Mental health workers' attitudes toward mental illness in Fiji

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KEY WORDS

attitudes, mental health, mental illness, mental health workers, Fiji

ABSTRACT

Objective
To survey mental health workers' attitudes toward mental illness in Fiji as a means of understanding the attitudes of these staff.

Design
A questionnaire survey using a previously validated scale: Attitudes Toward Acute Mental Health Scale (ATAMHS 33), was modified and distributed to registered nurses and mental health workers at a major mental health care setting in Fiji. The ATAMH (33) is a 33 item measure of attitudes developed specifically for use within inpatient mental health settings.

Setting
A major in-patient mental health care setting in Fiji providing primary, secondary and tertiary care.

Subjects
71 registered nurses and medical orderlies in a mental health setting in Fiji completed the measure.

Main outcome measure
The identification of mental health workers' attitudes toward mental illness in Fiji.

Results
The participants expressed both positive and negative attitudes toward individuals in mental health care. Positive attitudes can be identified in a range of answers to questions including psychosocial causational beliefs and when comparisons were made with physical health issues. Negative attitudes were expressed with respect to alcohol abuse and lack of self control, individuals with mental illness lacking control over their emotions, psychotropic medications being used to control disruptive behaviour, and that mental illness is caused by genetic factors. A number of questions provided mixed responses.

Conclusions
This paper provides a baseline of attitudinal measure of mental health workers in Fiji toward mental illness. It will enable future educational interventions to be evaluated and comparison to be made with other cultures and countries in the South Pacific region.

INTRODUCTION

Attitudes influence both professional and personal behaviour. In particular, stigma and discrimination associated with mental illness and expressed by mental health professionals as well as the general public, results in the under-use of mental health services (Esters et al 1998 in Emrich et al 2003). Contact with individuals who have mental illnesses, and education that replaces myth with fact, can decrease stigmatisation and positively affect attitudes (Halter 2004; Tay et al 2004; Emrich et al 2003; Read and Harre 2001).

For the past fifty years, programs aiming to de-stigmatise mental illness have advocated for medical rather than psychological explanations of mental illness. Biological and genetic factors have been promoted as underlying causes and people with mental disorders were considered 'ill' in the same sense as those with medical conditions. Current evidence however disputes the assumption that this information will result in more positive attitudes toward mental illness. In a survey of first year psychology undergraduates in New Zealand for instance, Read and Harre (2001) found that, contrary to the assumption of de-stigmatisation programs, genetic and biological causal beliefs were related to more negative attitudes toward those with mental illness.

Previous studies also demonstrate that health professionals have negative attitudes toward some aspects of mental illness. Hugo (2001) found that mental health professionals were less optimistic about prognosis and less positive about likely long-term outcomes when compared with the general public. In this study however mental health nurses were generally more optimistic than other health professionals. Jorm et al (1999) also found that compared to members of the Australian public, health professionals (ie general practitioners, psychiatrists and clinical psychologists) rated long-term outcomes more negatively and believed discrimination to be more likely. This may be because health professionals have greater contact with mental illness and individuals who have chronic or recurrent problems than the public and therefore may be more realistic in their assessment of long-term outcomes. If this is so, according to Jorm et al (1999), health professionals need to be aware of their attitudes and be careful about what expectations they convey to patients and their families. Certainly, negative attitudes toward mental illness appear to worsen the overall quality of life of individuals with mental disorders.

Further, providing culturally specific care involves ensuring that clinical staff are properly educated on underlying issues (Morrison and Thornton 1999). Cultural diversity in knowledge about and attitudes toward mental illness requires that this issue be explored in a wide range of cultures, especially in developing countries such as those in the South Pacific region.

Anecdotal evidence has suggested there may be stigmatizing attitudes toward mental illness in Fiji (Aghanwa 2004), although there have been no studies identified which survey the attitudes of mental health workers within Fiji. Aghanwa (2004) conducted 980 structured interviews with residents of Greater Suva, 25.3% (n = 248) of whom were health workers, to explore the extent of knowledge about mental illness and attitudes toward people with mental illness in Fiji. Health workers were recruited mainly from the general hospital and included all categories of health professionals and ancillary staff. Aghanwa's (2004) results showed that a far greater proportion of health workers than each of the other categories considered the hospital was a source of help for people with mental illnesses; expressed the greatest dislike for 'labelling'; and considered that persons with mental illness were significantly different from other people, "believ[ing] that the way the patients would be perceived would depend on the type of the mental illness" (p.370). This latter finding supports that from an earlier Australian survey (Hugo 2001) of the attitudes of mental health nurses, medical staff, and allied health staff toward depression and schizophrenia where these professional groups believed that people with schizophrenia would be more likely to experience discrimination.

To date, much of the research into attitudes has focused on a broad range of health professionals including medical practitioners and psychologists (eg Feifel et al 1999; Singh et al 1998), and comparisons of their attitudes to those of the general public (Kurihara et al 2000). More recently though, investigators have included or specifically assessed nurses' attitudes towards mental illness (eg Baker et al 2005; Halter 2004; Tay et al 2004; Emrich et al 2003; Hugo 2001; Morrison and Thornton 1999; Munro and Baker 2007). Baker et al (2005) developed, piloted and validated a new measure of attitudes in acute mental health care staff: the Attitudes Toward Acute Mental Health Scale (ATAMHS-33). The original 64-question measure was distributed to a sample of qualified and unqualified nurses working in mental health care units in the North of England. Factor analysis resulted in a final scale consisting of 33 questions. The authors of the ATAMHS-33 claim that the tool has the potential to inform development of strategies to reduce the impact of these attitudes on service user care and evaluate the effects of educational interventions addressing attitudinal issues in mental health care. Their findings identified five components of attitudes to consumers within acute mental health care settings: care or control, semantic differentials, therapeutic perspective, hard to help, and positive attitudes.

Using the ATAMHS-33 (modified - see 'Methods' section below) in the present study with a sample of Fijian nurses and medical orderlies may provide initial evidence that will inform future mental health educational programs in Fiji. In addition, it adopts the recommendations to refine and further validate the tool with more diverse cultural samples, as the Baker et al (2005) sample was drawn from densely populated, inner city units with high levels of deprivation which they noted could influence attitudes (Munro and Baker 2007; Baker et al 2005).

AIMS

The present study aimed to survey mental health workers' attitudes toward mental illness in Fiji as a means of understanding the attitudes of staff. Modification, piloting and validation of the ATAMHS-33 questionnaire (Baker et al 2005) to the Fijian nursing context also aimed to assist future development of an appropriate measurement tool for use in pre-and post-test assessments with future groups enrolled in a proposed mental health nursing postgraduate program commencing in Fiji in 2006.

METHOD

The project design was a questionnaire survey that aimed to provide a snapshot assessment of mental health workers' attitudes toward mental illness in Fiji. The measurement scale for this survey was an existing tool, the Attitudes Toward Acute Mental Health Scale (ATAMHS 33) which combines Likert scales (n=25) and Semantic Differentials (n=8). Six of the thirty-three questions were modified slightly to reflect differences in terminology, English expression, and health care context relevant for Fiji. For example, 'Patients who abuse substances should not be admitted to acute wards' was changed to 'Patients who abuse drugs and alcohol should not be admitted to hospital'. The investigators of this project and a Fijian nurse working in the field, reviewed and modified the questionnaire for content validity. The instrument was not translated into local languages, as the target population was drawn from several ethnic groups and a vast majority of the people in Fiji understand and speak the English language (Aghanwa 2004). The Likert questions were coded: 1-7, with 4 representing the neutral mid point. Seventy percent agreement in a single direction (either 1 to 3 or 5 to 7) was determined as group consensus for a question. The semantic differentials were scored on a 0-10 scale with a score of 5 indicating the mid point. A score greater than five represented a more positive attitude.

Data were also collected on the socio-demographic characteristics of participants, such as: age, gender, education, and occupation. Prior to administration of the survey, ethics approval was sought and gained from the relevant university Human Research Ethics Committee and the Fiji Ministry of Health Ethics Committee.

Recruitment of the sample

Participants were recruited from a group of registered nursing staff and medical orderlies attending a one-day workshop (repeated for four consecutive days) on mental health for staff at the only psychiatric hospital in Fiji which provides primary, secondary and tertiary care to clients throughout Fiji. The hospital has four wards and 190 beds and caters for clients with acute and chronic mental illnesses, as well as clients with intellectual disability and those on forensic orders. Medical orderlies comprise approximately two thirds of the staffing at the hospital and provide much of the day to day care of clients. Registered nurses form the remaining one third. The workshop aimed to provide professional development for the majority of the staff working at the hospital.

Inclusion criteria were: adults (18 years of age or more) who were able to comprehend and write the English language and were working as either a nurse or orderly in mental health care in Fiji.

Data Collection

The questionnaire was administered on one occasion only to a group of registered nurses and medical orderlies attending a workshop at St Giles Hospital in Fiji. An information sheet detailing the purpose of the survey and its requirements. Other relevant information was available to all potential participants as they entered the workshop venue. At the beginning of the workshop the first author explained the details of the project to all potential participants and administered the questionnaire to those who wished to take part. To avoid perceived or actual coercion of participants, local hospital staff were not involved in this process. To assist those participants with literacy difficulties, items on the questionnaire were read to the group when necessary and a Fijian nursing tutor and nurse (SG and SA) were available to assist the co-investigator or participants with clarification of specific literacy aspects. The questionnaire however was self-administered to the extent that participants' literary competence in English language permitted.

Data Analysis

Data were managed and analysed using the Statistical Package for the Social Sciences (SPSS Version 13). A number of statistical tests were performed on the data including initial descriptive statistics and attribution of the data to five previously identified components (Baker et al 2005). Attitudes of the registered nurses and medical orderlies were compared using chi-square test, and nonparametric correlation examined the significance of the association between some socio-demographic and knowledge/attitude variables. The $p<0.05$ level was used for statistical significance.

Table 1: Participants who completed the ATAMHS (33) (modified)

Variable	Number
Gender	
Male	27 (38%)
Female	44 (62%)
Position	
Nurse	23 (32.4%)
Orderly	48 (67.6%)
Level of education	
Tertiary	21 (29.6%)
Post-secondary certificate	12 (16.9%)
Secondary certificate	23 (32.4%)
Post-secondary certificate and Secondary certificate	12 (16.9%)
Missing	3 (4.2%)
Mental health course/certificate	
Yes	24 (33.8%)
Not stated	47 (66.2%)
Age range	
20-24	6
25-29	10
30-34	13
35-39	5
40-44	13
45-49	13
50-54	7
55-59	4

RESULTS

Of a potential 72 participants, 71 chose to take part in the survey, giving a response rate of 98.6%. This group constituted the vast majority of mental health workers at the hospital. The demographics of the

population can be found in table 1. Participants had worked in psychiatry from between 2 and 477 months (mean 170.3, SD 133.0 or median 132.0).

Ten questions received greater than 70% endorsement in one direction by the mental health workers (table 2). Responses to all semantic differential questions are described in table 3. Those semantic differentials with a mean score less than five are indicative of a poorer attitude toward service users.

Table 2: Questions which received greater than 70% endorsement in a single direction

Question Number	Question	% agreement Nurses n=23 (32.4%)	% agreement Orderly n=48 (67.6%)	Combined Cumulative %	Implication for attitude
Question 4	'Mentally ill patients have no control over their emotions'	16 (69.5%)	37 (77%)	75.7% disagree	Positive
Question 11	'Mental illness is the result of negative social circumstances'	15 (65.2%)	38 (79.2%)	75.7% agree	Positive
Question 12	'Many normal people would become mentally ill if they had to live in a very stressful situation'	16 (69.5%)	42 (87.5%)	81.7% agree	Positive
Question 13	'Those with a psychiatric history should never be given a job with responsibility'	21 (91.3%)	32 (66.6%)	74.6% disagree	Positive
Question 14	'Those who attempt suicide leaving them with serious liver damage should not be given treatment'	22 (95.6%)	42 (87.5%)	80.1% disagree	Positive
Question 23	'Psychiatric illness deserves as much attention as physical illness'	20 (86.9%)	38 (79.2%)	74.3% agree	Positive
Question 24	'The manner in which you talk to patients affects their mental state'	21 (91.3%)	43 (89.6%)	91.4% agree	Positive
Question 1	'People who abuse alcohol have no self control'	18 (78.2%)	41 (85.4%)	83.1% agree	Negative
Question 21	'Psychiatric drugs are used to control disruptive behaviour'	21 (91.3%)	42 (87.5%)	91.3% agree	Negative
Question 22	'Mental illnesses are caused by genetic factors'	15 (65.2%)	38 (79.1%)	76.8% agree	Negative

Table 3: Semantic differentials (scoring 0-10)

Semantic differential	Mean	SD	Implication for attitude
Safe-dangerous	4.1	2.7	Negative
Adult-child	7.2	2.6	Positive
Mature-immature	6.3	2.6	Positive
Optimistic-pessimistic	3.9	2.6	Negative
Cold hearted-caring	5.7	2.9	Positive
Polite-rude	4.1	2.7	Negative
Harmful-beneficial	3.9	2.9	Negative
Clean-dirty	4.6	2.9	Negative

There was no statistical difference between attitudinal scores and gender and those who had undertaken further mental health training or certificates. There were statistical differences between registered nurses and medical orderlies for two of the domains 'Care or control' (p=0.021), and 'Therapeutic perspectives' (p=0.036). Secondary certificates compared to tertiary also had a significant difference in one domain 'care or control' (p=0.006).

For overall comparison with the original study, data were clustered into the five domains identified (table 4).

Table 4: Domain scores for the five components (ATAMHS (33) modified)

Subscale	Number of items	Theoretical minimum	Theoretical maximum	Observed minimum	Observed maximum	Mean	SD	Skewness	Kurtosis
Care or control	12	12	84	32	66	47.8	7.64	0.357	0.002
Semantic differentials	7	0	70	13	61	32.7	9.8	0.518	0.588
Therapeutic perspective	6	6	42	9	39	28.3	6.3	-0.603	0.770
Hard to help	4	4	28	5	23	12.3	4.1	0.686	-0.013
Positive attitudes	4	4	31	7.4	29	23.6	4.3	-1.254	2.415
ATAMH (33) modified	33	26	255	104.3	201.4	114.6	18.1	0.572	0.882

DISCUSSION

Overall, there was evidence of both positive and negative attitudes toward people with mental illness by mental health workers in this study, with some differences in attitudes evident between registered nurses and orderlies. Only one of the questions (Question 13 in the domain 'Therapeutic Perspectives'), however is the same as the questions identified in Munro and Baker's (2007) finding of attitudinal differences between qualified and unqualified staff.

In the current study, unqualified staff held more positive as well as more negative attitudes than qualified staff. This is generally consistent with Munro and Baker's (2007) finding and overall conclusion that it cannot be assumed qualified staff will hold more positive attitudes than unqualified staff. It is possible that other variables such as professional development training or other support may have influenced their attitudes. Evidence of positive attitudes from all the mental health workers in this study (tables 2 and 3) can be identified in responses to seven of the Likert questions (Questions 4, 11, 12, 13, 14, 23, 24) and three of the semantic differentials (Adult:child; Mature:immature; Cold hearted:caring). The mean scores for these three semantic differentials were greater than five, which provides further evidence of positive attitudes toward people with mental illness. There is however potentially a methodological flaw with the semantic differential Adult-child and Mature-immature, as all staff worked within adult mental health services (over 16 years of age). These questions could have been misinterpreted as to working with children. Altering the wording to Childlike:adultlike may have elicited a different attitudinal response.

The current study's finding of positive attitudes by these mental health workers is generally consistent with Munro and Baker's (2007) although direct comparison was not made due to differences in the sample and context of care. The findings are also, while not directly comparable with Aghanwa's (2004) previous study in Fiji, broadly consistent with his conclusion that education about, and experience working with, mental illness may assist the development of more positive attitudes toward mental illness. In accordance with previous studies with nurses in particular, (Tay et al 2004; Emrich et al 2003; Hugo 2001), it is also possible that further education and training on mental illness and therapeutic strategies could result in the development of more positive attitudes for these mental health workers, including the medical orderlies who have had limited education in mental illness. As Baker et al (2005) identify however, evidence of positive attitudes alone does not indicate whether there is corresponding therapeutic behaviour and quality of care for clients. Research into clients' perceptions of these mental health workers' attitudes could provide greater understanding as to the effect, if any, of their positive attitudes on client care.

Three questions (table 2) provide evidence of these mental health workers' negative attitudes toward people with mental illness (Questions 1, 21, 22). This is in keeping with the findings of several other studies, although there are particular differences. In the Singh et al (1998) study which aimed to evaluate the impact of a psychiatric placement on 4th year medical students post placement, 92.7% of the sample of medical students disagreed that psychiatric drugs were used to control behaviour. However, 91.3% of mental health workers in the current study agreed with this statement. This conflict in agreement could provide evidence of the reliance on medication within mental health settings to manage difficult and challenging behaviour. This could be the experience of staff; given that these mental health workers work within inpatient settings, a notion of 'ill health' pertaining to clients admitted is probably common. However this appraisal does contribute directly to a poorer attitude toward service users. It is clear that a biological or genetic perspective of illness (Question 22) contributes toward a negative attitude and that a vulnerability perspective of mental illness is preferable to a biological one (Read and Harre 2001; Read and Law 1999; Cho and Mak 1998). Interestingly, more orderlies (79.1%) agreed with this statement than the nurses (65.2%). Two other questions (Q12 and Q13) in table 2 showed major differences in opinions between nurses and orderlies. Fifteen Likert questions appeared to show evidence of divided opinion.

This study presents new research into the attitudes of healthcare staff within Fijian mental health services. The data provides a baseline for future educational interventions which aim to improve both knowledge and attitudes of registered nurses and medical orderlies in Fiji. It will also enable comparisons to be made with other cultures and countries in the South Pacific region. With the introduction of a specialist postgraduate course for mental health nurses in Fiji, there is also opportunity for education on additional theoretical perspectives to that of the traditional biological explanation for mental illness. This brings a concomitant opportunity to explore therapeutic nursing strategies to address disruptive behaviours and symptoms of mental illness which complement and/or extend those of medication administration.

Limitations of the study

The limitations of the study include a relatively small sample of health workers working within one mental health inpatient setting in Fiji. The design of the questionnaire was originally influenced by the need to survey the attitudes of acute mental health nurses who worked with service users encountered within the UK. The scale as such may not have been transferable to a different country/culture. The amendment of some questions was required in order to more appropriately reflect Fijian mental health care contexts and use of language. There is also difficulty in comparing the attitudes of qualified and unqualified workers within this setting due to their differing roles and professional responsibilities.

Notwithstanding these limitations, this paper does present new data on the attitudes of mental health workers in Fiji. There is now a need to undertake a larger survey of attitudes toward mental illness by mental health workers. Further analysis of the formation of attitudes contained within the measure used in this study could use qualitative methodologies to explore in greater detail the development of attitudes.

CONCLUSION

Whilst this study has taken a cursory look at the issue of attitudes of mental health workers within Fiji, it has provided some important indications of registered nurses' and medical orderlies' perceptions of mental illness and people who have mental illness in Fiji. The attitudes of mental health workers in Fiji have not been sought previously. This important area of work is currently under-researched and further work could improve our understanding of the attitudes that mental health workers maintain and how these influence the quality of care consumers receive.

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