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REDUCING MENTAL ILLNESS STIGMA THROUGH PEER-LED INTERVENTIONS IN PUBLIC HEALTH SETTINGS

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Abstract

Our systematic review's primary goal was to find out how peer-led interventions affected the stigma associated with mental health issues. An extensive review of literature in five electronic databases between 1975 and 2021 for randomized controlled trials was carried out. A meta-analysis was used to determine whether peer-led interventions are effective at reducing stigma for key outcomes. Regarding secondary outcomes, clinical symptoms were not significantly impacted. Though not statistically significant, there was a favourable impact on empowerment and rehabilitation. Self-efficacy and seeking professional assistance were both statistically significantly impacted. The Honest Open Proud (HOP) subgroup demonstrated large reductions in distress related to disclosure and increased confidentiality, while the non-HOP subgroup experienced no alterations in withdrawal or confidentiality. Overall, peer-led interventions can increase recovery, empowerment, and self-efficacy but decrease stigma pressure and self-stigma, although they have no substantial effects on clinical symptoms or withdrawal, and rather facilitate motivation to pursue professional care. HOP intervention improves pain and secrecy associated with disclosure.

Keywords: Mental illness, public health, HOP, Effectiveness

1. INTRODUCTION

It has long been acknowledged that stigma is a significant obstacle to mental health treatment and rehabilitation. Three components make up stigma: behaviour (discrimination), emotion (prejudice), and cognition (stereotype). Self-stigma and public stigma are two stigma-related issues that people with mental illness frequently face [9]. To compare the effectiveness of peer-led health interventions across various health outcomes, we employed a rating system [10][16]. Three classifications were established: limited, mixed, and advantageous [18]. Beneficial effects showed that most studies that looked at a certain health outcome consistently found beneficial intervention effects on that particular outcome that were statistically significant [1] [15] [17].

Peer specialists finished the required 18-hour training on the CDSMP, which is one of the interventions with recognized training curricula (Lorig et al., 2014). Others finished the study team's sessions, which combined experiential and didactic learning. Other than identifying the person responsible for overseeing the peer experts, not much information was given on the tactics and procedures employed to oversee the peer specialists and guarantee the integrity of the interventions under review [13].

Subsequent research needs to concentrate on the most viable peer-based strategies, leveraging our results and the existing literature on health interventions among those with severe mental illness (SMI) [12]. For example, a National Institute of Mental Health-funded efficacy trial is underway to examine the efficacy of peer-provided behavioural weight-loss treatments, demonstrating the promise of peer-based strategies in reducing key health outcomes and risk factors among this population [2].

objectives:

first, to examine the cultural and historical aspects of stigma around mental health and how it affects people and communities; second, to assess how well-established community-based programs work to lessen stigma and improve early intervention; and third, to make practical suggestions for expanding these tactics to larger public health contexts [14].

2. METHODS

1. Search Strategy

The hunt for literature was not limited by language. The final chosen research is published in English, and non-English articles have been eliminated since they don't adhere to PICO's criteria. The following method of searching was applied. The search phrases "stigma" and "peer group" or "peer-led" were used. Annex 1 included details on how to search for MeSH terms and their cognates. Two PhD students independently examined the search results' titles and abstracts first. Following the first screening, the article's whole text was examined to see if it qualified for inclusion. Authoritative instructors would decide whether to include the paper if there was any uncertainty regarding the established literature. The screening instructions were given to the tutors beforehand [4].

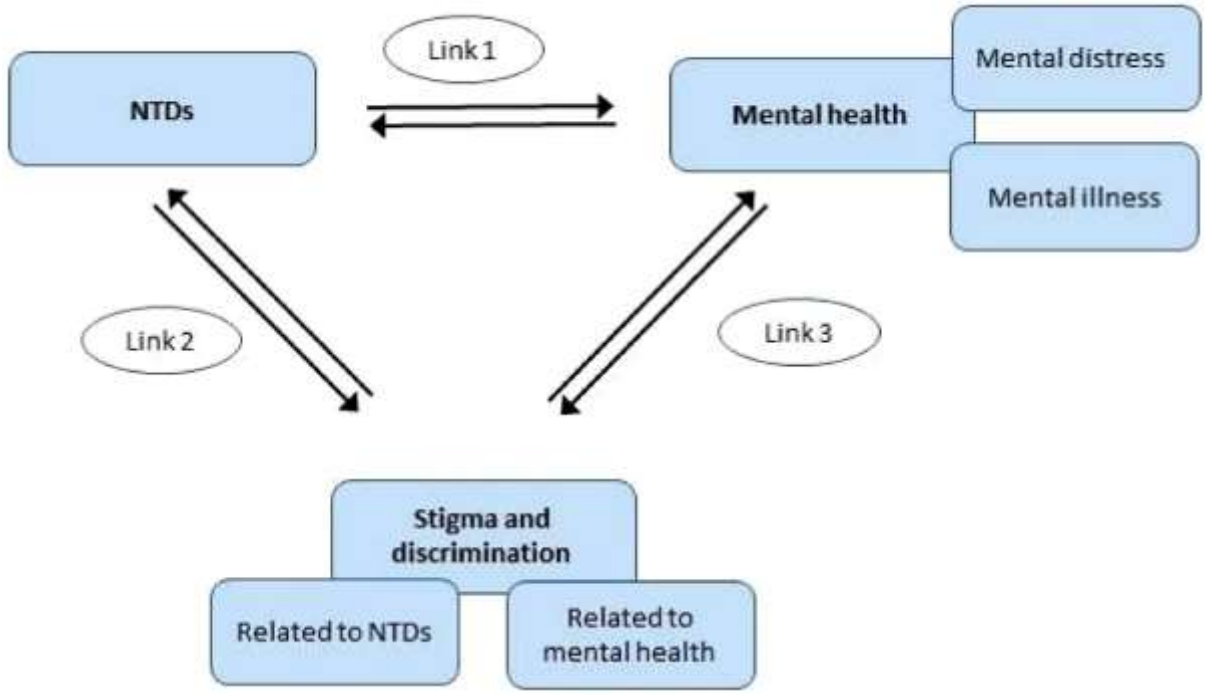

Figure 1: Conceptual framework

2. Inclusion and Exclusion Criteria

Trials that were finished, published, or unpublished could be included. Excluded were cluster RCTs, incomplete RCTs, and any research using non-randomized designs, such as quasi-experimental and partially randomized designs. Articles were considered if they met the following: they assessed the effect of any form of peer-led intervention using any research design, had participants with mental health problems or issues, and were designed to decrease stigma regarding mental illness [7-8] [6]. The following criteria were used to eliminate papers: case reports, informal peer-led interventions, lack of face-to-face interaction, and lack of connection to the stigma associated with mental illness [5]. Additionally, the study was disqualified if it exclusively included participants with developmental disorders (like autism), diseases often diagnosed in childhood (like conduct disorder), organic neuropathy (like dementia), or disorders connected to alcohol or drug addiction.

Table 1: Profile of the participant

		Frequency	Percentage
Gender			
	Male	84	49
	Female	99	51

Education	Pursuing Bachelor's degree	139	76%
	Master's degree or higher	44	24%
Income	2000- 10,000	180	98.36
	10,000- 25,000	2	1.10
	25,000- 40,000	1	0.54
	More than 40,000	0	0
Age	51-60 years	44	24
	46-50 years	139	76
	31-45 years	0	0
	20-30 years	0	0
Occupation	Undergraduate Student	139	76
	Postgraduate Student	44	24
	Non-Teaching Staff	0	
	Faculty Members	0	
	government or private sector	139	76
	self-employed	44	24
	Owner	0	

3. DATA EXTRACTION

From potential original papers, we drew out information on study design, details of intervention, inclusion criteria, participant characteristics, and statistical results (sample size, mean, and standard deviation) at post-intervention. Main outcomes were self-stigma and stigma stress, and secondary outcomes were clinical symptoms (depression, anxiety, hopefulness). [6-8]. Every intervention that was part of this review was a structured, randomized intervention that used a peer support group format. The included studies were of good quality. This study did have certain drawbacks, though. HOP interventions were employed in five of the seven included studies, which may introduce publication bias. Peer support was not the only factor separating the intervention group from the control group. This review's evidence was derived from the study's findings rather than being directly supported by actual data. There was inadequate standardization as a result of the indicators used to measure each outcome not being entirely consistent. Because few studies reported on specific outcomes, heterogeneity analyses were not possible. Also, follow-up data were not included in this meta-analysis

4. STATISTICAL ANALYSIS

We used the "change from baseline" method to combine and synthesize the data, since sample sizes in applicable. Because all data we retrieved were continuous variables, we applied the 95% confidence interval for the standardized mean difference (SMD). We only used post-intervention data (end-of-treatment data), even though in our research, follow-up data were also recorded.

Table 2: Reflective measurement models

Elements that the indicator capture	Outer Loadings	Indicator Reliability	Composite Reliability	AVE
What is the role of peer-led interventions in promoting mental health literacy and reducing stigma in public health settings?	0.900	0.810	0.929	0.767
	0.926	0.857		
	0.820	0.672		
	0.853	0.727		
What is the impact of peer-led interventions on mental health outcomes, such as help-seeking behavior and social support, in public health settings?	0.910	0.828	0.939	0.885
	0.971	0.942		
	0.740	0.547	0.848	0.651
	0.843	0.710		
	0.833	0.693		
How do peer-led interventions compare to traditional interventions in reducing mental illness stigma in public health settings?	0.708	0.501	0.838	0.636
	0.905	0.819		
	0.769	0.591		
What are the key components of successful peer-led interventions in reducing mental illness stigma in public health settings?	0.866	0.749	0.880	0.647
	0.782	0.611		
	0.765	0.585		
	0.803	0.644		
How do peer-led interventions impact attitudes and behaviors towards individuals with mental illness in public health settings?	0.931	0.866	0.925	0.860
	0.924	0.853		
What is the effectiveness of peer-led interventions in reducing mental illness stigma in public health settings?	0.944	0.891	0.913	0.780
	0.935	0.874		
	0.759	0.576		

How do peer-led interventions impact the mental health workforce and service delivery in public health settings?	0.910	0.828	0.939	0.885
	0.971	0.942		
	0.740	0.547	0.848	0.651
	0.843	0.710		
	0.833	0.693		
Can peer-led interventions reduce mental illness stigma among specific populations, such as youth or older adults?	0.708	0.501	0.838	0.636
	0.905	0.819		
	0.769	0.591		
What are the experiences and perspectives of peers who lead interventions aimed at reducing mental illness stigma in public health settings?	0.866	0.749	0.880	0.647
How do peer-led interventions impact attitudes and behaviors towards individuals with mental illness in public health settings?	0.935	0.874	0.880	0.647
What is the impact of peer-led interventions on mental health outcomes, such as help-seeking behavior and social support, in public health settings?	0.759	0.576	0.880	0.647

All of the included trials used peer-led interventions and were randomized. In order to decrease self-stigmatizing behaviours and enhance their reactions to perceived stigma, the three-to-ten-week intervention used organized group sessions led by one or two peer counsellors. In contrast to facilitating indiscriminate disclosure, HOP invites participants to do disclosure strategically across contexts. The intervention recognizes that disclosure is a matter of personal choice determined by one's surroundings.

A systematic search of literature revealed eight randomized controlled trials that were scrutinized in depth. The majority of studies included structured interventions that often-combined group discussions, exercise books, and psychoeducation. A fidelity test was also performed on the interventions' content. The three categories of interventions are Photovoice, IOOV-FC, and HOP. HOP intervention was utilized in five of the seven investigations, while IOOV-FC and Photovoice were employed in the other two.

5. CONCLUSION

Studies have shown that peer-led interventions can be beneficial, promoting recovery and empowerment and decreasing pressure of stigma and self-stigma. While these interventions did not significantly reduce clinical withdrawal symptoms, they could potentially have a positive boosting and prompting individuals to approach professional help. Confidentiality and distress associated to disclosure were considerably improved by the HOP intervention. Five papers reporting HOP intervention were included in this analysis, which could lead to publication bias. There wasn't enough research on some specific outcomes, therefore the findings should be considered cautiously. This review offers some encouraging empirical evidence in favour of student-focused anti-stigma programs related to mental health issues. Both public and self-shame were somewhat reduced by these approaches. This emphasizes the necessity of more inclusive, high-quality measurements with varied demographic samples. Longer-term interventions and time-series data should be used by researchers to adapt interventions as they unfold since short-term interventions tend to have only temporary impacts. Future research should examine the degree to which interventions can alter students' knowledge, attitudes, and beliefs and, in turn, promote earlier help-seeking behaviour.

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