Anti-discrimination education intervention delivered to final-year medical students as part of psychological medicine curriculum: comparative analysis of two alternative programs

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Context

- Healthcare provider discrimination is where healthcare providers carry negative stereotypes and prejudices that they enact towards clients they serve, even unknowingly or unwittingly
- Healthcare provider discrimination extends to all healthcare settings, including mental health settings
- Henderson reported frequencies of discrimination ranging from 16% to 44% in mental health care settings, and between 17% and 31% in physical health care settings

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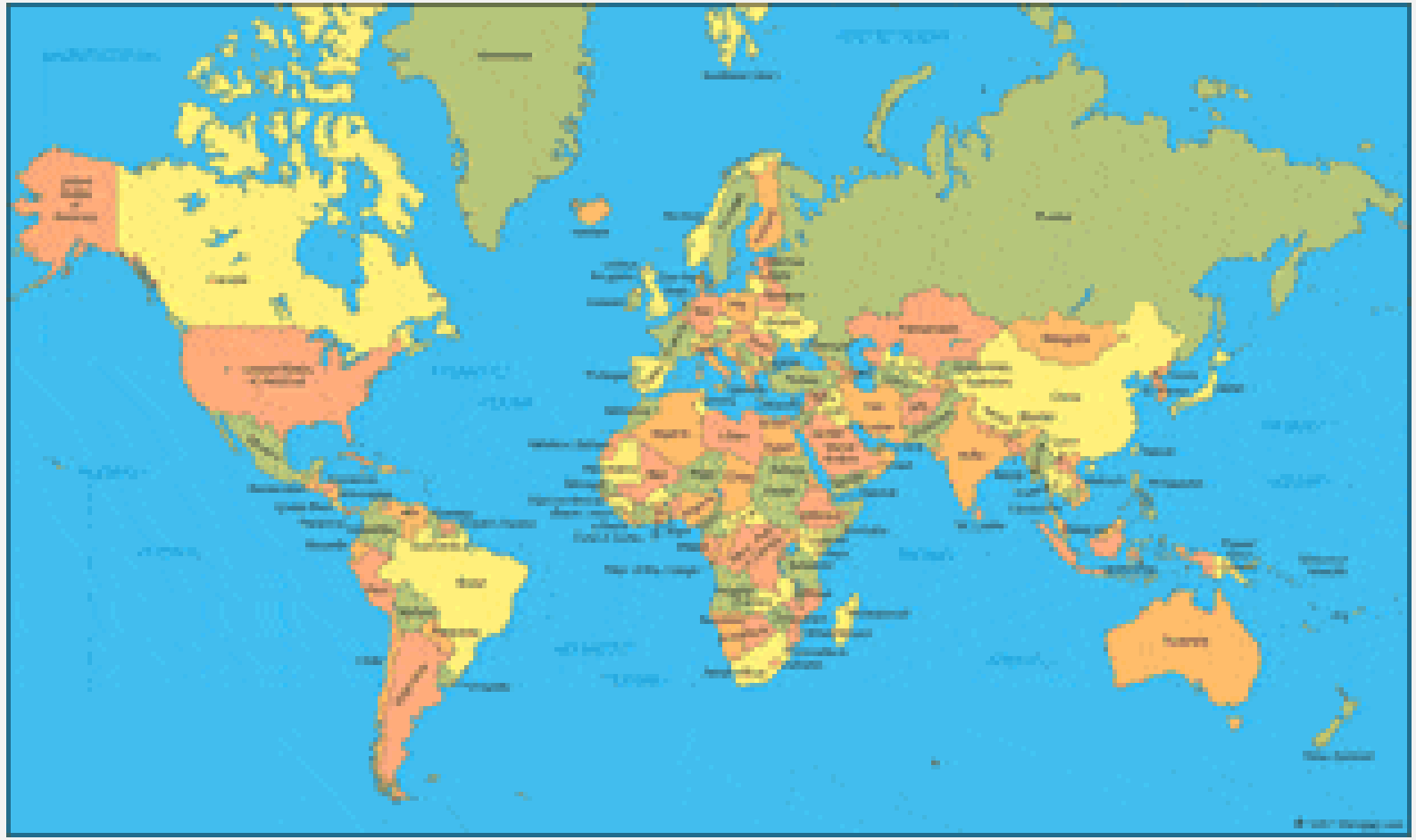
Healthcare discrimination is a global problem



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Negative stereotypes and prejudices are not harmless

- Stereotypes and prejudices are linked with discriminatory behaviours which are a core barrier to treatment and quality of care
- In the healthcare setting, those who experience mental distress also experience:
  - rejection and avoidance
  - blaming and punishment
  - shaming
  - poor prognosis and negativity about their chance of recovery
  - disempowerment
  - hostility
  - disrespect and insensitivity
  - disinterest

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Disparities in physical health care

These disparities result in reduced quality and effectiveness of treatment which leads to a poorer patient outcome, increases the risk of physical illness, and is a contributor to premature mortality

This may be due to:

- Withholding of help
- Lower levels of referral to a specialist
- Diagnostic overshadowing (misattribution of unrelated complaints to a patient's mental illness, somatisation and misdiagnosis)
- Refusal to treat psychiatric symptoms in a medical setting
- Interference with the therapeutic relationship which affects the levels of trust needed to fulfil the medical needs of an individual

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Additionally, perceptions that health care providers may respond negatively can lead to:

- Inhibition of help-seeking by those who experience mental distress
- Service avoidance
- Withdrawal from health services
- Treatment discontinuation
- Non-adherence to treatment planning and recommendations

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Roots of healthcare provider stereotypes & prejudice:

- Pessimism about recovery
- Feeling like what they (providers) do doesn't matter
- Seeing the illness ahead of the person
- Lack of skills and confidence, and
- Lack of awareness of their own prejudice

Knaak and Patten

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Contact-based educational interventions to reduce stereotyping, prejudice & discrimination

- Growing field
- Education about mental illness and social contact with those who experience mental distress show positive benefits
- Initiatives need to be:
  - Repeated over time
  - Tailored to target group
  - Have recovery focus
  - Involve personal testimony from a trained speaker who has lived experience of mental illness
  - Employ multiple forms of social contact
  - Teach skills that involve what to say and what to do
  - Employ myth-busting, and
  - Use an enthusiastic facilitator

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Undergraduate medical students

- Not traditionally targeted
- Medical student training programs could be one of best ways of reducing healthcare provider discrimination
- Since they will specialise across all healthcare settings and, as physicians, have considerable power within the healthcare provider hierarchy.
- Traditional psychiatric clerkships (e.g. clinical electives, lectures, small group work, and problem-based teaching) can have a positive impact on reducing negative stereotypes and prejudice but other studies show mixed results, no improvement, or more stereotyping and prejudice

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Our program – since 2011

- Department of Psychological Medicine, University of Otago, Wellington, New Zealand
- Incremental development of program
- Consistent with key ingredients of effective contact-based anti-discrimination programs for healthcare providers
- Embedded in curriculum for 5th and 6th year undergraduate medical students
- Unique feature: those with lived experience lead and facilitate all aspects of the program along with delivering personal testimonies
- Repeated over time (5th and 6th years)
- Evaluation embedded in the curriculum
- Considered to be one of the most extensive programs being delivered in this context

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Aim of this research

- Based on assessed attitudinal change this paper compares an extended version of the program run in 2015/2016 and a briefer program run in 2016/2017
- Hypotheses:
  - Our social contact-based educational intervention leads to a reduction in negative attitudes towards those who experience mental distress among undergraduate medical students
  - A longer, more extensive program leads to greater improvement in attitudes

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Methodology

- Participants were two cohorts of 6th year medical students studying at the University of Otago Wellington in 2015/2016 and 2016/2017
- Two similar mandatory teaching programs were delivered to participants.
- These programs formed part of the 5th and 6th year psychological medicine curriculum of the undergraduate medical degree.

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Programs: 2015/2016 vs 2016/2017 cohorts

2015/2016 Cohort	2016/2017 Cohort
5th year: Full-day service user-led and delivered workshop: • Personal testimonies from trained educators with lived experience of mental illness modelling a recovery focus (social contact), • Destigmatization exercise (myth-busting), and • Modules around communication, peer support, and supported employment 5-day placement in a service user-led and recovery focused community service where clients hosted students and engaged together with them through various activities (social contact). Reflection exercise focused on what recovery is, what the barriers to recovery are, and what healthcare providers can do to support recovery	5th year: One half-day (as opposed to the full-day) service user-led and delivered workshop Eliminated modules around communication, peer support and supported employment but continued the other elements One-day (as opposed to the 5-day) placement in a service-user led and recovery focused service Same reflection exercise

Programs continued

2015/2016 Cohort	2016/2017 cohort
6th year: Two, one-hour service user-led and delivered tutorials focused on supporting recovery Recovery-focused reading materials Short personal reflection on the service philosophy of recovery for people managing mental distress as part of the standard assessment process. This was a terms requirement that students were required to pass in order to pass their psychiatric attachment overall	6th year: Similar program

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6th year tutorials based on:

Rethink Personal Recovery Task framework:

- Minimizing impact of mental illness through supporting individuals to frame (make sense of the experience in a way that is meaningful to them) and self-manage; and

- Maximizing well-being by supporting individuals to develop a positive identity and valued social roles and relationships.

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Measures

- Recovery Attitudes Questionnaire (RAQ) (16 item, self report, 5-point Likert scale)
  - Factor One: Recovery is possible and needs faith
  - Factor Two: Recovery is difficult and differs among people
  - Lower score = more positive attitude towards recovery
- Opening Minds Scale for Healthcare Providers (OMS-HC) (20 item, self report, 5-point Likert scale)
  - Factor One: Attitudes of HC providers towards people with mental illness
  - Factor Two: Disclosure/help-seeking
  - Factor Three: Social distance
  - Lower score = more positive attitudes

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Results

* Paired t-tests. † Unpaired t-test. ‡ RAQ 16 item questionnaire excluding the non-traditional domain

		2015/2016			2016/2017			2016/2017 – 2015/2016	
Scale	Time	N	Mean (95% CI)	P*	N	Mean (95% CI)	P*	Difference	P†
RAQ‡	T1	72	25.3 (24.2, 26.4)		60	24.9 (23.7, 26.0)		-0.4 (-2.0, 1.1)	0.58
RAQ‡	T2	72	22.3 (21.1, 23.4)		60	21.4 (20.2, 22.6)		-0.8 (-2.5, 0.8)	0.31
RAQ‡	T2-T1	72	-3.0 (-3.9, -2.2)	<0.0001	60	-3.4 (-4.3, -2.5)	<0.0001	-0.4 (-1.6, 0.8)	0.52
OMS	T1	73	44.9 (43.0, 46.8)		58	44.9 (43.1, 46.6)		-0.0 (-2.7, 2.6)	0.98
OMS	T2	73	40.2 (38.2, 42.2)		58	42.6 (40.6, 44.5)		2.3 (-0.5, 5.1)	0.10
OMS	T2-T1	73	-4.7 (-6.3, -3.1)	<0.0001	58	-2.3 (-3.6, -1.0)	0.0008	2.4 (0.3, 4.5)	0.028

Results: RAQ

		2015/2016			2016/2017			2016/2017 – 2015/2016	
Scale	Time	N	Mean (95% CI)	P*	N	Mean (95% CI)	P*	Difference	P†
RAQ Factor1	T1	77	9.4 (8.8, 9.9)		61	9.0 (8.6, 9.5)		-0.3 (-1.0, 0.4)	0.41
RAQ Factor1	T2	77	7.5 (7.0, 8.0)		61	7.2 (6.8, 7.7)		-0.3 (-1.0, 0.4)	0.44
RAQ Factor1	T2-T1	77	-1.8 (-2.3, -1.4)	<0.0001	61	-1.8 (-2.2, -1.4)	<0.0001	0.0 (-0.6, 0.6)	0.93
RAQ Factor2	T1	72	3.8 (3.6, 4.1)		61	3.8 (3.6, 4.1)		-0.0 (-0.4, 0.3)	0.79‡
RAQ Factor2	T2	72	3.7 (3.5, 4.0)		61	3.7 (3.5, 4.0)		0.0 (-0.3, 0.4)	0.73‡
RAQ Factor2	T2-T1	72	-0.1 (-0.4, 0.1)	0.33	61	-0.1 (-0.4, 0.2)	0.55	0.0 (-0.3, 0.4)	0.82

Results: OMS-HC

		2015/2016			2016/2017			2016/2017 – 2015/2016	
Scale	Time	N	Mean (95% CI)	P*	N	Mean (95% CI)	P*	Difference	P†
OMS Factor1	T1	77	12.2 (11.5, 13.0)		59	12.4 (11.8, 13.1)		0.2 (-0.8, 1.2)	0.70
OMS Factor1	T2	77	10.6 (9.8, 11.3)		59	11.5 (10.7, 12.3)		0.9 (-0.2, 2.0)	0.10
OMS Factor1	T2-T1	77	-1.6 (-2.3, -0.9)	<0.0001	59	-0.9 (-1.5, -0.3)	0.003	0.7 (-0.2, 1.7)	0.14
OMS Factor2	T1	76	10.7 (10.0, 11.4)		59	10.6 (9.9, 11.2)		-0.1 (-1.1, 0.8)	0.77
OMS Factor2	T2	76	9.5 (8.8, 10.1)		59	9.8 (9.2, 10.5)		0.4 (-0.6, 1.3)	0.43
OMS Factor2	T2-T1	76	-1.2 (-1.7, -0.7)	<0.0001	59	-0.7 (-1.3, -0.2)	0.013	0.5 (-0.2, 1.3)	0.17
OMS Factor3	T1	75	8.4 (7.8, 9.0)		59	8.1 (7.5, 8.7)		-0.4 (-1.2, 0.5)	0.17 ‡
OMS Factor3	T2	75	7.8 (7.2, 8.4)		59	7.9 (7.3, 8.5)		0.1 (-0.7, 0.9)	0.66 ‡
OMS Factor3	T2-T1	75	-0.6 (-1.2, -0.1)	0.020	59	-0.2 (-0.7, 0.3)	0.46	0.5 (-0.3, 1.2)	0.23

* Paired t-tests. † Unpaired t-test. ‡ Wilcoxon rank-sum test.

Conclusions

- Both programs lead to significant improvements in attitudes on both the RAQ and the OMS-HC
- For OMS-HC, but not RAQ, the extended 15/16 program led to significantly greater improvement than the 16/17 program, with a difference of 2.4 (95%CI 0.3, 4.5) between years (p=0.028) indicating less improvement in response to the abbreviated program
- For RAQ, the improvement in attitudes was largely due to the factor “recovery is possible” suggesting more positive attitudes toward recovery for those in mental distress
- All OMS factors (“attitudes”, “disclosure/help-seeking”, “social distance”) showed statistically significant improvements for both cohorts, except for the factor “social distance” in year 2016/2017
- For both RAQ and OMS-HC, no individual factor showed a significant difference between the two cohorts

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Discussion

- Significantly reduced 2016/2017 program, of 1.5 days, was not as effective as the 2015/2016 program of 6 days in length in terms of the OMS-HC scores.
- It may be that student attitudes can be improved even if students are negative about the intervention.
- Possible ‘dose response’ between the experiential elements of the program and improvements in attitudes
- It is possible that both (reduced time with clients in recovery and more time with patients experiencing severe distress) impacted on attitudes specific to social distance for the 2016/17 cohort

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Call to action

What is called for is:

- greater integration of more extensive and repeated anti-discrimination training focused on recovery and involving multiple forms of social contact into the medical student psychological medicine curriculum
- throughout all teaching, learning materials, placement, supervision and assessment
- from the earliest possible stage

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