Author's response to reviews

Title: Levels of stigma among community mental health staff in Guangzhou, China

Authors:

Jie Li (biglijie@163.com)
Juan Li (ljpsy87@163.com)
Graham Thornicroft (graham.thornicroft@kcl.ac.uk)
Yuan guang Huang (yuan2011gz@163.com)

Version: 2 Date: 1 July 2014

Author's response to reviews: see over
Dear editors:

Firstly, We really appreciate your helpful advices on our paper. We have revised the paper as your advices and the results are showed as followed.

Answers to Lars Hansson

Major compulsory revisions

Q1. The results section is not very well structured. It would be a better choice to present results concerning the primary hypothesis first, and then the secondary hypothesis followed by the results concerning the psychometric properties of the instruments. The use of headings and numbered headings in the results section might also be reconsidered.

A1. Thanks for your advices. We have revised in the paper as your opinion.

Q2. The central theme of the title of the article is levels of stigma among community mental health staff, but very little is presented around this theme. There is a short paragraph in the results section covering this: “stigma scores”. It would be very interesting to learn more about the results in these respects. What do the results concerning RIBS, MAKS and MICA tell us about levels of stigma? Do they tell us about low or high levels of stigma among staff? Since the instruments have been used in several other studies it would be
informative if comparisons were made with other studies, especially in the perspective of introducing anti-sigma programmes among mental health care staff.

A2. Thanks for your advice. Since both the RIBS and MICA don’t have a boundary value. We have made a comparison with other study (very limited) in the discussion as your advice as followed:

To our knowledge, this is the first study to investigate the levels of stigma among community mental health staff in China. Our results showed relatively high levels of stigma toward people with mental illness among community mental health staff in Guangzhou. The mean score were 11.97, 16.8 and 51.69 for RIBS, MAKS and MICA respectively. To put this in context, Henderson et al use RIBS and MAKS to evaluate the impact on the general population of England’s Time to Change program, and their results showed that the mean scores were 14.5 for RIBS and 21.2 for MAKS [47]. Moreover, Ye Rong et al researched attitudes toward depression among medical students and their results showed that the mean score was 43.51 for MICA[38]. We can conclude that the community mental health staff in Guangzhou not only have low levels of stigma related knowledge of mental illness but also less likely to contact people with mental illness and held a relatively negative attitude toward them.

(Also see paragraph 1-2 in the part of discussion)

Q3. The hypothesis concerning gender differences was confirmed, male participants showing more negative attitudes according to RIBS. But is this statistically significant difference of any importance in
terms of focus of an anti-stigma programme? The difference was around 1.5 points in a scale ranging from 4-20. It should be discussed if this difference is of any “clinical” importance. The same goes for differenced in mental health literacy according to MAKS. Is a gender difference of 1.7 of any importance in a scale with a range from 6-30? A3. Thanks for your advice. We have reconsidered it. Although the difference reached to a statistical difference. There is no clinical importance. As we have revised in the paper:

In support of our hypothesis, there are clear gender differences in terms of behavioural discrimination and knowledge related to mental illness, which are also in line with previous studies [38, 48, 49], which have investigated, for example, teenagers or medical students. But the mean score of RIBS were 11.35 and 12.66 for males and females respectively. For the MAKS, the gender difference was even smaller. The slight difference make it difficult to draw a conclusion. In addition, evidence from other study also provided rather mixed results.[50]. Wang et al indicated that women had significantly more negative overall implicit attitudes, especially negative cognition and beliefs, toward mental illness than men [51], and we propose that future study may well explore levels of stigma measured using implicit measures.

（Also see paragraph 3 in the page 9）

Minor essential revisions

Q1. In the last sentence in the second paragraph on page two it is stated that mental health staff in China would contact patients by
phone rather than in person. What is the evidence for this? Is there a suitable reference to add for this claim?

A1. It is a pity that we couldn’t find a reference to support this claim in China. But we found another reference and we have revised in the paper as:

*Further there is some evidence to support the view that health care staff hold even more negative attitudes toward people with mental illness than the general population, for example in preferring to contact patients by phone than in person, because of perceptions of risk of violence [35].*

Q2. What is the rationale and hypothesis behind coding “Don’t know” in the RIBS and MAKS scale as 3, that is a neutral answer, on the totally disagree- totally agree scale? Would it not be a better option to exclude these participants from the relevant analyses?

A2. Thanks for your advice. As the instruction of MAKS/RIBS said, “don’t know” is coded as neutral for the purpose of determining a total score. We computed the total score just as the scale instruction. Participants who choose “don’t know” as an answer is equally to neither agree nor disagree at some degree. In addition, there is no evidence to exclude participants who responses to “don’t know”.
Q3. There is confusion in the use of the MAKS scale. In the methods section it is stated that the first six items covering different mental health literacy areas are used and summarized. On the other hand, in the results section table 3 is in the text presented as showing results concerning these first six items, but is actually different diagnostic categories. This has to be clarified. Which part of the instrument was actually used in for the correlational analyses?

A3. MAKS comprises 6 stigma-related mental health knowledge areas help seeking, recognition, support, employment, treatment and recovery and 6 items which inquire about knowledge of mental illness conditions. Items 1-6 are used to determine the total score and was used for the correlational analyses. Item 7 to 12 are designed to understand which situation is a type of mental illness in the participants’ eyes. For MAKS, only items 1-6 were included to compute a total score. So we listed the details of items 7-12 to show which situation is a type of mental illness in the participants’ eyes.

Q4. It is not stated in the data analyses what test was used to investigate test-retest reliability.

A4. We have revised as:

A *Pearson correlation coefficient of the total scores before and after one week period was calculated to assess the test-retest reliability.*
Q5. How was the subsample for the test-retest study selected. It is only stated that it used 79 participants. Was this selection based on a power-analysis?

A5. It is only 79 participants from the original sample of participants consented to complete the survey again.

Answers to Jyrki Korkeila

Q1. Some data on the validity and reliability of RIBS should be added to the first paragraph of instrument. Is there any corresponding data on MAKS? Table 3 describes responses to 5 items in MAKS. However, it is not clear what the statements are that the responder either disagree or agrees. Please, elaborate.

A1. Thanks for your advices. We have revised in the paper as followed: *The original version of RIBS has been showed to be a psychometrically robust measure with strong internal consistency (α=0.85) and test-retest reliability (r=0.75) [41].* 

*The stigma-related mental illness knowledge was assessed using Mental Health Knowledge Schedule (MAKS). Although MAKS was not developed to function as a scale to produce a total score, it was designed, to be used in conjunction with other attitude- and behaviour-related measures [45]. MAKS comprises 12 items. The first 6 items cover stigma-related mental health knowledge areas: help seeking, recognition, support, employment, treatment and recovery. For example, 'Most people with...*
mental health problems want to have paid employment.” Items 7-12 assess opinions about which condition are types of mental illness to help contextualize the responses to other items, for example, ‘Depression.” A 5-point Likert scale was used and response options range from 1=totally disagree to 5=totally agree. “Don’t know” was valued 3 for the purposes of determining a total score. The total score was calculated by adding the response values for only items 1-6 and can range from 6 to 30. A higher score indicates more knowledge.

Q2. On page 6, 1st paragraph in results: there was no difference, obviously there was not significant difference?
A2. Thanks for you advice. We have revised in the paper.

Q3. Discussion: This section should begin with stating the main result of the study and continue to commenting the previous research and moving the “limitations” toward the end of the discussion.
A3. Thanks for your advice. We have revised it in the paper.

Q4. In the introduction, stigma is grouped into three categories: 1) ignorance, 2) attitudes and 3) discrimination. It might clarify the discussion, if the results would be discussed in this order. I did not find adequate discussion on ignorance, just a terence of women possibly having better knowledge.
A4. Firstly, thanks for your references. The purpose of the research were: 1) to study the level of stigma among community mental health staff based on RIBS, MAKS, MICA; 2) to discover which demographic variables are associated with discrimination prior to designing an intervention study; 3) to test the reliability, validity and acceptability of the Chinese version of the RIBS. Hence, the discussion mainly developed according to the purposes. As your advice, the first purpose was discussed in accordance to ignorance, attitudes and discrimination. We added some discussion on ignorance. In addition, we also discussed the responses of Table 2 and Table 3 considering that these items don’t included to compute the total score of each scale.

With kind regards

Jie Li

Vice-President, Guangzhou Psychiatric Hospital, China