134 – MDRU; 189 – LDMU; 296 – ICCT). However, although the focus is on general ICCU, there are NNICC responses in the field of Mental Health that aim to respond to situations with varying degrees of psychosocial disability and dependency resulting from serious mental illness (Serviço Nacional de Saúde, 2023; Unidade de Gestão e Acompanhamento da Rede Nacional de Cuidados Continuados Integrados, 2022).

Since no study has ever been published in Portugal evaluating stigma and discrimination among NNICC professionals, the aim of this study is to describe the levels of stigma and discrimination towards people with MI among professionals working in general ICCU.

2. Methods

2.1. Type of study

This study is characterised as quantitative, observational, analytical and cross-sectional, since its purpose is to assess the relationship between variables, using measures based on assessment instruments that result in numerical data and then statistical data analysis. Thus, there is no intervention on the part of the researchers, only observation and recording of data from the sample. It is considered to be analytical and cross-sectional in nature, as the aim is to understand whether there is stigma and discrimination associated with people with MI at a given point in time (Ward Creswell, 2018; Yilmaz, 2013).

2.2. Participants

The sampling method was non-probabilistic snowball sampling (Marôco, 2018). The study involved an online questionnaire using the *Google Forms* platform, comprising sociodemographic questions, as well as the application of two evaluation instruments as a way of assessing stigma towards people with MI. The questionnaire was publicised nationwide. The study's inclusion criteria were individuals aged over 18 working in a general Integrated Continuing Care Unit.

2.3. Instruments

To carry out this study, a sociodemographic questionnaire and two standardised assessment instruments were used: the Attribution Questionaire (AQ-27) and the Community Attitudes Toward Mental Ilness (CAMI).

2.3.1. Sociodemographic questionnaire (appendix 1)

The sociodemographic questionnaire was developed to characterise the sample and consisted of questions such as age, gender, nationality, marital status, educational qualifications, place of work in an ICCU, professional area, length of time working in an ICCU, type of ICCU in which they work, presence of a family member with MI, degree of kinship and contact with a family member with MI.

2.3.2. Evaluation Instruments

The AQ-27 is an assessment tool that involves 9 dimensions of stigma: Responsibility, Pity, Irritation, Dangerousness, Fear, Help, Coercion, Segregation and Avoidance (Sousa et al., 2008). The AQ-27 is made up of different items with variations in the characteristics of the MI being assessed, especially the severity of the condition. The AQ-27 comprises a report of an individual with schizophrenia, followed by 27 statements that must be scored using a 9 point likert scale, where 1 means "not at all" and 9 means "very much". The results are calculated using the average scores obtained for the items that make up each dimension. The Avoidance questions are scored inversely. Higher scores correspond to greater stigma towards people with MI and each of the dimensions of the AQ-27 varies between 3 and 27 points (Pinto et al., 2020; Sousa et al., 2012). The preliminary version of the AQ-27 in Portuguese has an alpha of 0.88, close to that reported in other studies carried out in Portugal, namely 0.7631 and 0.83 (Ferrari et al., 2020; Sousa et al., 2012).

The CAMI – Community Attitudes towards Mental Illness is an instrument validated for the Portuguese population and developed by Taylor & Dear in 1981 to assess the attitudes of the general public towards people with MI. (Lopes, 2020; Taylor & Dear, 1981). Initially this questionnaire consisted of 40 questions, but later adjustments were made so that there was a scale with 27 questions and a shorter one with 12 questions. This study used the 27-question scale, which has been validated for the Portuguese population. The scale is divided into two factors, specifically prejudice and exclusion, corresponding to questions 1-3, 11-18, 25 and 26, and tolerance and support in the community, corresponding to questions 4-10, 19-24 and 27. The classification is made according to a likert scale from 1 (Strongly Agree) to 5 (Strongly Disagree) in questions 1-3, 11-18, 25 and 26, while in questions 4-10, 19-24 and 27 it is made inversely, with 5 (Strongly Agree) and 1 (Strongly Disagree). The higher the score, the less stigmatising the attitudes. *Cronbach's* alpha for prejudice and social exclusion was 0.699 and for tolerance and support in the community 0.634 (Lopes, 2020).

2.4. Procedures

Initially, scientific research was carried out, outlining the study's objective and questions, as well as analysing and selecting the assessment instruments to be used. The study was then sent to the Ethics Committee of the School of Health, Polytechnic Institute of Porto, and was approved under process number CE0049D.

Data was then collected by sharing the online questionnaire with professionals from various ICCU. Emails were sent to the units and shared on social networks with the aim of obtaining sociodemographic data for the application of the two evaluation instruments mentioned. Based on the answers to the questionnaire, a document was generated in Microsoft Office Excel format for the data to be analysed using the *Statistical Package for the Social Science (SPSS) software*.

In order to take part in the study, the participants had to complete a declaration of informed consent, in accordance with the *Declaration of Helsinki* (WMA, 2001). The statement was made up of information on the purpose of the study, the methods used and the processing of the data. In order to ensure the protection of the participants, they were not identified and all the data collected was used solely and exclusively for academic purposes, ensuring total anonymity and confidentiality of the information collected.

2.5. Statistical Analysis

After collecting the data, a statistical analysis was carried out using the *Statistical Package for the Social Science (SPSS)* 28.0 for *Windows software* with a significance level of 0.05 and a 95% confidence interval for all the statistical tests applied (Marôco, 2018; Pestana Maria, 2014).

Initially, the variables were recoded – age, gender, nationality, marital status, educational qualifications, professional area, region of the ICCU in which they work, length of time working in a ICCU, type of ICCU, presence of a family member diagnosed with MI and questions from the selected assessment instruments. The characteristics of the sample were analysed using descriptive statistics. Nominal variables were categorised using absolute (n) and relative (%) frequencies. Quantitative variables were categorised using measures of central tendency such as mean (X) and measures of dispersion such as standard deviation (SD), minimum and maximum. Normality was checked for all variables using *skewness* and *kurtosis*. Asymmetry measures the distribution's deviation from symmetry, while *kurtosis* measures the distribution's flattening from a normal distribution (Cain et al., 2017). Thus, when it was found that the variables did not follow normality, non-parametric tests were carried out and when they did follow normality, parametric tests. Comparisons between the assessment instruments (total score and subscales) and the variables were made using independent *Student's t-tests* and one-way *ANOVA*. *Pearson's* and *Spearman's* correlation coefficients were used to assess the association between the instrument values and age and years of experience in ICCU (Marôco, 2018).

3. Results

3.1. Characterisation of the sample

The study sample is characterised by 163 individuals who work in a general ICCU setting, of whom 146 (89.6%) are female and 17 (10.4%) male (Table 1). The average age of the individuals was 34.36 years. Most of the participants were Portuguese. Regarding marital status, 44.2% were single and 32.5% were married. Regarding academic qualifications, most of the participants had a bachelor (64.4%). In addition, data was collected on the region in which they worked in the ICCU, with the highest number of participants from the North (57.7%) and Centre (27.7%). It was possible to identify 14 professional areas, with more participants in Nursing (23.9%), occupational Therapy (22.1%), Physiotherapy (11.7%) and Psychology (6.1%). Concerning the number of years they had been working in the ICCU and the type of ICCU they worked in, the majority of participants had been working for between 1 and 5 years (41.7%) and in more than one unit

(50.3%), respectively. It should also be noted that 25.8% of the participants in the sample have a family member with MI.

Table 1: Socio-demographic characterisation of the participants and sociodemographic characterisation regarding the variables: Region of the ICCU where they work, length of time working in a ICCU, type of ICCU where they work, professional area and presence of a relative with MI.

Variable	Minimum	Maximum	Mean (SD)		
Age	21	59	34.36±5.62		
				(n)	(%)
Gender		Female		146	89.6
		Male		17	10.4
Nationality		Portuguese		160	98.2
		Brazilian		1	0.6
		French		1	0.6
		Moldavian		1	0.6
Marital Status		Single		72	44.2
		Married		53	32.5
		Cohabiting/living together		30	18.4
		Divorced		6	3.7
		Widowed		2	1.2
Academic qualifications		Secondary Education		15	9.2
		Vocational Course		12	7.4
		Bachelor		105	64.4
		Master		31	19.0
		Doctorate		0	0
Region where you work		North		94	57.7
		Centre		44	27.0
		LTV		15	9.2
		Alentejo		6	3.7
		Algarve		4	2.5
Professional Area you work in ICCU		Medical action assistant		22	13.5
		Nurse		39	23.9
		Physiotherapist		19	11.7
		Physiatrist		1	0.6
		General Practice		1	0.6
		Nutritionist		3	1.8
		Psychologist		10	6.1
		Speech Therapist		3	1.8
		Occupational Therapist		36	22.1
		Social Worker		13	8.0
		Cleaning Auxiliary		1	0.6
		Socio-cultural Animator		5	3.1
		Technical Director		8	4.9
		Receptionist		2	1.2
Time working in a LTV		Less than 1 year		20	12.3
		1 - 5 years		68	41.7
		More than 5 years		40	24.5
		More than 10 years		35	21.5
		CU		15	9.2

Type of ICCU you work in	MDRU	27	16.6
	LDMU	37	22.7
	ICCT	2	1.2
	More than one service	82	50.3
Presence of a relative with MI	Yes	42	25.8
	No	121	74.2

LTV – Lisbon and Tagus Valley, CU – Convalescence Unit, MDRU – Medium Duration Unit, LDMU – Long Duration Unit, ICCT – Integrated Continued Care Team (Home Support).

3.2. Statistical analysis of the AQ-27 and CAMI evaluation instruments

The AQ-27 scale is divided into nine subscales. The higher the value, the greater the stigma towards people with mental illness.

The subscale with the highest value is Help (Table 2). In the CAMI assessment tool, the minimum score for the Prejudice and Exclusion factor was 39.00 and the maximum was 65.00. In the Tolerance and Support in the Community factor, the minimum was 41.00 and the maximum was 70.00. As for the total score, the minimum was 81.00 and the maximum 135.0 (Table 4). The average total score was 115.60. In this assessment tool, higher values represent lower stigmatising attitudes towards people with mental illness.

Table 2: Total score AQ27 according to the nine dimensions, factors and Total Score CAMI.

		Minimum	**Maximum**	**(X ± SD)**
Total Score AQ27	Responsability	3.00	23.00	7.58±3.76
	Pity	5.00	27.00	15.71±5.45
	Anger	3.00	27.00	6.53±3.69
	Dangerousness	3.00	27.00	7.49±4.12
	Fear	3.00	27.00	7.02±4.10
	Help	9.00	27.00	23.46±3.72
	Coercion	5.00	25.00	14.83±4.05
	Segregation	3.00	27.00	7.21±4.36
	Avoidance	3.00	27.00	11.09±5.36
CAMI: Prejudices and Social Exclusion		39.00	65.00	57.91±5.41
CAMI: Tolerance and support in the community		41.00	70.00	57.69±5.89
Total Score CAMI		81.00	135.00	115.60±9.82

X– mean; SD – standard

3.3. Comparative analysis of sociodemographic variables with assessment instruments

Table 3 shows the results of the subscales of the AQ-27 instrument according to the sociodemographic variables. For the gender variable, at a significance level of 0.05, the AQ-27 subscales Irritation and Segregation are significantly different. At the same time, the same is true for the professional area variable, for the Fear, Help and Segregation subscales. In the remaining variables, region of the ICCU, years of work in the ICCU, type of ICCU and presence of a family member with MI are not significantly different, since $p > 0.05$.

There was greater stigma towards people with MI among individuals working in the Algarve region, as seen in the Pity, Coercion and Segregation subscales of the AQ-27. One of the regions with the least stigma and discrimination is the Alentejo, where the Dangerousness and Fear subscales are the lowest. With regard to years of experience in ICCU, professionals with less than one year's experience in ICCU scored higher on the Pity subscale. As for the type of ICCU, the CU and ICCT have values that are associated with greater stigma and discrimination, visible in the Responsibility, Fear and Dangerousness subscales. In the professional area, speech therapy stands out, especially in the Pity and Dangerousness subscales. As for the presence of a family member with MI, the absence of a family member corresponds to greater stigma, as can be seen in the Dangerousness, Fear and Avoidance subscales.

Table 3: AQ27 subscales values according to participant characteristics.

		AQ27 A		AQ27 B		AQ27 C		AQ27 D		AQ27 E		AQ27 F		AQ27 G		AQ27 H		AQ27 I	
Variable		(X±SD)	*p*	(X±SD)	*p*	(X±SD)	*p*	(X±SD)	*p*	(X±SD)	*p*	(X±SD)	*p*	(X±SD)	*p*	(X±SD)	*p*	(X±SD)	*P*
Gender	Female	7.71±3.85	0.146*	15.87±5.49	0.563*	6.28±3.24	0.002*	7.38±3.87	0.276*	6.92±3.83	0.216*	23.76±3.57	0.188*	14.83±3.89	0.077*	7.10±3.97	0.030*	10.88±5.19	0.563*
	Male	6.47±2.69		14.35±5.10		8.76±6.12		8.41±5.92		7.94±6.02		20.88±4.09		14.82±5.39		8.12±6.97		12.88±6.51	
Region where you work	North	7.81±3.99	0.703**	15.66±5.46	0.980**	6.50±3.80	0.621**	7.57±3.98	0.656**	7.07±4.08	0.565**	23.51±3.41	0.955**	14.82±3.95	0.136**	7.04±4.12	0.367**	11.23±5.23	0.937**
	Centre	7.55±3.30		15.91±5.58		7.11±3.69		7.93±4.80		7.59±4.66		23.41±4.14		15.40±4.03		7.89±5.92		10.95±5.68	
	LTV	7.33±4.27		15.06±6.31		5.66±3.37		6.46±3.60		5.80±3.27		23.60±3.56		12.86±4.01		5.73±3.77		10.13±5.06	
	Alentejo	5.83±2.86		16.00±4.82		6.16±3.60		6,33±2.80		5.66±2.16		22.33±6.65		13.66±4.08		6.83±3.31		12.16±6.76	
	Algarve	6.25±2.63		16.75±2.50		5.00±2.83		6.00±2.45		6.25±2.50		24.00±2.45		17.75±5.56		9.75±6.40		11.25±5.74	
years of work in ICCU	Less than 1 year	7.55±4.19	0.904**	16.75±6.12	0.436**	6.50±5.35	0.972**	7.20±5.30	0.836**	6.85±5.32	0.651**	24.05±3.22	0.070**	14.25±3.72	0.850**	6.90±5.27	0.899**	10.15±6.42	0.096**
	1 – 5 years	7.38±3.75		15.93±5.80		6.43±3.07		7.48±3.15		7.49±3.15		23.65±3.92		14.91±4.11		7.16±4.26		10.59±5.21	
	More than 5 years	7.95±3.77		15.92±5.17		6.52±3.69		7.17±3.91		7.17±3.91		24.10±2.69		14.65±3.88		7.02±3.60		10.67±4.35	
	More than 10 years	7.57±3.68		14.45±4.62		6.80±3.85		8.00±5.26		8.00±5.26		22.03±4.35		15.20±4.44		7.68±4.91		13.08±5.76	
Type of ICCU you çwork in	CU	8.33±5.16	0.140**	16.87±5.56	0.378**	6.60±3.44	0.644**	8.80±4.26	0.796**	8.07±4.18	0.843**	24.60±3.37	0.290**	14.87±4.50	0.897**	7.46±4.64	0.540**	10.53±5.73	0.988**
	MDRU	7.96±3.67		15.40±5.40		6.37±2.76		8.11±3.02		7.74±3.09		23.33±3.72		15.52±4.26		6.66±3.25		10.93±5.31	
	LDMU	6.97±2.51		15.48±4.87		7.24±4.55		7.57±4.74		6.76±4.53		23.86±4.08		14.72±4.35		8.38±5.49		11.08±5.88	
	ICCT	14.00±9.90		8.50±0.71		9.50±3.53		8.00±7.07		9.00±8.48		22.50±4.95		14.00±7.07		6.50±4.94		9.00±7.07	
	More than one service	7.44±3.74		15.88±5.71		6.19±3.60		6.99±4.07		6.67±4.11		23.13±3.63		14.66±3.78		6.83±4.04		11.30±5.13	
Professional Area you work in ICCU	Medical action assistant	8.36±4.40	0.098**	17.00±5.60	0.358**	7.68±6.15	0.499**	8.95±6.99	0.499**	8.95±7.13	0.559**	22.59±4.70	0.625**	16.55±4.42	0.907**	10.40±6.40	0.950**	11.95±7.11	0.961**
	Nurse	7.07±3.03		16.46±4.95		6.61±2.90		7.92±2.98		6.66±2.83		23.51±3.17		14.36±3.89		6.69±4.04		11.54±5.28	
	Physiotherapist	6.73±3.30		15.37±4.87		6.00±3.38		6.26±3.20		6.05±2.91		23.00±3.00		14.31±3.83		5.63±2.45		10.79±3.37	
	Physiatrist	7.00		24.00		13.00		11.0		12.00		22.00		11.00		3.00		20.00	
	General Practice	8.00		26.00		8.00		5.00		8.00		27.00		20.00		3.00		13.00	
	Nutritionist	6.66±3.51		17.33±5.86		3.66±1.15		7.33±1.52		6.33±0.57		26.33±1.15		12.00±1.73		5.00±2.00		9.00±6.00	
	Psychologist	7.20±3.76		16.30±5.98		6.60±3.24		7.10±4.09		7.10±4.30		25.60±2.06		14.20±3.32		5.20±2.61		7.50±4.27	
	Speech Therapist	4.00±1.00		19.33±10.78		8.66±2.88		11.33±2.88		11.33±4.16		26.66±0.57		15.00±7.21		8.33±4.51		15.00±4.00	
	Occupational Therapist	8.63±5.11		14.52±5.27		6.13±3.09		7.05±3.97		6.80±3.77		23.19±4.05		14.66±4.33		6.91±3.69		10.39±5.26	
	Social Worker	6.84±2.27		14.76±5.27		7.00±3.82		8.07±3.40		7.23±3.32		22.15±4.52		14.31±3.50		8.69±3.68		13.15±4.74	
	Cleaning Auxiliary	9.00		25.00		5.00		6.00		4.00		16.00		19.00		12.00		17.00	
	Socio-cultural Animator	8.20±1.64		10.80±4.81		4.20±1.64		4.40±1.52		4.20±1.64		25.60±1.14		12.80±3.49		4.80±2.48		8.40±4.83	
	Technical Director	8.12±2.79		13.87±4.64		5.50±3.29		5.50±3.16		5.87±3.60		25.62±1.59		16.62±3.96		7.50±5.01		8.75±4.27	
	Receptionist	7.00±2.83		12.50±4.95		9.50±0.70		9.50±3.53		9.00±2.82		18.50±4.95		18.50±0.70		11.00±7.07		18.00±2.83	
Presence of a relative with MI	Yes	6.52±2.79	0.181*	15.33±6.40	0.075*	6.21±3.28	0.334*	7.07±4.59	0.729*	6.62±4.66	0.689*	24.71±3.43	0.176*	13.66±4.37	0.376*	6.05±4.49	0.672*	9.02±5.75	0.157*
	No	7.95±3.99		15.84±5.11		6.65±3.84		7.63±3.95		7.16±3.90		23.02±3.73		15.23±3.88		7.61±4.26		11.81±5.04	

*AQ27A- AQ27 Responsability; AQ27 B - AQ27 Pity; AQ27 C - AQ27 Anger; AQ27 D - AQ27 Dangerousness; AQ27 E - AQ27 Fear; AQ27 F - AQ27 Help, AQ27 G - AQ27 Coercion, AQ27 H - AQ27 Segregation, AQ27 I - AQ27 Avoidance; X– mean; SD – standard deviation; LTV - Lisbon and Tagus Valley, CU - Convalescence Unit, MDRU - Medium Duration Unit, LDMU - Long Duration Unit, ICCT - Integrated Continued Care Team (Home Support) ;*T-student test; **ANOVA 1 factor.*

Based on the analysis of the results of the CAMI assessment tool, shown in Table 4, it was possible to see that in terms of gender, women have less stigma towards people with MI. The Alentejo region has the highest score, which also means less stigma, and the Algarve region, on the other hand, has the most stigma. Participants with more professional experience in ICCU have more stigmatising attitudes. In terms of professional area, psychology professionals showed better results, with less stigma, in contrast to medical action assistants and speech therapists, who showed more stigma towards people with MI. Finally, participants with a family member with MI had less stigmatising attitudes.

In terms of homogeneity, all the variables were not significantly different at a significance level of 0.05.

Table 4: CAMI total value according to participant characteristics.

Variable		CAMI Total Score	
		(X ± SD)	*p*
Gender	Female	115.92±9.80	0.942*
	Male	112.88±9.83	
Region where you work	North	115.57±10.05	0.816**
	Centre	115.89±9.96	
	LTV	115.07±8.74	
	Alentejo	118.50±8.41	
	Algarve	110.75±11.32	
Years of work in ICCU	Less than 1 year	116.00±9.44	0.111**
	1 - 5 years	117.10±9.38	
	More than 5 years	115.87±8.06	
	More than 10 years	112.14±12.02	
Type of ICCU you work in	CU	118.87±9.50	0.701**
	MDRU	116.15±9.23	
	LDMU	114.86±9.13	
	ICCT	113.00±15.56	
	More than one service	115.22±10.35	
Professional Area you work in ICCU	Medical action assistant	108.68±9.40	0.023**
	Nurse	116.59±9.95	
	Physiotherapist	114.79±10.13	
	Physiatrist	110.00	
	General Practice	118.00	

	Nutritionist	117.67±5.03	
	Psychologist	121.30±5.54	
	Speech Therapist	110.00±25.36	
	Occupational Therapist	118.83±8.26	
	Social Worker	111.15±9.09	
	Cleaning Auxiliary	124.00	
	Socio-cultural Animator	118.40±9.88	
	Technical Director	116.75±7.78	
	Receptionist	113.50±0.71	
Presence of a relative with MI	Yes	117.55±11.26	0.280*
	No	114.93±9.22	

*X – mean; SD – standard deviation; LTV - Lisbon and Tagus Valley, CU - Convalescence Unit, MDRU - Medium Duration Unit, LDMU - Long Duration Unit, ICCT - Integrated Continued Care Team (Home Support), *T-student test; **ANOVA 1 factor*

Regarding the correlations between the variables age and years of work in the ICCU with the score of the AQ-27 subscales and the total CAMI score, weak to moderate correlations were observed (Schober & Schwarte, 2018).

Only in AQ-27 in the Coercion subscale was there a weak positive correlation with age (r= 0.212; p=0.007). In the Help subscale of the AQ-27, there was a weak negative correlation with years of work in the ICCU (r=-0.144; p=0.067). Regarding to CAMI, there was a moderate negative correlation (r=-0.230; p=0.003) with age, which means that as age increases, stigmatising attitudes towards people with MI decrease (Table 5).

Table 5: Association between AQ27 subscales, CAMI total values and sociodemografic scales (age and years in ICCU).

	AQ27 A		AQ27 B		AQ27 C		AQ27 D		AQ27 E		AQ27 F		AQ27 G		AQ27 H		AQ27 I		CAMI Total	
Variable	r	*p*	R	*p*	r	*p*	R	*p*	r	*p*	r	*p*	r	*p*	r	*p*	r	*p*	r	*p*
Age	0.194	0.013	-0.120	0.126	0.002	0.981	-0.010	0.902	-0.027	0.733	-0.040	0.612	0.212	0.007	0.107	0.174	0.072	0.359	-0.230	0.003
Years in UCC	0.050	0.530	-0.095	0.227	0.027	0.731	0.010	0.899	-0.022	0.783	-0.144	0.067	0.025	0.749	0.053	0.503	0.162	0.039	-0.151	0.054

AQ27A- AQ27 Responsability; AQ27 B - AQ27 Pity; AQ27 C - AQ27 Anger; AQ27 D - AQ27 Dangerousness; AQ27 E - AQ27 Fear; AQ27 F - AQ27 Help, AQ27 G - AQ27 Coercion, AQ27 H - AQ27 Segregation, AQ27 I - AQ27 Avoidance; r – Pearson's/Spearman`s Correlation.

4. Discussion

Having presented the results of this study, we will now discuss them in the light of the existing evidence, taking into account the objective defined for the research: to analyse stigma and discrimination towards people with MI by professionals working in general ICCU. By analysing both assessment instruments, we can see that there are low levels of stigma and discrimination against people with MI among professionals in general ICCU, which is a positive factor in raising awareness and acceptance of MI and, consequently, greater recovery for people with MI. (Avdibegović & Hasanović, 2017; Pinto et al., 2020).

By analysing the AQ-27 assessment tool, it was possible to see that in the gender variable, males show greater stigma compared to females, although the difference between the factors in the tool is relatively small. It should be emphasised that in the Dangerousness and Fear factor, males have the highest score. As for the Help factor, which represents the recognition of the need that people with MI have to be helped and that they need this help, the female gender stands out, thus observing greater availability and willingness on the part of women to help people with MI, compared to men. According to Andrew Bradbury's study, women also have less stigmatising attitudes, but when comparing mental illnesses, they show greater stigma towards schizophrenia than anxiety (Bradbury, 2020). In another study, the authors suggest that women feel more benevolent towards people with MI, thus justifying this helping behaviour. It should be noted that the female gender has been assigned the task of caring since time immemorial, so social rights, responsibilities and cultural beliefs related to behaviour can have an effect on health. (Gur & Kucuk, 2016).

Concerning the region of the ICCU, the CAMI instrument found more stigmatising attitudes in the Algarve. In the Alentejo region, there were fewer stigmatising and discriminatory attitudes. It is known that the Alentejo has more reported cases of MI in Portugal, more specifically a diagnosis of depression, according to a study by the Doctor Ricardo Jorge National Institute. However, although there are more individuals with MI in the Alentejo, there is less stigma in this region, which proves to be a very positive result (Santos et al., 2016). This may be due to a greater awareness and knowledge of MI in this region. Another relevant factor is the type of diagnosis, it is known that there is greater stigma towards schizophrenia than depression (Norman et al., 2012; Schomerus et al., 2022).

Concerning length of experience in the ICCU, the AQ-27 did not reveal any major differences between the groups, but the CAMI instrument showed that more years of professional

experience was associated with more stigmatising attitudes. One possible explanation for these results is the fact that health professionals are often suffering from work-related burnout, which is associated with less conscious and friendly attitudes towards people with MI (Henderson et al., 2014).

In relation to the type of ICCU, we can see that professionals working in the ICCU context have more stigmatising attitudes. When it comes to intervention in a home setting, there may unintentionally be greater observation of the MI person's own context, where the MI person generally exhibits more associated behaviours and this contributes to a greater presence of stigmatising and discriminatory attitudes and thoughts (Hubbeling & Smith, 2022). There are also high levels of stigma in the long-stay LDMU. It should be noted that this type of unit is home to people with high levels of dependency, such as bedridden individuals whose cognitive abilities are often severely compromised. Compared to the other types of unit, in CU where the stay is up to 30 days, the individuals are generally more autonomous and less dependent, with low levels of stigma and discrimination. In the MDRU, with maximum stays of 90 days, there are also low levels of stigma.

In the professional field, medical action assistant and speech therapists stand out, showing greater stigma towards people with MI. When a person with MI is approached in healthcare, the knowledge that the person has a diagnosis of MI increases the desire for social distancing, discomfort in assessing and treating the person in a medical emergency context (Henderson et al., 2014). In addition, people with MI tend to be particularly rejected and are often considered difficult, manipulative and less deserving of care (Knaak et al., 2017)(Minas et al., 2011). Professionals reveal negative attitudes when caring for people with MI, displaying attitudes of futility and report that it is difficult to build a relationship with people with MI (Tyerman et al., 2021). Another factor that contributes to the presence of stigma, specifically among health professionals, is due to the negative effects of professional training, which often fails to address important concepts for raising awareness of MI. Concerning to speech therapists, AQ -27 shows attitudes associated with Fear, Dangerousness and Avoidance in relation to people with MI. When analysing the speech therapy training study plan, these professionals do not have any units on mental illness, which may also contribute to these results (Fernandes et al., 2022). Other professional areas such as nursing, medicine, psychology and occupational therapy have study plan that address MI. In addition to speech therapy, physiotherapy also has higher levels of stigma and discrimination among professionals in this field. Psychologists, on the other hand, show low

levels of stigma, proving that more training on the subject helps to reduce stigma and discrimination against people with MI (Fernandes et al., 2022). Furthermore, bearing in mind that the field of tends to have less schooling and according to some research, this has a great influence on the presence of stigma and discrimination towards people with MI and concludes that fewer years of schooling are associated with more stigmatising and discriminatory attitudes. (Aflakseir et al., 2019). When analysing the degree of proximity between professionals and users of the ICCU, nurses are the professionals who establish the most contact with users, since with the exception of the ICCU typology, they are present at all stages of the day and can be found in all types of units. Compared to other areas, nurses show low levels of stigma.

Finally, regarding the presence of a family member, in both assessment instruments, not having one corresponds to more stigmatising attitudes towards the person with MI. This can be explained by the fact that as family members deal with the symptoms of people with MI, they learn about mental illness and how they can provide support, often becoming the strongest pillars of the person with MI. Family members can therefore play an important role in the life of the individual with MI, since the support they provide promotes better recovery through their involvement in treatment and daily life (Aass et al., 2022; Ong et al., 2021).

Although this study revealed low levels of stigma and discrimination, its presence is inevitable. It is known that lack of awareness is identified as the main factor for the presence of stigma in MI in some social groups. At the same time, interpersonal factors such as social skills, physical appearance, positive and negative symptoms of mental illness, personal experiences, peer relationships and the image that the media displays of people with MI also contribute to the presence of stigma (Ansari et al., 2008). A study of medical students in Portugal suggests that theoretical training and contact with people with MI are factors that contribute to changes in attitudes and stigma. Students who had already studied or interned in psychiatric wards showed fewer attitudes and greater willingness to include people with MI in the community (Pinto et al., 2020). Thus, practices such as social contact, including testimonies from people with lived experience of MI, and educational approaches are fundamental strategies for reducing stigma in healthcare (Carrara et al., 2019; Knaak et al., 2017).

In short, it is important to emphasise the importance of creating initiatives based on mental health literacy as psychoeducation, where topics such as stigma and mental illness are addressed, in order to increase the involvement and integration of people with MI in the community, and consequently a better approach on the part of health care professionals, such as in the ICCU in

general. In this way, more awareness-raising activities should be created, where topics associated with mental illness literacy should be included in the training study plan for these professionals in this type of institution.

Finally, as a limitation of this study, we can point to the fact that it had a small sample, which could have an impact on the inference of the results. In addition, given the results, future studies could benefit from including more variables, such as the frequency of contact with people with MI and the existence of sensitisation/awareness-raising activities for people with MI. Further studies are suggested, namely analysing the impact of stigma towards people with MI on intervention by professionals and analysing the impact of awareness raising actions on stigma among professionals. Another suggestion would be to analyse stigma and discrimination against people with MI according to the region's development category, more and less developed.

5. Conclusion

The aim of this study was to describe the levels of stigma and discrimination against people with MI among professionals working in the general ICCU.

The study shows that the rate of stigma towards people with MI among professionals in general ICCU is low, which is positive. These results may be due to a greater willingness to accept MI and also to the presence of more initiatives in favour of mental health after the COVID-19 pandemic. Another reason for these results is the indirect contact with this population in the professional context. In addition, it is known that stigma is influenced by cultural and contextual value systems that differ over time and between different contexts (Subu et al., 2021).

The study showed that the people who show the most stigma and discrimination towards people with MI are the professionals who have the most experience in general ICCU. Regarding the region of Portugal, the Alentejo stands out as having the least stigmatising attitudes and coincidentally, according to previous studies, the region of Portugal with the most MI diagnoses. In terms of professional areas, more stigmatising attitudes were observed among speech therapists and medical action assistants. In contrast, psychologists stand out as having the least stigma towards people with MI.

To summarise, it is important to create initiatives such as educational programmes or literacy programmes based on mental health literacy, as well as direct contact with people with MI, in order to reduce levels of stigma and discrimination. These initiatives allow professionals to gain a better understanding of the symptoms of MI, and consequently a better approach to people with

MI in the ICCU, since the absence of stigma towards people with MI brings great benefits, contributing to greater success in their recovery.

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Appendix

Appendix 1

Sociodemographic questionnaire

1. Age: _____ years
2. Gender:
   - ☐ Male
   - ☐ Female
   - ☐ Other
3. Nationality _____
4. Marital status:
   - ☐ Single
   - ☐ Married
   - ☐ Cohabiting/living together
   - ☐ Divorced
   - ☐ Widowed
5. Academic qualifications:
   - ☐ Secondary Education
   - ☐ Vocational Course
   - ☐ Bachelor
   - ☐ Master
   - ☐ Doctorate
6. Do you work in a long-term care unit?
   - ☐ Yes
   - ☐ No
7. Which region of the Integrative Continuing Care Unit do you work in?

_____

8. What professional area do you work in?
   - ☐ Medical Action Assistant
   - ☐ Nurse
   - ☐ Physiatrist

- ☐ Physiotherapist
- ☐ General Practice
- ☐ Nutritionist
- ☐ Psychologist
- ☐ Speech Therapist
- ☐ Occupational Therapist
- ☐ Other: _____

9. How long have you been working in a long-term care unit?
   - ☐ Less than 1 year
   - ☐ 1-5 years
   - ☐ More than 5 years
   - ☐ More than 10 years
10. Which type of Integrative Continuing Care Unit do you work in? (If you work in more than one type, please tick which ones)
   - ☐ Convalescence Unit (CU)
   - ☐ Medium Duration and Rehabilitation Unit (MDRU)
   - ☐ Long Duration and Maintenance Unit (LDMU)
   - ☐ Integrated Continuous Care Team – Domiciliary (ICCT)
11. Do you have a relative with a mental illness?
   - ☐ Yes
   - ☐ No

11.1. If yes, who? (if applicable, you can tick more than one option)
   - ☐ Parents
   - ☐ Brothers
   - ☐ Husband/Wife
   - ☐ Child
   - ☐ Other: _____

11.2. How much contact do you have with this person? (If you have more than one relative, consider the one with whom you have the most contact)
   - ☐ None
   - ☐ Rarely

- Often
- Very Often