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Original article

Reported and intended behaviour towards those with mental health problems in the Czech Republic and England

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ABSTRACT

This is one of the first studies, which compares the level of stigmatizing behaviour in countries that used to be on the opposite sides of the Iron Curtain. The aim was to identify the prevalence of reported and intended stigmatizing behaviour towards those with mental health problems in the Czech Republic and to compare these findings with the findings from England. The 8-item Reported and Intended Behaviour Scale (RIBS) was used to assess stigmatising behaviour among a representative sample of the Czech population ($n = 1797$). Results were compared with the findings of an analogous survey from England ($n = 1720$), which also used the RIBS. The extent of reported behaviour (i.e., past and present experiences with those with mental health problems) was lower in the Czech Republic than in England. While 12.7% of Czechs reported that they lived, 12.9% that they worked, and 15.3% that they were acquainted with someone who had mental health problems, the respective numbers for England were 18.5%, 26.3% and 32.5% ($P < 0.001$ in each of these items). On the other hand, the extent of intended stigmatizing behaviour towards those with mental health problems is considerably higher in the Czech Republic. Out of maximum 20 points attached to possible responses to the RIBS items 5–8, Czechs had a lower total score ($x = 11.0$, SD = 4.0) compared to English respondents ($x = 16.1$, SD = 3.6), indicating lower willingness to accept a person with mental health problems ($P < 0.001$). The prevalence of stigmatizing behaviour in the Czech Republic is worrying. Both, further research and evidence based anti-stigma interventions, should be pursued in order to better understand and decrease stigmatizing behaviour in the Czech Republic and possibly across the post-communist countries in Central and Eastern Europe.

1. Introduction

Stigma and discrimination towards people with mental illness are consistently identified as priorities in the political agendas and action plans of international organizations such as the European Union and World Health Organization (WHO) [18,51,52,54]. Also, a Roadmap for Mental Health Research in Europe (ROAMER) initiative put forward stigma as a fundamental societal challenge [30]. Prioritisation of stigma at the policy level is supported by growing research, which demonstrates that stigma and discrimination have a devastating impact on the life of a person with mental illness. They result in exclusion and reduction in opportunities from many life domains, such as employment, housing, and education [9,36,43,47]. This might become even more pronounced during times of austerity [22]. Stigma can be internalised and transformed into self-stigma, resulting in a reduction in self-esteem and self-efficacy [21,41]. Additionally, many studies on various population samples demonstrate that stigma is associated with less willingness to seek professional help [5,19,27,33,50]. This has been shown again in a recent systematic review, which included 90,189 participants from 144 studies [7] and across European countries [38], both confirmed a negative effect of stigma on help seeking. Stigma and discrimination may therefore significantly influence the course of the illness in relation to recovery and contribute to reduction of the quality of life of the people with mental health problems.

Stigma refers to a specific attributive process which assigns socially discrediting characteristics to people or phenomena, and

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which leads to the exclusion of the individual or phenomenon from the sphere of normality into the sphere of deviation [28]. In the area of mental health and illness, stigma is understood as a problem of ignorance, prejudice, and discrimination [48]. There seems to be a broad consensus that interventions, programs, and campaigns which aim to improve knowledge, attitudes and behaviour among the public can lead to the reduction of stigma [2,11–13].

People with mental illness continue to be stigmatised all over the world, with Europe being no exception [3,14,49]. Anti-stigma campaigns, however, do not have a long tradition in post-communist Central and Eastern European countries. In the Czech Republic, only one large-scale campaign which was a part of the international program Open the Doors and several other small-scale programs were conducted [4]. The majority of these programmes were cultural events, which included concerts, debates, and other activities described in the review article by Beldie et al. [4]. Other activities, not mentioned in that article, include Pure Soul and People among People initiatives which are both public awareness campaigns that are targeted on the general population, mainly web-based, and contain general information about severe mental illnesses, interviews and artwork. These activities have mainly been organized by NGOs and lacked sufficient funding and formal evaluation. Therefore, the impact of these activities is not clear. Activities that adapt or build upon interventions that have been shown effective abroad are scarce in the Czech Republic and the problem of stigma is still perceived as one of the greatest challenges in the Czech mental health care development [32].

Stigma has become the focus of Czech mental health policy only recently. In 2013, it was defined as one of the main strategic goals of the ongoing mental health care reform in the Czech Republic [37]. On the other hand, in the UK, stigma was raised as an issue already in connection with deinstitutionalization, which started around 50 years ago, and large anti-stigma campaigns were launched as early as in 1990s [15,31,42]. Evaluations of these campaigns showed significant improvements of public attitudes towards depression [40] and towards individuals with mental health problems generally [23].

A recent review of research on stigma in Europe revealed a dearth of publications from the former Communist bloc [25]. According to communist propaganda, there were officially no social problems in communist societies, and people with mental illness were systematically excluded from these societies into large asylums [32]. The current state of mental health care in the Czech Republic has been described elsewhere; the most important is that the system of care still relies on large mental hospitals, the availability of community care is fairly limited, and the system is substantially under-financed and afflicted by frequent changes at the post of minister of health [16,17,53]. Although there have been several initiatives to reform Czech mental health care, and recently a new strategy of mental health care reform was issued by the Czech Ministry of Health [37], deinstitutionalization has not yet been implemented. The substantial degree of institutionalization, low awareness among public about mental health issues, and structural discrimination which is reflected, among other things, in the low percentage of health budget that is dedicated to mental health, may be considered as major differences between public mental health in England and Czech Republic [46,53]. We assume that both, the post-communist heritage, which is still present in the current state of mental health care as well as the above-mentioned lack of anti-stigma programmes, might have contributed to considerable public stigma against those with mental health problems. In this research, we hypothesized differences in public stigma between England and Czech Republic.

In this study, we aimed to identify the level of reported and intended discriminating behaviour toward people with mental health problems in a nationally representative sample of Czech adults and to identify the relationship between sociodemographic characteristics and reported and intended discriminating behaviour. Furthermore, we aimed to compare the prevalence of reported and intended stigmatising behaviour in the Czech Republic with the prevalence in England.

2. Methods

2.1. Data and subjects

We used data from a nationally representative omnibus survey entitled the Survey of Opinions and Attitudes of Citizens of the Czech Republic toward issues of health and healthy lifestyles, which has been carried by INRES-SONES agency. The fieldwork was carried out by 311 trained interviewers between 18 November and 6 December 2013. Quotas were used to ensure nationally representative figures for age, gender, and number of voting districts to be randomly selected within each of the country's administrative region. One hundred and eighty-two out of an overall 14,802 voting districts were selected and a random route sampling method was utilized to recruit 10 respondents in each of these districts. A total of 2089 randomly selected respondents were approached in the Czech Republic. Out of these, 14% refused to participate in the study, primarily due to lack of time, doubts about the purpose of the study, or because the study seemed too long to the respondents. According to interviewers' records there were no differences in participation between males and females, individuals aged 15 to 19 years old were more likely to refuse participation, while those older than 65 years were more likely to agree to participate. However, *P*-values are not available to confirm statistical significance of these differences.

Data for the English population were collected as part of the National Attitudes to Mental Illness Survey, an omnibus survey commissioned by the Department of Health and done among a nationally representative sample of adults residing in England [26]. The survey which included the RIBS was carried out using Computer Assisted Personal Interviewing (CAPI). Face-to-face interviews were also conducted and respondents were selected using random selection of streets in a given voting district. The study took place at the respondent's home between 25 February and 1 March 2011. The study was organized by the Information Centre for Health and Social Care and the survey was carried out by 150 trained interviewers [6].

2.2. Measures

The Reported and Intended Behaviour Scale (RIBS) [20] was used to assess reported and intended stigmatising behaviour. It has been used and validated in various countries, including England [24], Sweden [29], China [35] and Japan [56]. Its test-retest reliability has been found moderate/substantial and its internal consistency substantial [20]. The RIBS consists of two parts with four items in each of them. Items 1–4 ask whether a respondent is, or has ever been, living with, working with, neighbouring with or continuing a relationship with someone with mental health problems. Items 5–8 then ask whether a respondent would be willing to do so in the future. The RIBS was translated into Czech following the guidelines of the World Health Organization [55]. The scores from 1 to 5 were attached to possible responses to the RIBS items 5–8, i.e. "strongly disagree", "disagree", "neither agree nor disagree", "agree", and "strongly agree". These scores were consequently added together, so that the highest possible score was 20 and indicated a strong agreement with each of the four items. Analogously the lowest score of 4 indicated a strong disagreement with each of these items. This may be viewed as the