

Utilizing Contact-Based Interventions for the Reduction of Mental Health Stigma in Persons of

Haitian Descent

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### **Abstract**

**Purpose:** To implement a contact-based intervention and observe its effects on mental health stigma in those of Haitian descent and reduce stigma. Contact-based interventions are meant to reduce stigma by having individuals with mental illness speak to the public about their experience, both struggles and successes that they face (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016). This type of intervention can entail either face to face contact or audio/visual media, such as a video. It is suggested that this intervention has been an effective way to reduce stigma towards mental health (NASM,2016).

**Methodology:** This is a quasi-experimental study design. Participants were given the Stigma 9 questionnaire (Stig-9), a validated stigma assessment tool, before and after the implementation of a contact-based intervention.

**Results:** The contact-based intervention was associated with a decline in mental health stigma. However, the results were not statistically significant due to the small sample size obtained.

**Implications for Practice:** Reducing stigma in the Haitian community is needed in order to encourage and improve conversations regarding mental health with healthcare providers. Eliminating this barrier can contribute to early detection of mental illnesses and timely delivery of care if needed. Because of the positive correlation between using a contact-based intervention and the reduction of mental health stigma in this single community, there is reason to implement this intervention to other communities as well.

**Keywords:** Contact-based interventions, Haitians, mental health, stigma

## Utilizing Contact-Based Interventions for the Reduction of Mental Health Stigma in Persons of Haitian Descent

Mental illness is a topic that has been met with stigma and avoidance within many groups of people. This is particularly true in individuals of Haitian descent (Dieujuste, 2016). Within the Haitian community, mental illness is not particularly discussed due to the perceived negative connotations that it brings (Dieujuste, 2016). For Haitians, having stigma can result in the delay of the identification of a mental illness, which in turn can delay care (2016). More importantly, stigma does not allow Haitians to have an open conversation about mental health and its importance in overall health (2016). Therefore, the objective of this project is to reduce stigma by way of contact-based interventions in the Haitian community.

Contact-based interventions are meant to reduce stigma by having individuals with mental illness speak to the public about their experience, both struggles and successes that they face (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016). This type of intervention can entail either face to face contact or audio/visual media, such as a video. The ensuing dialogue promotes positive interaction between the two groups and brings a sense of normalcy to the individual dealing with mental illness. It also allows for a sense of understanding for those who are not familiar with, or reluctant to talk about, mental health illness (2016). NASEM suggests that this intervention has been an effective way to reduce stigma towards mental health.

### **Background and Significance**

According to the 2015 American Community Surveys (ACS), there were approximately 676,000 Haitian immigrants in the United States (as cited by Schulz & Batalova, 2017).

According to Derr (2016), despite the fact that immigrants face a unique set of struggles that can

bring about mental health problems, only 8% use mental health services (Derr, 2016). Mental health stigma is attributed to this low utilization of services (Derr, 2016). There is a significant lack of data regarding how many individuals of Haitian descent have a mental illness. Again, this can be attributed not only to the lack of research on this topic as it relates to Haitians, but also because of the stigma present in the Haitian community when it comes to mental health.

The National Alliance on Mental Health (NAMI) states that “stigma is when someone, or even your yourself, views a person in a negative way just because they have a mental health condition. Some people describe stigma as a feeling of shame or judgement from someone else” (National Alliance on Mental Health, 2019). Stigmatization of mental health is known to have negative consequences, one of which includes its effects on seeking care. Clement et al. (2014), conducted a systematic review that found that stigma has a minimal to moderate negative effect on people seeking care in the presence of mental illness. For many mental health illnesses, such as psychosis or depression, a delay in care can worsen the progression of the disease (2014). Therefore, it is important to reduce stigma to encourage conversation regarding mental health and mental illness and to seek treatment, if needed.

In the Haitian culture, the cause for mental illness is believed to be derived mainly from supernatural forces (Dieujuste, 2016). Christianity and/or the religion of voodoo is practiced by many individuals of Haitian descent (Dieujuste, 2016). Some may consult religious leaders in the case of illness whether mental or physical. Once a person is known to have a mental illness, if there is a witnessed decline in function, the person is often times labeled as “fou” or crazy (Dieujuste, 2016). This can bring shame to the family (Dieujuste, 2016). Conversation of the ailment may stay within the immediate family and may not be made known to others. Due to this shame, families are hesitant to seek assistance or treatment from clinical mental health providers

(Stuart, 2016). The shame associated with the ailment further propels stigmatization of mental illness within the Haitian community (Stuart, 2016).

### **Needs Assessment**

On January 12, 2010, the country of Haiti suffered a tremendous earthquake that resulted in the immigration of Haitians to the United States. Allen et al. (2015), conducted a study evaluating some of the health necessities of Haitians in Boston Massachusetts after the earthquake. Of the many health concerns expressed, mental health services were at the forefront. The authors expressed that the natural disaster had a significant impact both on those in the country of Haiti and those here in the U.S. They continued to say that the narratives of the participants of the study “suggested high levels of trauma ...[and a] wide range of psychological, emotional, and physical health symptomatology” (2015). There is probable cause to believe there are people of Haitian descent dealing with mental health issues. Unfortunately, the literature is limited as to how many there are. The literature is also limited regarding the utilization of mental health services among those who may have a mental health illness (Derr, 2016). Stigma is a significant barrier when it comes to addressing mental health issues. More research needs to be done to examine stigma and mental health among the Haitian community.

### **Purpose Statement**

The purpose of this project is to implement a contact-based intervention and observe its effects on mental health stigma in those of Haitian descent. The ultimate goal is to reduce stigma.

### **Clinical Question**

In individuals of Haitian descent, does a contact-based intervention reduce mental health stigma?

### **Objectives and Aims**

The aim of this project was to implement an intervention and see if it would reduce stigma. The assumption is that lowering stigma may promote more open dialogues with primary care providers and subsequently improve patient outcomes if one were to suspect a mental health condition within themselves or a loved one.

The objectives of this project include: (1) identify baseline levels of stigma towards mental health in those of Haitian descent by utilizing a stigma assessment tool; (2) implement a contact-based intervention by way of an in-person 45- to 70-minute session where a trained individual with a mental illness speaks about their experience; and (3) evaluate the effectiveness of the intervention by re-measuring stigma after the intervention has been implemented, with the expectation of a decrease in stigma from the baseline assessment.

### **Literature Review**

A literature review was done to analyze two important aspects of the study. The first review was done to examine the literature that is present regarding mental health stigma in the Haitian population. The second literature review focused on finding evidence that would support the hypothesis of the effects of contact-based intervention on the reduction of mental health stigma. For the purposes of this project, it is important to define certain concepts for the comprehension of the reader. The databases used were EBSCO host and PubMed.

### **Definitions**

In this study, *Haitians* consisted of anyone who was of Haitian descent, either by way of being born in Haiti or being the offspring of Haitian immigrants residing in the United States.

*Contact-based intervention* is any activity that entails an individual living with a mental illness

giving a first-hand account about their experiences to a person or group of people. This could be face to face or a recorded audiovisual source.

### **Mental Illness and Haitians**

For the first review, the words *Haitians*, *mental illness*, and *stigma* were used in the two databases. The search was limited to 2010 to the current year because it appears that there was a spark in interest in the mental health of the Haitian community due to the tragic earthquake that occurred in that year (Messiah et al., 2014; Safran, Chorba, Schreiber, Archer, & Cookson, 2011). Despite this, the search yielded only one article that addressed the presence of mental health stigma in the Haitian community. The search was then broadened to *Haitians* and *mental illness* within the same time frame mentioned above. This resulted in 43 articles (excluding duplicate articles found from both databases). A review of the abstracts of these articles revealed that the papers were on the topic of the mental illnesses found in this population. Some of those illnesses included: depression, anxiety, and post-traumatic stress disorder (Brunnet, Bolaséil, Weber, & Kristensen, 2018). Other topics discussed were perceived stress and resilience (Blanc, Rahill, Laconi, & Mouchenik, 2016). The authors of these articles evaluated and discussed these mental health topics in relation to a variety of scenarios ranging from Haitians living with HIV to examining the mental state of individuals after the 2010 earthquake (Safran, Chorba, Schreiber, Archer, & Cookson, 2011). It is important to note that many of the articles expressed the need for more evaluation of mental health within the population, but more specifically in the country of Haiti (Eustache et al., 2017). Many expressed the lack of utilization of mental health services as well. These findings further support the need to evaluate all aspects of mental health in Haitian people. Be that as it may, of these 43 articles only two were applicable to the focus of this DNP project. One of the articles consisted of a literature review that summarized the present literature



on mental health in the Haitian population. The authors of the review explored “basic epidemiology of mental illness, common beliefs about mental illness, explanatory models, idioms of distress, help-seeking behavior, configuration of mental health services and the relationship between religion and mental health” (Pierre et al., 2010). The other article chosen was the study yielded from the first search concerning mental health stigma in those of Haitian descent (Dieujuste, 2016).

### **Contact-based Education and Stigma**

The second review focused on interventions and reduction of mental health stigma. The keywords used for this search were: *contact-based education*, *stigma*, and *mental illness* in the two databases previously mentioned. The search resulted in a total of 93 articles. Exclusion criteria were then added to make the search more concise and pertinent to the project. The databases allowed for filters or the use of Boolean operators. The criteria entailed excluding the words: children, youth, and specific mental illnesses in the title or abstract of the articles. One of the aspects of this DNP project is to observe the effects of the intervention on stigma towards mental illness, not one particular disease. For the inclusion criteria the focus was on randomized controlled studies, systematic reviews, and quasi-experimental study experiments in hopes that they would provide the least amount of bias. Another component of the inclusion parameters was the word *reduction* to be present in the title of the study or the subject and/or abstract, again because this is the aim of the proposed DNP project. With all of this, 10 articles were selected. As seen in the systematic reviews, most of the evidence expressed that contact-based interventions have positive effects on stigma or on the different components of stigma (Gronholm, Henderson, & Thornicroft, 2017; Mehta et al., 2016). Many of the quasi-experimental and randomized control trials also saw reductions in stigma either in minimal or

moderate amounts whether in students, physicians, or different ethnic groups (Martinez-Martinez et al., 2019; Wong, Collins, Cerully, Yu, & Seelam 2018; Vinson, Abdullah, & Brown, 2016). It is important to highlight this fact because many of the studies done on this topic have been performed on a variety of populations with positive effects on stigma. This brings the expectation that the results can be replicated among various groups.

Despite the positive effects present in much of the evidence evaluated, inconsistencies in the literature are present. Some of the researchers propose that there is little known about the lasting effects of contact-based interventions on stigma (Mehta et al., 2015). From the evidence that is present regarding the sustaining effect of contact-based interventions, it is proposed that the data is weak or not definitive (Thornicroft et al., 2016; Yamaguchi et al., 2019). There is a need for more research to be done on whether this means of stigma reduction can have enduring effects. If so, further research will need to be conducted to evaluate what means can help maintain the positive outcomes.

Another inconsistency present in the research findings is that although the studies have been conducted on a variety of populations, most have been done in high income countries and not in low to middle income countries (Thornicroft et al., 2016). With the burden of mental health being a significant global issue, it is important to take all types of socio-economic populations into consideration. In lieu of the inconsistencies present, contact-based interventions still remain a means to aid in the reduction of mental health stigma.

### **Theoretical Framework**

The theoretical framework used to guide this project is Dr. Gordon Allport's Contact Theory. Originally known as Contact Hypothesis, this theory has been examined to help facilitate intergroup relations to reduce prejudice. Dr. Thomas Pettigrew, a renowned expert in

the social science of race is credited with revising the hypothesis to what is now known as Intergroup Contact Theory (1998). He expanded upon Allport's theory by outlining the effects of intergroup interaction over time with the influence of Contact Theory. An adaptation of this outline has been applied to the components of this DNP project in the concept map (Appendix B). In Allport's most famous work, *The Nature of Prejudice*, he outlines the environment in which prejudices can be reduced amongst dissonant groups (1954). There are 4 essential elements necessary to obtain positive effects in this interaction: "equal status, common goals, intergroup cooperation, and support of authorities, laws, and customs" (Allport, 1954; Pettigrew, 1998). For the purposes of this project, the two groups are the trained individuals who speak about their experiences with mental health (Group A) and individuals of Haitian descent who will hear about those experiences (Group B).

### **Equal Status**

Allport explains that there must be the mutual perception of equality amongst the two parties. Although this can be interpreted in many ways, evidence supports this idea (Pettigrew 1998). Allport explains that differences in schooling, socioeconomic status, and skill should be minimized if it will influence the perception of equality among the two groups. In this project, intentionally highlighting differences will not be done. If this happens by way of meaningful communication between the two groups naturally, it will not be hindered. This will further promote the idea of interpersonal communication to help reduce prejudice and/or stigma between the two groups (Allport, 1954).

### **Common Goals**

Allport proposes that if there are common goals among the groups, reduction of prejudice can happen (1954). In regard to this DNP project, both groups involved will be there for the

purposes of engaging in conversation relating to mental illness. Through this interaction, reduction in stigma is anticipated. Pettigrew explains “prejudice reduction through contact requires an active, goal-oriented effort” (1998, para 4).

### **Intergroup Cooperation**

The intergroup contact must happen without the presence of competition. Both groups must work harmoniously to attain the goals. Mutually, both parties should be willing to participate in the interaction. By the participants signing consent to witness the presentation this is a start to mutual cooperation to reduce stigma.

### **Support of Authorities, Laws, or Customs**

Both groups must be aware that there is an authority that encourages or supports the interaction. Aside from the organizers of the interaction, there is a call to address mental health stigma by both local and global governments (Vigo, Thornicroft, & Atun, 2016). This can serve as the authority. There is a general understanding that mental health is a topic that needs to be discussed for individuals of all backgrounds (Vigo, Thornicroft, & Atun, 2016).

### **Methodology**

This project consisted of a quasi-experimental study design. Participants were given the Stigma 9 questionnaire (Stig-9), a validated stigma assessment tool, before and after the implementation of a contact-based intervention. The intervention entailed a 60 minute presentation from an individual living with a mental health condition. This trained individual spoke to the participants about their lived experience with mental illness and what it is like. A video recording was also shown to the participants to reinforce the content provided by the speaker. This video consisted of persons living with a mental health condition speaking of their experiences.

**Setting**

The setting for this project was in the building of a large Protestant church in northern New Jersey. The population of the church consists of approximately 850 members. The congregants are predominantly of Haitian descent, spanning multiple generations, and economic and educational backgrounds. Worship services and group meetings take place every day of the week, with the largest gatherings being on Sundays. There are three worship services every Sunday.

**Study Population**

The population from which the sample was derived is a predominantly Haitian congregation. The inclusion criteria were English speaking men and women over the age of 18. The participants also needed to be of Haitian descent. Exclusion criteria included anyone under the age of 18. As previously defined, for the purposes of this study, someone of Haitian descent is a person who was born in Haiti or whose parents were both born in Haiti. The study will aimed to have at least 40 participants. From the literature review that was performed, the smallest sample size used in a similar study was 40 individuals with statistically significant results (Vinson, Abdullah, and Brown, 2016).

**Study Interventions**

Subjects participated in the study by completing the Stigma 9 questionnaire. The questionnaire is a nine-component assessment that examines “cognitive, behavioral and affective aspects of perceived mental health-related stigma” (Gierk, Lowe, Murray,& Kohlmann, 2018, p. 822). The higher the score of the assessment the “stronger the expectations of negative societal beliefs, feelings, and behaviours towards the mentally ill” (2018, p. 822). Factor analyses that

have been done on the tool show a single factor structure signifying that a simple total score can summarize the data provided by this questionnaire.

After completing the questionnaire, the participants then witnessed the presentation by NAMI. This nationally recognized organization provides a program called In Our Own Voice. This program conducts speaking engagements throughout the country with persons who are trained to speak about their mental health conditions and their recovery. As stated by NAMI, this session has been used for “community education and reducing stigma” (NAMI, 2019, para. 1). The participants listened to firsthand accounts of living with a mental illness from the aforementioned trained individual along with other individuals via video recording. As per NAMI, the speaker spoke about the difficulties they faced; acceptance of their mental illness from family members, friends and society; coping skills they learned; and their future aspirations (2019). The subjects were then able to ask questions to the presenters. The time of the entire presentation, including questions, was approximately 70 minutes. The participants then completed the Stigma 9 questionnaire again after the presentation.

### **Outcome Measures**

As mentioned before, the Stigma 9 questionnaire is a 9-question assessment tool that assesses mental health stigma. The tool uses a 4-point Likert scale: disagree = 0, somewhat disagree = 1, somewhat agree = 2, and agree = 3. The inferential statistics used to examine this tool have shown “high internal consistency and reasonable external and internal validity” (Gierk, Lowe, Murray & Kohlmann, 2018, p. 825). When the questionnaire was developed, the psychometric properties and applicability was evaluated among persons with mental health disorders. The content of the questionnaire was also discussed among mental health clinicians to further validate the content. The internal consistency of the Stig-9 is high: Cronbach’s  $\alpha=.88$ .

**Risk/Harms**

There was minimal risk posed in the participation of this study. Some potential emotional or psychological discomfort was considered due to the nature of the topics being discussed. There was a licensed professional counselor present in the unforeseen event that an individual was affected by what was being shared by the presenters. Achille Dejean MA, LPC was the board-certified counselor that was on site. The aim of this study was not to treat or diagnose any mental health conditions of the participants. Participants remained anonymous in the completion of the pre and posttests provided after the presentation. In order to link the pre-and post-test responses, each pair of assessments was allotted a random number. Only the student investigator and her project chair had access to the answers provided on the survey forms.

**Subject Recruitment**

During the announcement portion of the worship services on Sundays, the pastor informed congregants that a presentation about mental illness would be given on a specified date. This took place for a minimum of four consecutive Sundays. The announcement explained that the presentation would be provided by speakers living with mental illness from the National Alliance on Mental Illness (NAMI) and that participants would be asked to complete a questionnaire before and after the presentation. Flyers were also posted on the announcement bulletin board in the lower level of the church. Recruitment of participants took place in a room provided by the facility every Sunday after the conclusion of the service. Those interested in participating received informed consent and information regarding the study, along with contact information of the student investigator if there were any questions or concerns regarding the study. Prospective participants were made aware that attending the presentation was allowed without having to participate in the study and that participation in the study was voluntary.

Recruitment continued up to the day of the presentation, so that individuals would be able to give consent and volunteer to participate in the study if they were unable to previously. (See Appendix C for posted bulletin)

### **Consent Procedures**

At the conclusion of every service, the student investigator was available in the first floor of the church to obtain informed consent and answer questions regarding the study. There, individuals signed the informed consent. The day of the presentation, those who wanted to participate in the study were able to do so as well. (See Appendix C for informed consent form).

### **Subject Costs and Compensation**

Attendance and participation in the study was at no cost to the participants. Participants did not receive any compensation for participating in the project.

### **Project Timeline**

See Appendix F.

### **Economic Considerations**

The only expenses that were accrued to conduct the study are the materials for the survey. The location where the study was conducted was free of cost, as well as the presentation provided by NAMI. The student investigator covered the costs noted above (see Appendix E).

### **Data Security**

Participants remained anonymous for the completion of the pre and post-tests provided after the presentation. In order to link the pre- and post-test responses, participants were assigned a random number. They were asked to place this number on both their pre-test and post-test in order to link the two documents. Only the student investigator and the project chair would have access to the answers provided on the survey forms.



## **Data Analysis**

### **Results**

The intent of this study was to examine if a contact-based intervention would reduce stigma towards mental illness in those of Haitian descent. The results analyzed show that the contact-based intervention was associated with a decline in mental health stigma. However, the results were not statistically significant. This may have been due, in part, to the fact that the desired minimum sample size of 40 was not met. There were a total of 36 intervention participants, but only 20 of them completed both the pre- and post-intervention Stigma-9 questionnaires. Given the positive findings, it is possible that a larger sample may have yielded statistically significant results.

Approximately 53% of the 36 participants were male (n=19) and about 47% were female (n=17). Ages ranged from 18 years of age to above 65 years of age. A majority of the participants were between the ages of 45-54. Another important aspect to the demographics of this study was being of Haitian decent. All of the participants were of Haitian decent, with 86% of the subjects having been born in Haiti.

### **Findings**

A Wilcoxon Signed Ranks Test was used to analyze the data using the Statistical Package for Social Sciences (SPSS). The non-parametric test was chosen based on the study's small sample size and non-normal distribution. Mental health stigma was measured using the Stigma- 9 questionnaire. A Likert scale was used with questions ranging from 0-disagree, 1-somewhat disagree, 2-somewhat agree, 3-agree, yielding a total score of 0 to 27, with higher total scores indicating a greater degree of stigma felt by the participant.

The mean pre-test score of the participants was 13 and the post-test score 10, indicating a decrease in stigma in the study subjects. This indicates an associated decline with a contact-based intervention and mental health stigma. However, the results were not statistically significant:  $p=.058$ .

### **Discussion**

Besides the study's small sample size, there are a number of other possible explanations for the lack of significant study findings. Firstly, there may not have been an adequate amount of time for the participants to reflect on the presentation to really analyze the impact on their beliefs and attitudes. There was a constraint on time due to a worship service that was to be held after the presentations. Therefore, there is a possibility that not all questions may have been answered. Although the study participants were able to speak English, a translation during the presentation (with the permission of the speaker) was provided for those who were there to just witness the presentation and may not have been English speaking. This could have interfered with the fluency of the information given by the presenter, thus affecting how the study participants received the information.

During the question and answer portion of the presentation, many of the observers verbalized that there was stigma present in the Haitian community and that they were aware of it. Some participants even felt so moved by the presenter's story that they shared experiences of dealing with mental health illness in their own lives and the stigma that they faced. What was most significant, is that some of the participants verbalized the importance of seeking a medical professional if one were to suspect issues with their individual mental health. The point was made that this could be done in conjunction with other means, such as praying or speaking to one's pastor.

**Implications/Recommendation**

**Clinical practice and education .**The results of this study indicate that there is some impact on mental health stigma after being educated on an individual's experience with mental illness. Knowledge related to the person living with a mental illness helps bring a different perspective towards this individual. For clinical practice, health care providers, social workers, nurses, and others in the healthcare field can refer patients to organizations such as NAMI if they suspect barriers related to mental health stigma. Expanding initiative to reduce mental health stigma can have impact on the economics, quality, and safety of the healthcare delivery system.

**Economics, quality, and safety.** In the year 2013, the amount of spending towards mental health disorders surpassed the costs of heart conditions (i.e., \$201 billion versus \$147 billion, respectively, Roehrig, 2016). The economic burden reflects the prevalence of these conditions, but also highlights the need to address them. NAMI reports that there is \$100 billion lost in productivity due to untreated mental disorders (2019). Mental health stigma is a contributing factor to untreated mental illnesses. Addressing stigma and attempting to reduce it can encourage individuals dealing with mental disorders to seek the appropriate care they need. Safer practices can be executed if people feel comfortable speaking about mental health. Reducing stigma among healthcare providers can also lead to better practice of addressing mental health during routine office visits.

**Healthcare policy.** There have been many advances in government policy to address the topic of mental health. In 2016, the United States House of Representatives passed a law titled the *Helping Families in Mental Health Crisis Act*. This act addresses a myriad of components to the treatment of mental health. It strengthens response teams responsible for mental health crisis calls in various communities. It has initiated specific instruction to different law enforcement

personnel on how respond to those who may be mentally ill. It has also influenced the mental health workforce with loan repayment programs and funding for pediatric tele health consultations as it relates to mental illness. This act has also propelled the importance of integrating physical health with mental health at primary care visits. It has allowed Medicaid to provide same day billing for mental health and substance abuse services. Concurrently, it holds insurance plans accountable for the proper coverage of mental health and substance use ailments (NAMI,n.d). However, initiatives specifically towards reducing stigma are still needed.

Gronholm, Henderson, Deb and Thornicroft (2017) explored different programs that various international governments implemented to help address stigma in their communities similar to the one provided by NAMI. All of these programs were able to aid in the reduction of stigma.

### **Sustainability**

Further research is needed to explore the lasting effects of contact interventions on mental health stigma. In this particular setting for this study, holding workshops or seminars quarterly regarding mental health could aid in the sustainability of stigma reduction. There are often blood pressure screenings done monthly by some of the medical professionals in this particular church. Discussions regarding mental health could be incorporated during these sessions as well. Recurrent conversations between those who stigmatize persons with mental disorders and those living with mental disorders will aid in the continuation of stigma reduction. Organizations such as NAMI must continue to be prominent advocates for more contact-based encounters in order to sustain positive outcomes. NAMI has also implemented a “Break the Stigma” program to provide more awareness towards stigma and practices on how to eliminate it. More importantly, individuals who have been impacted by the journeys should be encouraged to share what they have learned.

Dissemination of this study's results can help spread awareness of the fact that contact-based interventions can have an effect on stigma. The student investigator will present the findings at the DNP poster day. Dissemination of the results could also be done by sharing the research found in this study to different groups in the community such as government officials, law enforcement, and healthcare professionals. NAMI provides their presentation to all groups.

### **Conclusion**

Contact-based interventions can reduce mental health stigma in persons of Haitian descent. Mental health stigma is particularly present in the population despite the fact that they face a unique set of mental health struggles. With stigma being a barrier to utilization of services, it is reassuring to know that there is a means that could potentially address this barrier. Although this study involved persons in a single Haitian community, the results provide justification for expanding the model to other communities and settings.

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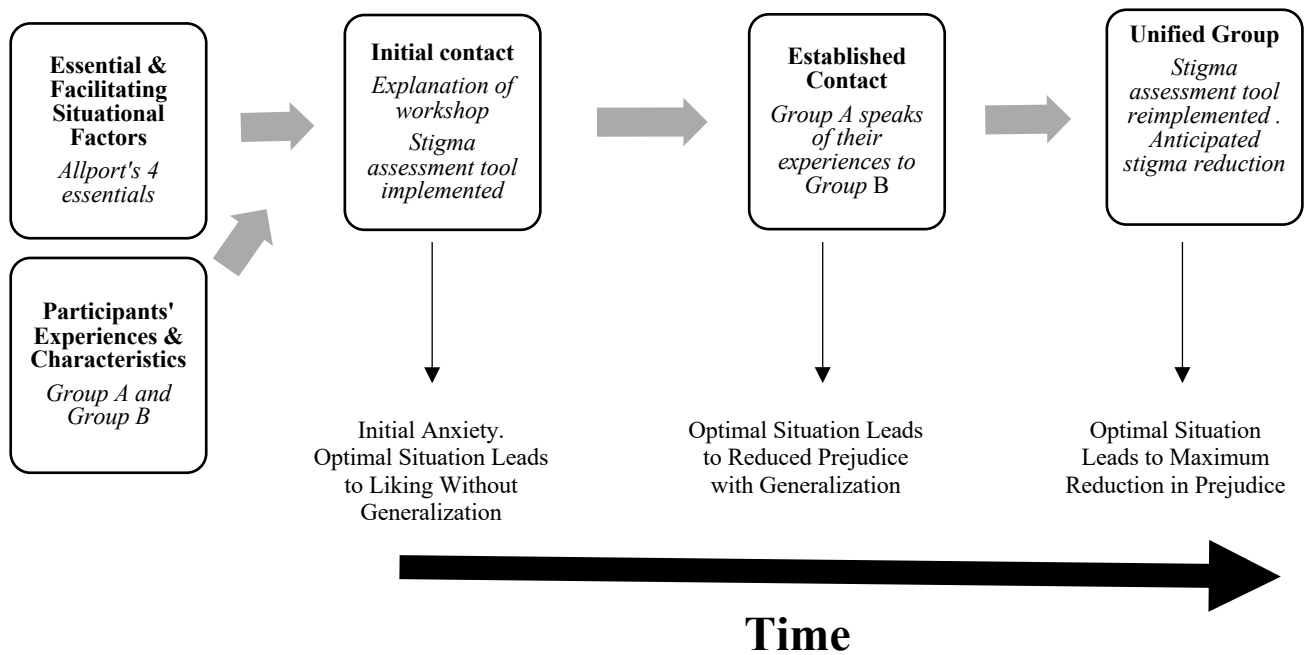
Long-term effects of filmed social contact or internet-based self-study on mental health-related stigma: A 2-year follow-up of a randomised controlled trial. *Social Psychiatry and Psychiatric Epidemiology*, 54(1), 33-42. doi:10.1007/s00127-018-1609-8

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## Appendix A

## Concept Map

Adapted from Gordon Allport's Contact theory



## Appendix B

## Evidence Table

In individuals of Haitian descent, does contact-based interventions reduce mental health stigma?

Article	Author and Date	Evidence type	Sample, Sample size, Setting	Study findings that help EBP Question	Limitations	Evidence Level and Quality
<b>Effects of contact-based mental illness stigma reduction programs: age, gender, and Asian, Latino, and White American differences</b>	Wong, C.E., Collins, L.R., Cerully, L.J., Yu, W.J., Seelam R. (2018).	Quasi-Experimental	4122 participants. A statewide campaign was implemented that established a wide range of contact-based educational programs. Those who participated in any of the programs qualified for the study. Mental illness stigma assessments were given pre intervention and post	Instant reductions in stigma were observed in all the ethnic groups used in the study. Comparisons were also made amongst the “young adults” and “older adults”. Both groups also presented with reductions in stigma. “Young adults exhibit greater improvements in negative beliefs about the contributions ( $\beta = -0.10$ ; $SE = 0.03$ ), dangerousness ( $\beta = -0.10$ ; $SE = 0.03$ ), and recovery	Absence of control group. Study measured only immediate effects. Long term follow-up would be needed to evaluate sustained decreases in stigma.	Level II Good quality

			intervention.	of individuals affected by a mental illness ( $\beta = 0.16$ ; $SE = 0.04$ ) compared to older adults”(2018).		
<b>Long-term effects of filmed social contact or internet-based self-study on mental health-related stigma: a 2-year follow-up of a randomized controlled trial</b>	Yamaguchi, S., Ojio Y., Shuntaro, A., Bernick P., Ohta, K., Watanabe, K., Thornicroft, G., Shiozawa, T., Shinsuke, K. (2018).	Randomized Controlled Study	249 participants at the University of Tokyo. Three groups: filmed social contact, internet-based self study, and non-active control. First two groups were given an initial 30 min intervention. After, they received emailed repeated filmed social contact and self study interventions every 2 months	Reduction of stigma after repeated exposure to the interventions. 2 assessment tools were used: Reported and Intended Behaviour Scale (RIBS-J), and the Mental Illness and Disorder Understanding Scale (MIDUS). “RIBS-J intended behaviour subscale scores between the filmed social contact group and the control group ( $B = 0.95$ , 95% $CI = 0.01$ , 1.90;	Number of participants that actually watched the repeated emails was not monitored. Actual adherence was not tracked. Follow up was done regardless of adherence.	Level 1 High quality

			over a 1 year period Study entailed a follow up regarding the effects of contact-based interventions on stigma towards mental health..	p = 0.049)”(2018)		
<b>Interventions to reduce discrimination and stigma: the state of the art</b>	Gronholm, P., Henderson, C., Deb T., Thornicroft, G. (2017).	Systematic review- Narrative synthesis	Narrative synthesis done. Total amount of works reviewed not given.-	Significant amounts of studies have shown that contact-based interventions have positive effects on stigma. However, the review questions whether these short term interventions have lasting effects (2017).	Comprehensive search strategy not used or stated in study	Level V
<b>Impact of skill-based approaches in reducing stigma in primary care physicians: results</b>	Beaulieu, T., Patten, S., Knaak S., Weinerman, R., Campbell, H., Lauria-Horner, B. (2017).	Double blind, cluster randomized controlled trial	111 community-based family physicians were randomized into an intervention group	From this study, a contact-based education program was established in various practices for primary care	There were lower than expected assessments completed by the physicians which contributed to	Level I Good quality

<p><b>from a double-blind, parallel-cluster, randomized controlled trial</b></p>			<p>and control group. 72 doctors were able to complete the pre and post assessment and were considered in the main analysis.</p>	<p>providers in British Columbia. The program involved a 3.5-hour workshop that encouraged contact with an individual with mental illness along with other activities that would enhance skills with patients in the clinical setting. Although there was not a significant effect on overall stigma, the study found that there was a decrease on “preference of social distance”, a significant component of stigma. The researchers concluded that the study provided “preliminary evidence of a positive effect on</p>	<p>decreased ability to find significant effects in scores pre intervention and post intervention. This contributed to a type II error. Lack of time also played a role in reduction of participants .</p>	
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				stigma... (Beaulier et al., 2017).		
<b>Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: systematic review</b>	Mehta, N., Clement, S., Marcus, E., Stona AC., Bezborodovs, N., Evens-Lacko, S., Palacios, J., Docherty, M., Barley, E., Rose, D., Koschorke, M., Shidhaye, R., Henderson, C., Thornicroft, G. (2015)	Systematic review	Six databases used from 1980 to 2013 to search for quantitative studies. 80 studies used	Found a number of systematic reviews that supported contact interventions in the reduction of stigma or negative attitudes. But not enough done to evaluate long term effects. "For attitude outcomes SMDs ranged from 0.05 to 71.22 with a median effect size of 70.26, indicating a small reduction in stigmatising attitudes. For behavioural outcomes SMDs were calculated in one intervention which showed a small (SMD = 0.22) effect in reducing stigmatising	Unable to fully assess studies that only provided abstracts that were in English. There may have been studies published before 1980 that were not evaluated. Publication bias: studies showing no benefit might be published less than those that do	Level III



				behavior” (2015).		
<b>Effectiveness of direct contact intervention with people with mental illness to reduce stigma in nursing students</b>	Martinez-Martinez, C., Sanchez-Martinez, V., Sales-Orts, R., Dinca, A., Richard-Martinez, M., Ramos-Pichardo, J. (2019).	Quasi-experimental	180 nursing students within three universities in Valencia, Spain	The Mental illness stigma attribution questionnaire was utilized before and prior the intervention. The intervention consisted of a 90 min session with mental health practitioner, an individual with a mental illness, and a family member related to someone with a mental illness. The participants mentioned above gave first hand accounts about mental health and illness as it relates to them. Student were then allowed to ask questions. There were decreases in negative feelings: “fear, feelings of	Lack of randomization and absence of a control group	Level II Good quality

				danger, avoidance, segregation and coercive attitudes” all specific aspects of stigma.		
<b>Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials</b>	Griffiths K., Carron-Arthur A., Parsons A., Reid R., Kathleen M. (2014).	Meta-Analysis of randomized controlled studies	8246 from initial keyword search using “mental illness” and “stigma”. 34 papers made the study. 33 of which were RCTs	From the analysis studies that included “consumer contact” (contact-based) interventions had an association with lowering stigma related to mental illness compared to mass media interventions (internet educational sessions, educational, pamphlets).	Multiple effect sizes used in the studies analyzed. Limited papers on consumer contact along on “mental illness stigma”	Level 1 High quality
<b>Educational intervention to decrease stigmatizing attitudes of undergraduate nurses towards</b>	Bingham, H., O’Brian, A. (2018).	Quasi-Experimental	40 first year undergraduate nursing students in New Zealand.	The educational intervention used was “face to face” contact with an individual with a mental illness. Students were able to	Small sample size. Bias: Students may have answered as a way to please professors. Collection of the data was from	Level II Good quality

people with mental illness				hear directly from the patients about their experiences. A validated tool: The Attribution questionnaire (AQ-27) was used. It is a tool created to assess programs that were created to eliminate mental illness stigma (2014). The results showed that there were positive significant changes of stereotypes and stigmatizing views towards the mentally ill.	the professors. This in turn can affect internal validity.	
<b>Evidence for effective interventions to reduce mental-health-related stigma and discrimination</b>	Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C., Henderson, C. (2016).	Systematic reviews of "RCTs, repeated cross-section population survey with control group, repeated cross sectional population	8 systematic reviews, and 8,143 quantitative studies	Researchers of this study proposed "Social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes	"Narrative review" approach used for this review. Authors suggest that this could entail some selection bias. Findings may not be able to be	Level II Good quality

		survey without control group. Longitudinal panel study with control group, pre-post controlled, pre-post controlled pre-post uncontrolled" (2016).		in the short term" (2016). Of the studies reviewed that dealt with contact, this entailed direct social contact and "first hand narratives" either in person or filmed.	generalized to Low/Middle income countries because the information found for this class was minimal.	
<b>Mental Illness Stigma Intervention in African Americans : Examining Two Delivery Methods</b>	Vinson, E.S., Abdullah, T., Brown, T. (2016).	Quasi-Experimental	158 African American university students. Ages 17-50 years of age.	The intervention consisted of an in person contact information session from someone suffering from panic disorder. The person spoke about their experience, identifying his symptoms initially, then eventually seeking help. His account was recorded and then shown to a second group. Two assessment tools were used: Social	No control group. Also because the study was applied to a specific population, this limits being able to generalize the findings to other groups.	Level III Good quality

				Distance Scale and the Attribution Questionnaire. The former looks to see how willing the individual would be to interact with someone with a mental illness. The latter examines views and beliefs about people with mental illness. The results showed a decrease in negative attitudes towards people with mental illnesses.		
<b>Mental health service use among immigrants in the United States: A systematic review</b>	Derr, A.S. (2016).	Systematic Review	Sixty two articles used from 5,020 articles found from initial search.	Study examined different types of immigrants including those of Caribbean descent. Despite need of mental health services, these services are used less	Only cross sectional studies examined.	Level 1 Good quality

				than those who are not immigrants due to negative views or beliefs towards mental health (2016). This support the need to evaluate the presence of mental illness in Haitian people.		
<b>The concept of stigma in mental illness as applied to Haitian Americans</b>	Dieujuste C. (2016)	Concept Analysis	N/A	Further supports the stigma that Haitians have towards mental health. “	No quantitative data	N/A

## Appendix C

## Informed Consent

## Posted Bulletin

**CONSENT TO TAKE PART IN A RESEARCH STUDY**

**Title of Study:** In individuals of Haitian descent, does contact-based interventions reduce mental health stigma?

**Principal Investigator:** Dr. Ann Bagchi, PhD,DNP,FNP-C, APN

**Co-Investigator:** Jo-Ann Dejean BSN, RN

**STUDY SUMMARY:** This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. It is your choice to take part or not.

The **purpose of the research** is to: reduce stigma or negative attitudes towards mental illness. If you take part in the research, you will be asked to take a survey assessing your views towards mental illness. Then you will witness a 40-70 minute presentation provided by speakers from the National Alliance on Mental Illness (NAMI). You will then take the same survey assessing your views towards mental illness. Your time in the study will take maximum 4 hours.

**Possible harms or burdens** of taking part in the study may be emotional or psychological discomfort due to the topics that will be discussed. Possible benefits of taking part may be a better understanding of individuals living with mental illness.

**An alternative to taking part in the research study** Your alternative to taking part in the research study is not to take part in it.

The information in this consent form will provide more details about the research study and what will be asked of you if you choose to take part in it. If you have any questions now or during the study, if you choose to take part, you should feel free to ask them and should expect to be given answers you completely understand. After all of your questions have been answered and you wish to take part in the research study, you will be asked to sign this consent form. You are not giving up any of your legal rights by agreeing to take part in this research or by signing this consent form.

**Who is conducting this study?**

Jo-Ann Dejean is the Co-investigator that will be conducting the study. Dr. Ann Bagchi is the Principal Investigator of this research study. A Principal Investigator has the overall responsibility for the conduct of the research. There are often other individuals who are part of the research team. Jo-Ann Dejean may be reached at [REDACTED]

The Principal investigator or another member of the study team will also be asked to sign this informed consent. You will be given a copy of the signed consent form to keep.

**Why is this study being done?**

The purpose of this study is to attempt to reduce stigma (negative beliefs/attitudes) towards mental illness in individuals of Haitian descent through an oral and visual presentation by a person living with mental illness.

**Who may take part in this study and who may not?**

Individuals of Haitian descent over the age of 18 may participate in the study. For the purposes of this study, someone of Haitian descent is a person who was either born in Haiti or have one or more parents who were born in Haiti. Participants must be able to read and understand English due to the fact that the assessment being administered will be in English. Exclusion criteria includes anyone who is under the age of 18 or not of Haitian descent.

**Why have I been asked to take part in this study?**

You have been asked to participate in this study to examine the effects on stigma towards mental illness by way of an oral and visual presentation by a person living with mental illness speaking about their experience with mental illness.

**How long will the study take and how many subjects will take part?**

The study will consist of a one-time 40 to 70-minute presentation from an individual living with a mental illness. There will be an additional 30 minutes for a stigma assessment that will be taken before the presentation and after the presentation. The day of the presentation will take no longer than 5 hours. Analysis and write up of the results will take approximately 3 months. The study will consist of a minimum of 40 participants.

**What will I be asked to do if I take part in this study?**

Participants will be given the Stigma 9 questionnaire (Stig-9), a validated stigma assessment tool before and after a presentation. The presentation will be a 40 to 70-minute presentation from an individual living with a mental health condition. This trained individual will speak to the participants about their lived experience with mental health and what it is like. A video recording will also be shown to the participants to reinforce the content provided by the speaker(s).

**What are the risks of harm or discomforts I might experience if I take part in this study?**

There is minimal risk posed in the participation of this study. Some potential emotional or psychological discomfort could be experienced due to the nature of the topics being discussed. There will be licensed professional counselors present in the unforeseen event that an individual is affected by what is being shared by the presenters. The aim of this study is not to treat or diagnose any mental health conditions of the participants.

**Are there any benefits to me if I choose to take part in this study?**

The benefits of taking part in this study may be learning about mental illness and having a better understanding of a person living with a mental illness. However, it is possible that you may not receive any direct benefit from taking part in this study.

**What are my alternatives if I do not want to take part in this study?**

Your alternative is not to take part in this study.

**Will I receive the results of the research?**

In general, we will not give you any individual results from the study.

**Will there be any cost to me to take Part in this study?**

There is no cost to be part of this study



**Will I be paid to take part in this study?**

You will not be paid to take part in this study.

**How will information about me be kept private or confidential?**

All efforts will be made to keep your personal information in your research record confidential. Participants will remain anonymous in the completion of the pre and posttests provided after the presentation. In order to link the pre and post test responses, participants will be asked to place the last four digits of their phone number with a letter at the end. Only the student investigator and her project chair (Principal Investigator) will have access to the answers provided in the tests given. They will be immediately discarded after the completion of data collection and analysis of the results.

**What will happen if I do not wish to take part in the study or if I later decide not to stay in the study?**

It is your choice whether to take part in the research. You may choose to take part, not to take part or you may change your mind and withdraw from the study at any time.

If you do not want to enter the study or decide to stop taking part, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

You may also withdraw your consent for the use of data already collected about you, but you must do this in writing to Jo-Ann Dejean at [REDACTED].

**Who can I contact if I have questions?**

If you have questions about taking part in this study or if you feel you may have suffered a research related injury, [REDACTED]

If you have questions about your rights as a research subject, you can contact the IRB Director at: Then delete the other 2 IRBs: Newark HealthSci IRB (973)-972-3608; or the Rutgers Human Subjects Protection Program at (973) 972-1149 or email us at [humansubjects@ored.rutgers.edu](mailto:humansubjects@ored.rutgers.edu).

**AGREEMENT TO PARTICIPATE****Subject Consent:**

I have read this entire consent form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form and this study have been answered. I agree to take part in this study.

Subject Name (Print): \_\_\_\_\_

Subject Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Investigator/Individual Obtaining Consent:**

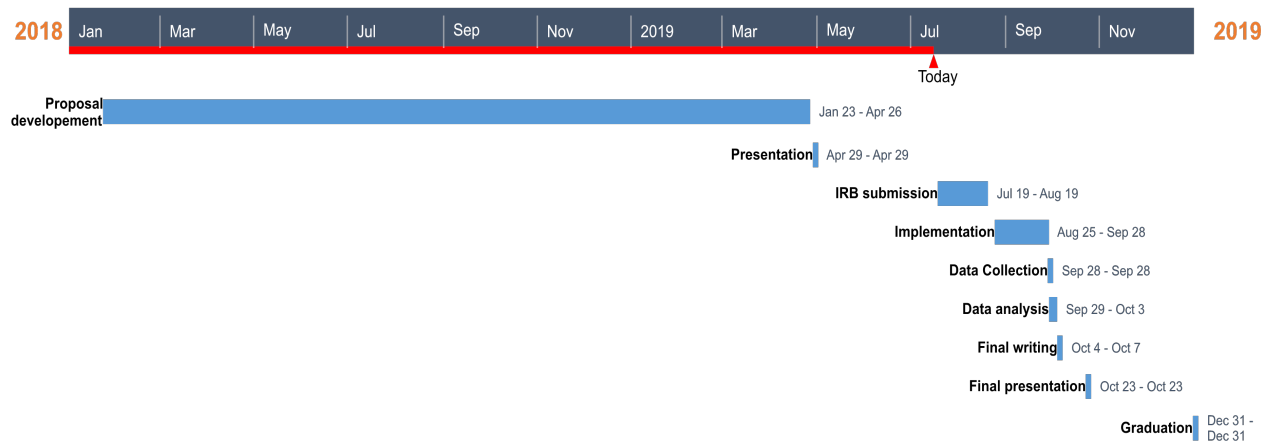
To the best of my ability, I have explained and discussed all the important details about the study including all of the information contained in this consent form.

Investigator/Person Obtaining Consent (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix D

## DNP Project Timeline



## Appendix E

## DNP Project Budget

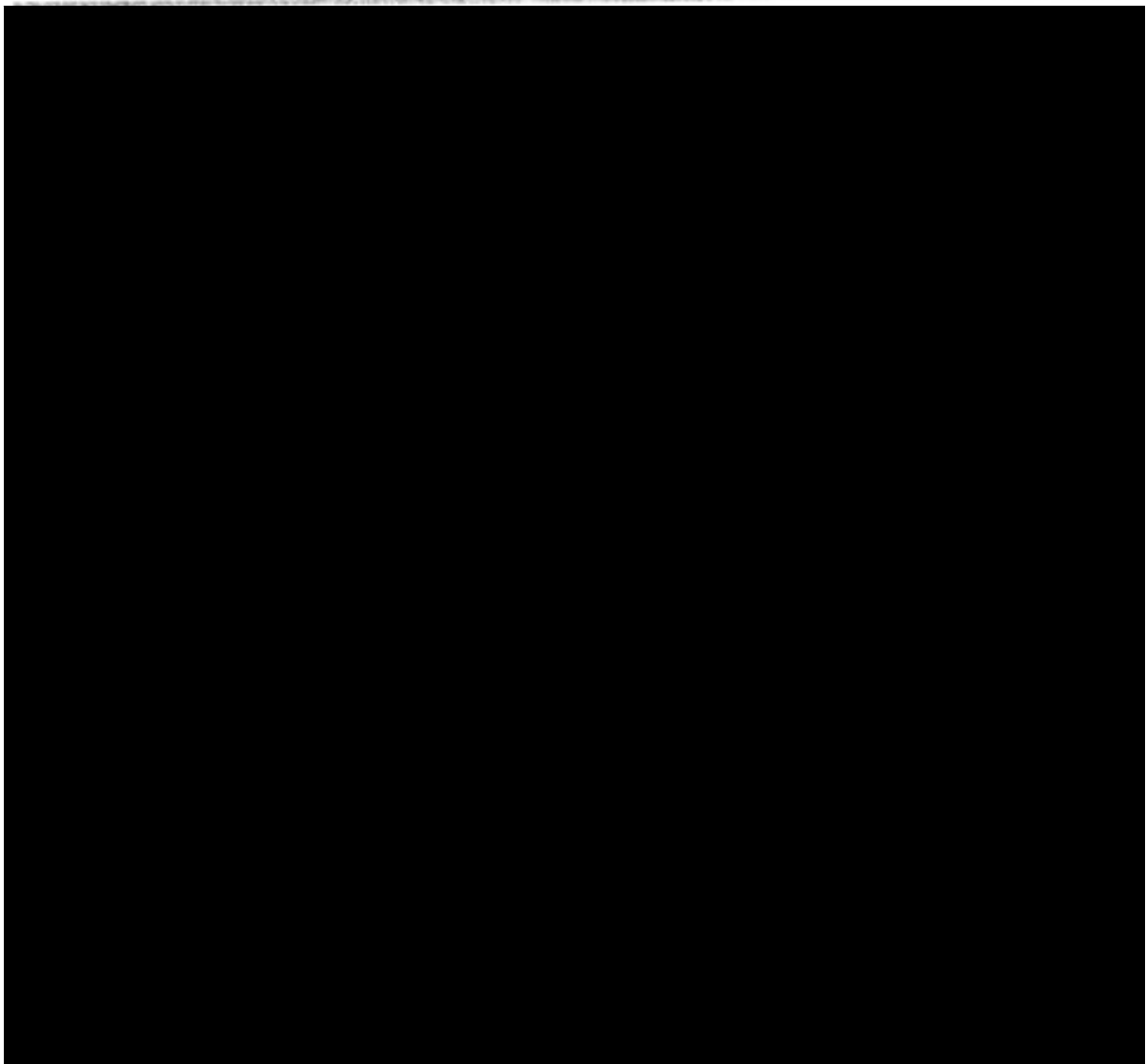
	1. \$20.00 (96 pencils)
	2. \$41.00 (For laser jet at home printing Surveys 100ct, Informed consent 100ct)
Total	<hr/> \$61.00

## Appendix F

## Stigma-9 Questionnaire

I think that most people...	disagree	somewhat disagree	somewhat agree	agree
... take the opinion of someone who has been treated for a mental illness less seriously.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... consider someone who has been treated for a mental illness to be dangerous.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... hesitate to do business with someone who has been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... think badly of someone who has been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... consider mental illness to be a sign of personal weakness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... hesitate to entrust their child with someone who has been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... do not even take a look at an application from someone who has been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... do not enter into a relationship with someone who has been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... feel uneasy when someone who has been treated for a mental illness moves into the neighbourhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12/27/2019

<https://eirb.rutgers.edu/eIRB/td/Doc/0/JM4C5SV0JD/K356CFG4PKSM593/FromString.html>**RUTGERS**  
**eIRB****Arts & Sciences IRB -  
New Brunswick**  
335 George Street  
Suite 3100, 3rd Floor  
New Brunswick, NJ 08901  
Phone: 732-235-2866**Health Sciences IRB -  
New Brunswick/Piscataway**  
335 George Street  
Suite 3100, 3rd Floor  
New Brunswick, NJ 08901  
Phone: 732-235-9806**Health Sciences IRB -  
Newark**  
65 Bergen Street  
Suite 511, 5th Floor  
Newark, NJ 07107  
Phone: 973-972-3608**DHHS Federal Wide Assurance Identifier:**  
FWA00003913**IRB Chair Person:** Cheryl Kennedy**IRB Director:** Carlotta Rodriguez**Effective Date:** 11/7/2019**Approval Date:** 10/17/2019**eIRB Notice of Approval for Initial Submission # Pro2019001584**

12/27/2019

<https://irb.rutgers.edu/IRB/td/Doc/0/JM4C5SV0/JK356CFG4PKSM593/fromString.html>

<b>Pregnancy Code:</b>	No Pregnant Women as Subjects	<b>Pediatric Code:</b>	No Children As Subjects	<b>Prisoner Code:</b>	No Prisoners As Subjects
<b>Protocol:</b>	Research protocol(revised-without tracking)	<b>Consent:</b>	Informed consent (without tracked changes-clean).pdf	<b>Other Materials:</b>	Document with NAMI video links.pdf Church announcement.pdf Recruitment flyer.pdf Stigma-9 Questionnaire.pdf

#### \* Study Performance Sites:

Rutgers University - School of Nursing

366 Ackerson Hall 180 University Avenue  
Newark, NJ 07102Mount Olive Church of God  
Mount Olive Church of God Annex Building24 Cleveland Street Orange NJ 07050  
29-37 N Essex Street Orange NJ 07050

#### ALL APPROVED INVESTIGATOR(S) MUST COMPLY WITH THE FOLLOWING:

1. Conduct the research in accordance with the protocol, applicable laws and regulations, and the principles of research ethics as set forth in the Belmont Report.
2. **Continuing Review:** Approval is valid until the protocol expiration date shown above. To avoid lapses in approval, submit a continuation application at least eight weeks before the study expiration date.
3. **Expiration of IRB Approval:** If IRB approval expires, effective the date of expiration and until the continuing review approval is issued: **All research activities must stop unless the IRB finds that it is in the best interest of individual subjects to continue. (This determination shall be based on a separate written request from the PI to the IRB.) No new subjects may be enrolled and no samples/charts/surveys may be collected, reviewed, and/or analyzed.**
4. **Amendments/Modifications/Revisions:** If you wish to change any aspect of this study, including but not limited to, study procedures, consent form(s), investigators, advertisements, the protocol document, investigator drug brochure, or accrual goals, you are required to obtain IRB review and approval prior to implementation of these changes unless necessary to eliminate apparent immediate hazards to subjects.
5. **Unanticipated Problems:** Unanticipated problems involving risk to subjects or others must be reported to the IRB Office (45 CFR 46, 21 CFR 312, 812) as required, in the appropriate time as specified in the attachment online at: <https://orra.rutgers.edu/hssp>
6. **Protocol Deviations and Violations:** Deviations from/violations of the approved study protocol must be reported to the IRB Office (45 CFR 46, 21 CFR 312, 812) as required, in the appropriate time as specified in the attachment online at: <https://orra.rutgers.edu/hssp>
7. **Consent/Assent:** The IRB has reviewed and approved the consent and/or assent process, waiver and/or alteration described in this protocol as required by 45 CFR 46 and 21 CFR 50, 56, (if FDA regulated research). Only the versions of the documents included in the approved process may be used to document informed consent and/or assent of study subjects; each subject must receive a copy of the approved form(s); and a copy of each signed form must be filed in a secure place in the subject's medical/patient/research record.

<https://irb.rutgers.edu/IRB/td/Doc/0/JM4C5SV0/JK356CFG4PKSM593/fromString.html>

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<https://eirb.rutgers.edu/eIRB/td/Doc/0/JM4C5SV0JD/K356CFG4PKSM593/fromString.html>

**8. Completion of Study:** Notify the IRB when your study has been stopped for any reason. Neither study closure by the sponsor or the investigator removes the obligation for submission of timely continuing review application or final report.

9. The Investigator(s) did not participate in the review, discussion, or vote of this protocol.

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