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Stigma towards mental illness and substance use issues in primary health care: Challenges and opportunities for Latin America

Jaime C. Sapag^{a,b}, Brena F. Sena^a, Inés V. Bustamante^c, Sireesha J. Bobbili^b, Paola R. Velasco^a, Franco Mascayano^{d*}, Rubén Alvarado^{d*} and Akwatu Khenti^b

^aDepartments of Public Health and Family Medicine, School of Medicine, Faculty of Medicine, Pontificia Universidad Católica de Chile, Santiago, Chile; ^bOffice of Transformative Global Health, Centre for Addiction and Mental Health, Ontario, Canada; ^cAcademic Department of Public Health, Administration and Social Sciences, Universidad Peruana Cayetano Heredia, Lima, Peru; ^dSchool of Public Health, Universidad de Chile, Santiago, Chile

ABSTRACT

Stigma towards mental illness and addictive disorders is a global problem and one of the main obstacles in tackling this issue remains the effective integration of mental health services into primary health care (PHC). In Latin America, information has significantly increased on the existence of stigma; however, little is known about effective interventions to prevent stigma and promote recovery-oriented practices in PHC. The aim of this study is to understand the existing evidence regarding mental health stigma in PHC with a special focus on the Latin American region. A scoping review of the literature related to mental health stigma in PHC was conducted. Two hundred and seventeen articles were evaluated; 74 met inclusion criteria and 14 additional articles were selected from references of search results. Results were subdivided into five different perspectives: users, family members and significant others, health professionals, contextual factors, and potential effective interventions. Only nine studies were based in Latin America, and only one described an intervention to reduce stigma in mental health services, not specifically in PHC. We found an urgent need to develop interventions to understand and reduce stigma in PHC settings, especially in Latin America.

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Mental health; mental illness; stigma; primary health care; substance use; Latin America

Introduction

Mental illness and substance use problems (MISUP) represent a major public health challenge. Close to 14% of the global burden of disease can be attributed to neuropsychiatric issues, mostly due to common mental health challenges including depression, anxiety, alcohol use, substance use disorders, and psychoses (Prince et al., 2007). There is an urgent need to effectively address unmet mental health needs worldwide (WHO, 2013). The gap between MISUP treatment needs and available resources is especially significant in developing countries (Patel, 2007) such as in Latin America, where populations are exposed to risk factors related to inequalities of income, education, and housing (de Andrade et al., 2015; WHO, 2013).

A high prevalence of MISUP among primary health care (PHC) users has been reported worldwide (WONCA-WHO, 2008), and in Latin America (Araya, Alvarado, Sepúlveda, & Rojas, 2012; Serrano-Blanco et al., 2010). A recent study in Brazil reported a prevalence of 41.4% for common mental disorders among people accessing PHC centres (Borges et al., 2016). PHC has been presented as a unique opportunity for improving care for those with MISUP through accessibility, early detection, holistic and continuous care, and the coordination of services (Corrigan et al., 2014; WHO,

CONTACT Jaime C. Sapag  jsapag@med.puc.cl

*Present address: Institute of Health Sciences, Universidad de O'Higgins, Rancagua, Chile.

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2013). PHC may also be able to resolve up to 90% of mental health issues (Goldberg & Huxley, 1980; PAHO, 2009).

Thirty years after the WHO/UNICEF PHC Conference in Alma-Ata, there is a worldwide movement to strengthen PHC and address mental health issues (Walley et al., 2008). A few efforts are underway in Latin America towards the integration of mental health services into PHC (PAHO, 2014; Sapag, Rush, & Ferris, 2016). However, stigma toward MISUP persists as a global concern (Stuart, Arboleda-Florez, & Sartorius, 2012; WHO, 2013) and has been cited as one of the main obstacles in better integrating mental health into PHC. Negative attitudes and behaviours about persons with MISUP have been shown to have detrimental effects on the quality of life of people receiving care (Stuart et al., 2012; Verhaeghe & Bracke, 2007).

Goffman (1963) defines stigma as an 'attribute that is deeply discrediting' and that reduces the target 'from a whole and usual person to a tainted, discounted one' (p. 3). According to Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999), 'Stigma exists when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold' (p. 377). Stigma also has negative effects in the general health care system where people labelled as mentally ill are less likely to benefit from the depth and breadth of available physical health care services than other people (Desai, Stefanovics, & Rosenheck, 2005).

There is a great need to advance MISUP stigma studies in Latin America in order to generate an evidence base to develop cultural relevant and context-specific interventions to address stigma in PHC in the region (Mascayano, Tapia, & Gajardo, 2015; Mora-Rios, Bautista-Aguilar, Natera, & Pedersen, 2013; PAHO, 2014; Yang et al., 2013).

Through a scoping review of available literature, we aim to expand the current understanding of stigma toward people with MISUP in PHC settings, with an emphasis on Latin America.

Methods

We conducted a scoping review (Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010) through a search of the PubMed, Medline, SciELO, EMBASE, CINAHL, PsycINFO, ERIC, Social Sciences Abstracts, the Cochrane Library, and Google databases. Searches were conducted in English, Portuguese, and Spanish languages. Based on Mays, Roberts, and Popay (2001) a scoping review aims to 'map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as stand-alone projects in their own right'.

We searched articles published between January 2002 and August 2016 using the following keywords: 'stigma', 'mental health', 'mental illness', 'substance use', 'substance abuse', 'addiction', 'primary care', 'primary health care', 'community health care'. These keywords were combined to reach the relevant search results. Our eligibility criteria for initial search results included any article published between the time period selected resulting from the combination of keywords as follows: 'stigma' AND 'mental health' AND 'primary care'; OR 'stigma' AND 'mental illness' AND 'primary care'; OR 'stigma' AND 'mental health' AND 'substance abuse' AND 'primary care'; OR 'stigma' AND 'mental health' AND 'substance use'; OR 'stigma' AND 'mental health' AND 'primary care' AND 'addiction'. We chose to include articles from any and all regions of the world in an attempt at capturing all potential articles from Latin America, and any and all potential lessons to be learned from other regions of the world that may be relevant.

A review of titles and abstracts was undertaken to find those that matched the keywords of the search. Articles whose primary focus of interest was MISUP stigma in primary care were included. Articles that comprised the keywords 'stigma' and 'mental health' for example, but did not include 'primary care' or 'primary health care' were excluded.

The initial scoping review of the databases yielded a total of 217 articles. Of these, 74 articles met the inclusion criteria. Additional relevant articles ($n = 14$) were found through a search of references from articles that included all of the keywords of interest. Titles and abstracts were reviewed independently by two authors, BS and JS, and selected independently based on inclusion criteria and

relevance. After the independent selection, the two authors met to discuss any discrepancies. During a second review stage, articles focused only on the Latin American region were identified.

Figure 1 summarises the search and article selection flow chart.

Results

A majority of the initial 217 articles identified focused on overall mental health services and identified stigma in PHC as one of the critical factors limiting access and quality of care to people faced with a MISUP. A small sub-group of articles (88) were specifically tailored to the reality of PHC. Most of the identified publications were based on qualitative studies; some used quantitative surveys to assess the problem; and a few evaluated the issue in Latin America.

The results are presented in the two sub-sections below. The first summarises the evidence in Latin America and the second focuses on the reality at the global level.

The reality in Latin America

Few articles address stigma toward MISUP among PHC providers in the Latin American region. Table 1 presents the selection of articles that were identified through the scoping review process in the region.

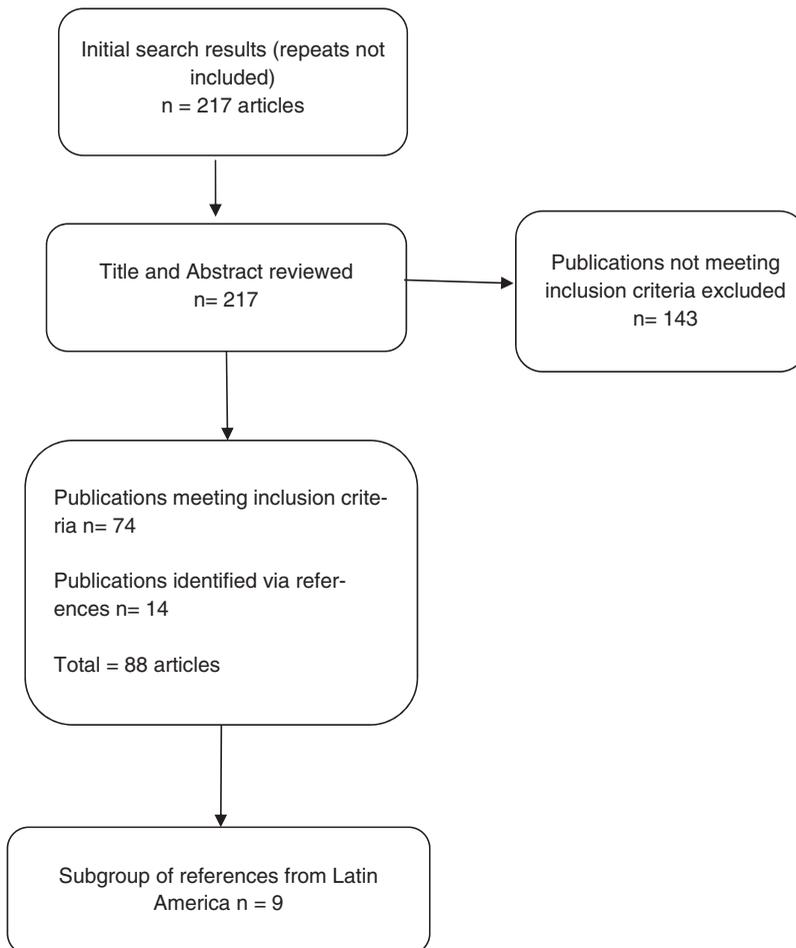


Figure 1. Search and article selection flow chart.

Table 1. Description of search results from Latin America.

Study	Country	Design	Aim	Main stigma-related results
Mascayano et al. (2016)	Latin America and the Caribbean	Systematic review of the literature	Twenty-six studies from seven countries in Latin America and the Caribbean were evaluated and arranged into the following categories: public stigma, consumer stigma, family stigma, and multiple stigmas.	<ul style="list-style-type: none"> • Some stigma results similar to those reported in high-income settings. • Some findings concerning public and family stigma differed from those reported in Western European countries. • Interventions designed to reduce stigma in this region may benefit from considering contextual cultural dynamics.
Acuña and Bolis (2005)	All Latin America	Literature review and analysis	Established the importance of stigma as barrier to access to health services, and identified ways to reduce exclusion due to stigma that go beyond the protection of the rights of the individual and within the framework of the extension of social protection in health.	<ul style="list-style-type: none"> • Development of policies, and strategies aimed at extending social protection in health to persons with mental illness • Reinforcement by an analytical-operational approach
Scazufca et al. (2016)	Brazil (São Paulo and Manaus)	Quantitative study with older adults (1291) and professionals (469) in PHC	Investigated three domains of public stigma (perceived negative reactions, perceived discrimination, and dangerousness) against older adults with depression.	<ul style="list-style-type: none"> • Prevalence of three stigma domains was between 27.6% and 37.6% among older adults • Among health professionals, prevalence of three stigma domains was between 19.8% and 44.6% • Importance of educating public and PHC providers in Brazil on stigma
Amaral-Sabadini, Saitz, and Souza-Formigoni, (2010)	Brazil	Quantitative study with PHC staff	Explored the association between primary care professionals' attitudes towards people with substance use issues (including stigma) and their readiness to implement clinical prevention practices.	<ul style="list-style-type: none"> • More stigmatising attitudes towards people with substance use issues among PHC staff were associated with less readiness to implement services for them.
Ronzani, Higgins-Biddle, and Furtado (2009)	Brazil (São Paulo and Minas Gerais)	Explored views of PHC providers in Southeast Brazil on the use of alcohol and other drugs that reflect stigma, moralisation, or negative judgment.	609 PHC professionals responded to a survey	<ul style="list-style-type: none"> • Confirms stigmatisation toward people affected by substance use issues by PHC providers. • Urgent call for effective interventions to prevent stigma.
Schilling et al. (2015)	Chile	RCT to assess feasibility, acceptability, and preliminary impact of a psychosocial intervention to reduce self-stigma among users	Psychosocial intervention was developed and tested through an RCT in two regions in Chile.	<ul style="list-style-type: none"> • Promising intervention to reduce stigma of mental illness within Chile and other Latin American countries

(Continued)

Table 1. Continued.

Study	Country	Design	Aim	Main stigma-related results
		with severe mental illness.		<ul style="list-style-type: none"> • Feasibility to scale up within mental health services.
Yang et al. (2013)	Chile	Proposed a new formulation of how culture affects stigma to create validated tools to assess stigma's culturally specific effects in Chile.	Identified initial hypotheses for how stigma might threaten people's capacities to participate in fundamental activities that 'matter most' in the Chilean context.	<ul style="list-style-type: none"> • Developing such measures promises to aid efforts to address culture-specific forms of stigma, and to facilitate implementation of community mental health services.
Robillard (2010)	Peru	Understand gendered social cues that produce stigma against mental illness enacted by general population.	Ethnographic and qualitative methods including a field ethnography of two health centres, one psychiatric hospital, and participants' households and neighbourhoods, two group discussions with members of the general population participating in gender-specific social support groups ($N = 12$), and illness narratives of men and women with a severe and persistent mental illness ($N = 22$), conducted at a low income, urban district of Peru.	<ul style="list-style-type: none"> • Gender roles are segregated into specific social and economic fields. • Gendered expectations shape both the experience of a severe and persistent mental illness and the stigmatisation of people with mental illness in a gender-specific way.
Caplan et al. (2016)	Dominican Republic	Qualitative study of health care providers.	Assessed mental health care in five regions of the Dominican Republic from the perspectives of health care providers, including barriers to care.	<ul style="list-style-type: none"> • Stigmatising attitudes among health care providers influences quality of care • Mental health care should be integrated into primary care and should include appropriate training.

Two of the articles focused on the Latin American region as a whole, three on Brazil only, two in Chile, one in Peru, and one in the Dominican Republic. Most of them were based on literature reviews or qualitative data. Some included a quantitative approach to assess MISUP stigma among PHC providers. Only one study was an intervention; however, it was not fully tailored to PHC.

Overall, the two regional articles confirm the relevance of stigma and its negative effects on people with MISUP. Even in articles without a main focus on PHC, the relevance of preventing stigma in PHC was highlighted as it is considered to be a strong limiting factor in the access and quality of care. This is aligned with the WHO Plan of Action and the PAHO Mental Health Strategy (2013), which recommend a comprehensive approach from policy to action at the local level, including the importance of strengthening mental health services in PHC.

A study in Dominican Republic (Caplan et al., 2016) specifically targeting health providers, confirmed that stigmatising attitudes among health care staff influences quality of care. The authors advocate for an active integration of mental health into PHC, as well as the education of both providers and patients to reduce stigma.

In Brazil, Ronzani et al. (2009) demonstrated that the use of alcohol and other drugs is a behaviour stigmatised by health professionals. In particular, the use of tobacco, marijuana/cocaine, and

alcohol were the most negatively judged behaviours ($p < .05$) and people affected by dependence on those substances were severely stigmatised and presented high rates of rejection. The authors recommend actively planning and implementing anti-stigma interventions in PHC settings. Another study with PHC staff in São Paulo (Amaral-Sabadini et al., 2010) concluded that more stigmatising attitudes towards people with substance use issues among PHC staff were associated with less readiness to implement services for them. Also in Brazil, Scazufca et al. (2016) identified stigma among health professionals toward people with dementia, finding differences in levels of stigma between two cities, which they attribute to different contextual realities.

A Peruvian study (Robillard, 2010) incorporated a gendered perspective to better understand the problem. The authors argued that gender roles are important in this context for they shape both the experience of severe and persistent MISUP, and the associated stigmatisation of people with these conditions in a gender-specific way. The gendered experience of stigmatisation is thus highlighted as a topic to be further understood in Peru. This might also be a problem present in other realities of Latin America, where 'machismo' is strongly embedded.

A study by Yang et al. (2013) in Chile, created culturally relevant instruments to measure stigma, presenting hypotheses for how it might threaten the ability to participate in fundamental activities that 'matter most' in this context; for example, a man's capability to protect the honour of the family, and a woman's competence to be a 'holy and pure' mother. Many of the elements presented may be important to consider when planning an intervention to reduce stigma in PHC. Schilling et al. (2015) went beyond understanding the problem in Chile to develop and test an RCT approach for a psychosocial intervention to reduce self-stigma, though the programme did not specifically target PHC.

Worldwide situation

Existing evidence demonstrates the negative effects of stigma in PHC toward people with MISUP, and shows that stigma varies depending on contextual and cultural realities as well as the specific MISUP condition (Thara & Srinivasan, 2000). Most of the identified studies explored the problem from the following four different perspectives: users, family members and significant others, health professionals, and preliminary evidence on potential effective interventions.

Users

Users perceive a negative effect of stigma toward people with MISUP in PHC both in terms of their own MISUP condition, as well as in the access and quality of care. Users are affected by stigma in their own communities and at PHC facilities (Kermode, Bowen, Arole, Pathare, & Jorm, 2009). A recent study from Campbell et al. (2016) indicated that high stigma predicted a lower likelihood of appropriate care for depression in PHC. In a cross-sectional study with 177 Latino immigrants in PHC, Caplan and Buyske (2015) identified stigma itself as a factor associated with the presence of depression.

Roeloffs et al. (2003) assessed how stigma affected 1187 depressed patients from 46 PHC clinics in the United States and found that 67% of them expected depression related stigma to have a negative effect on employment, 59% on health insurance, and 24% on friendships.

Research focused on understanding barriers to help-seeking among people with MISUP identified stigma as one of most substantial factors in all spectrums of the life cycle. For instance, a recent study by Salaheddin and Mason (2016) concluded that stigma toward MISUP may explain why young people are reluctant to seek help from others and that PHC represents a screening opportunity to facilitate access to care. In rural areas, users also identify stigma as a barrier for effective support in PHC (Hill, Cantrell, Edwards, & Dalton, 2016).

Studies confirm the presence of stigma in PHC, both for mental illness as well as for substance use issues (Smye, Browne, Varcoe, & Josewski, 2011). Chen et al. (2016) focused on vulnerable

populations, assessing the impact of stigmatising attitudes on depression outcomes among immigrant populations with psychiatric conditions, finding a negative effect of stigma on depression outcomes.

Further, Menke and Flynn (2009) examined the relationship between depression, mental health stigma, and treatment in a sample of 1103 African American and white PHC patients. Overall, African American patients reported greater mental health stigma than Whites. The results show the multiple stigmas faced in PHC.

Preliminary work has also been conducted to validate instruments to measure stigma among users in PHC. Interian et al. (2010) evaluated 6 specific scales with a sample of 200 Spanish-speaking Latino PHC patients, for example.

Family members and significant others

The role of family members and significant others may be important and strongly affected by stigma. A study by Dempster, Davis, Faye Jones, Keating, and Wildman (2015) reported that the lower self-stigma, the greater the help-seeking among African American parents of children with MISUP needs. The findings reveal the importance of considering parent stigma in the design of care models to ensure the provision of appropriate preventive and treatment services in PHC. The problem is also relevant in rural areas (Polaha, Williams, Heflinger, & Studts, 2015), where stigma also appears to present as a barrier, but only for some parents.

Perlick et al. (2007) conducted research with caregivers of 500 people with DSM-IV bipolar disorder and found that perceived stigma was positively associated with caregiver depressive symptoms, controlling for patient status and socio-demographic factors. The results suggest that caregivers' perceptions of stigma may negatively impact their own mental health and reduce their coping abilities.

Health professionals

In a study of health professionals in both mental health and PHC settings, Corrigan et al. (2014) identified stigma as a critical issue. Health professionals who endorsed stigmatising characteristics of the patient were more likely to believe he/she would not adhere to treatment and were therefore less likely to refer the patient to a specialist or refill their prescriptions.

PHC providers have also identified the importance of stigma in the context of substance use issues, especially alcohol (Turner, 2009). Bell, Dru, Fischer, Levit, and Sarfraz (2002) concluded that even where there has been increased involvement of PHC in addressing alcohol needs, with training and support for practitioners, there is underlying stigma associated with both addiction and substitution treatment.

A study conducted with 500 family physicians in Hong Kong (Lam, Lam, Lam, & Ku, 2013) examined their views on schizophrenia and depression, and the influence of demographic variables. Physicians were much more willing to work with a patient with depression and to deal with their needs (60.9%) compared with somebody with schizophrenia (37.0%). In this particular study, multiple ordinal logistic regression analyses showed that doctors with the following characteristics were more likely to have concerns or stigma regarding mental health patients: 'having longer years of practice', 'being female', 'working in hospital', 'employed in public sector', and 'not having a relative/friend with mental health problems'.

Kapungwe et al. (2011) explored health care providers' attitudes towards people with mental illness within 2 districts in Zambia, using a pilot tested structured questionnaire with 111 PHC professionals. Widespread stigmatising and discriminatory attitudes among PHC providers was found toward mental illness and those who suffer from it. They concluded that their findings and results along with a few others conducted in Africa 'have challenged the notion that stigma and discrimination of mental illness is less severe in African countries'.

However, the literature also presents favourable results suggesting the potential role of PHC professionals in recovery. A study in Finland (Ihalainen-Tamlander, Vähäniemi, Löyttyniemi, Suominen, & Välimäki, 2016) qualitatively assessed the attitudes of PHC nurses toward people with

MISUP. Attitudes primarily included a willingness to help and feelings of concern and sympathy towards these users. However, younger nurses or those without additional mental health training expressed a fear of patients. The authors recommend paying special attention to professional education and on-the-job training to prevent stigma among health professional. This openness among nurses was also identified in a qualitative study in Kenya (Mendenhall et al., 2016), where mental health services were viewed as a priority and promoted its integration into PHC as a way of protection from competing health priorities, financial barriers, stigma, and social problems.

Very few studies examine how stigma is managed in PHC practice. Dossa and Welch (2015) examined how general practitioners (GPs) manage medical documentation of stigmatising mental health and non-mental health information in Massachusetts. GPs expressed difficulties with, and inconsistent strategies for, documenting stigmatising information. The authors noted that this lack of consistency undermines the potential of medical documentation to efficiently facilitate continuous, coordinated health care. This is a concrete example of how relevant it is to consider stigma in the process of collaborative care provision.

Contextual factors

Finally, other structural and wider health system factors that limit the quality of the services provided in PHC for people with MISUP were highlighted. For example, Trude and Stoddard (2003) examined how practice setting and environment influences PHC physicians' ability to refer patients for medically necessary mental health services. They found that PHC physicians face greater challenges referring patients to mental health services compared to other medical services.

There are other critical factors such as racism, sexism, prejudice against immigrants and other ethnic and linguistic minorities that affect stigma. For example, there has been a well-documented association between stigma and violence, for instance in the case of homophobia, with obvious impacts on the mental health and well-being of victims (Hein & Scharer, 2013).

It is also essential to recognise the existence of multiple conditions/diseases in the same human being that contribute to how a person may perceive and be affected by stigma. For instance, a recent study in Rio de Janeiro, Brazil, explored the reality of stigma and discrimination among people living with HIV and the intersection of multiple social inequities (Kerrigan, Vazzano, Bertoni, Malta, & Bastos, 2017).

Evidence regarding effective strategies to reduce stigma towards mental illness and substance use issues

There is a dire need to develop comprehensive approaches to address stigma in PHC. Shim and Rust (2013) highlighted the importance of having a coordinated action to reduce stigma associated with MISUP, noting that mental health and physical health should be understood as inextricably linked. A qualitative study in Jamaica (Hickling, Robertson-Hickling, & Paisley, 2011) showed that deinstitutionalisation and the integration of community mental health care with PHC services, including a community involvement approach, reduced stigma toward MISUP.

Some articles also recommend addressing the stigma problem as a part of a comprehensive approach of mental health integration into PHC. Hirdes and Scarparo (2015) point to the main barriers and facilitating factors to support the process of integration, including epistemological, political, and professional issues, considering the reduction of stigma and discrimination and the development of new skills for professionals in PHC.

Several studies identified specific actions as potentially effective to address stigma in PHC. For example, Li, Li, Huang, and Thornicroft (2014) assessed stigma among health professionals in PHC before and after implementing a targeted capacity-building programme. The training showed to be an effective way to improve community mental health staff attitudes toward people with a mental illness in the short term, as well as to reduce the social distance between staff and people with a mental illness. In addition, Flanagan et al. (2016) reported preliminary evidence suggesting that a

photo-voice intervention might be effective to reduce stigma among PHC providers (Flanagan et al., 2016).

Shared decision making (SDM) also had positive effect on reducing MISUP stigma in PHC. For example, research conducted by Butler (2014) on family participation in care and its potential for improving the quality of child mental health care, found that higher levels of SDM were associated with lower stigma regarding mental health treatment and lower parent-perceived child mental health impairment. However, Patel, Schnall, Little, Lewis-Fernández, and Pincus (2014) also suggest based on their study in PHC in New York, that stigma can also be a barrier towards SDM.

Tailoring anti-stigma strategies to the reality of the target population also seems crucial. For instance, Cramer et al. (2014) conducted a study with men affected by depression and anxiety disorders and concluded that participation in guided group interventions, such as peer support, for example, reduced stigma. Special attention also seems to need to be paid on hard-to-reach groups. Kovandžić et al. (2011) ran a secondary analysis of qualitative data from seven previously reported studies focused on the experiences of people from hard-to-reach groups indicating both extensive commonalities between experiences of people from different hard-to-reach groups, and considerable diversity within each group. The authors point to one main common facilitator (communicated availability of acceptable mental health services) and two main common barriers (lack of effective information and multiple forms of stigma) to equitable access to primary mental health care.

Discussion

This article summarises some of the existing evidence on stigma toward people with MISUP in PHC settings. It is one of the first efforts to identify existing literature through a scoping review in this field. Most of the studies on stigma and health providers focus on mental health specialised services and/or on how people with MISUP perceive stigma as a generic barrier to care. In recent years, more attention has been given to PHC settings in keeping with the urgency and relevance of integrating mental health into PHC. In particular, this article focused on reviewing the literature on MISUP stigma in PHC towards identifying relevant interventions in Latin America.

Stigma towards MISUP is found within PHC worldwide and in Latin America (PAHO, 2014). The phenomenon of stigma is complex and moved by different factors. However, potential opportunities have been presented to prevent or mitigate its negative effects indicated by users, family and significant others, as well as by health professionals themselves. Conditions are stigmatised in different ways and intensity (e.g. schizophrenia vs. depression or alcohol dependence vs. cocaine dependence). The existence of multiple stigmas and their potentially simultaneous effects was identified as an important topic in the literature reviewed (Corrigan et al., 2014).

Most of the studies included in our review focus on understanding the problem in PHC, but very few of them touched on interventions towards tackling this issue. However, some principles were identified for building future interventions. Over the past four years, a pilot intervention funded by the Canadian Institutes of Health Research – CIHR – to address stigma in PHC settings, with a focus on immigrant populations, has been implemented in three community health centres across Ontario, Canada (Evidence Exchange Network for Mental Health and Addictions [EENET], 2014; Khenti, Bobbili, & Sapag, 2012). The project demonstrates a potential foundation for future research and implementation of meaningful anti-stigma interventions. Currently a cluster randomised controlled study funded by Grand Challenges Canada is also being completed in the south of Lima, Peru (Mental Health Innovation Network [MHIN], 2016), and a related research project supported by a Chilean federal grant FONDECYT is being implemented in Chile (Sapag et al., 2016). The mixed methods study is focused on examining and understanding in depth the phenomenon of stigma toward people with MISUP in PHC, considering the perspectives of both health professionals and users within the particularities of the Chilean local context.

Our current review has some limitations. First, it is based on just a few studies with diverse approaches. In addition, the identified initiatives have their own limitations and potential biases,

including: (a) non-response bias, (b) social desirability bias, (c) difficulties to measure attitudes, (d) limited validity of surveys, (e) external validity threatened by limitation of sample, (f) inferring behavioural responses from reported intentions, (g) cross-sectional studies in terms inference of causality, and (h) the own limitations of the scoping review process (since it is potentially less comprehensive and structured than a systematic review and aims instead at searching broadly to ‘scope’ the available literature on the topic of interest and does not necessarily evaluate or rank the quality of the evidence found). However, it is also fair to say that most of the studies have included specific measures to address their own potential biases and limitations. In addition, the close adherence to the protocol set out for conducting the scoping review contributed to a meaningful review of the relevant literature.

In terms of measuring mental health stigma among health providers, few instruments have been validated in the recent years. One of the main challenges of measuring stigma in Latin America is the lack of validated, culturally relevant, instruments, and qualitative studies that capture the deep socio-cultural factors and complexities of stigma (Yang et al., 2013).

Finally, it is important to identify implications and recommendations for future research and for the development of effective and sustainable interventions. According to the findings, interventions should include conducting contact-based training for health professional, creating safe spaces where health care practitioners can reflect on stigma problems, defining protocols to identify and address existing or potential stigmatising situations, promoting stigma-free and recovery-oriented environments, policies and practices (Sapag, Mohamoud, & Khenti, 2012).

Mental health access and quality of care are negatively affected by modifiable mental illness-stigma related attitudes/behaviours of PHC professionals. Understanding the interrelated components of stigma in PHC will contribute to the definition and implementation of comprehensive and effective anti-stigma/pro-recovery interventions within the public health system in Latin America.

Disclosure statement

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