Master's in Medicine in Psychiatry: Dissertation

High levels of stigma towards substance use and depression amongst non-specialist health workers in South Africa

Student:

Dr Richard P. Goncalves

MBChB (UCT)

Student number: GNCRIC001

University of Cape Town, Faculty of Health Sciences

Department of Psychiatry and Mental Health

Email: gncric001@myuct.ac.za

Cellphone: 083 716 1569

Supervisor:

A/Prof Goodman Sibeko (goodman.sibeko@uct.ac.za)

Co-supervisors:

Prof Bronwyn Myers (bronwyn.myers@mrc.ac.za)

A/Prof Jessica Magidson (jmagidso@umd.edu)

Initial submission: 28 June 2022

Submitted with corrections: 29 November 2022

Table of Contents

Declaration

I, Dr Richard Paul Goncalves, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university. This dissertation has been submitted to the Turnitin module and I confirm that my supervisor has seen my report and any concerns revealed by such have been resolved with my supervisor.

Signature: Signed by candidate

Date: 28/06/2022

Acknowledgements

My heartfelt gratitude goes to the primary supervisor of this MMed research project, Prof Goodman Sibeko, who I am proud to call a mentor. Your big ideas and unending support have been invaluable.

I was also privileged to have the excellent supervision of Prof Bronwyn Myers and Prof Jessica Magidson, whose research acumen and constant patience were much appreciated.

I wish to thank Dr Jennifer Belus, Alexandra Rose, Kristen Regenauer, and Kim Johnson for assistance with data collection, data analysis and manuscript editing.

Thanks also to Prof Dan Stein and Dr Carrie Brooke-Sumner for their thoughtful suggestions as reviewers of my Research Protocol.

Thank you to project MIND and TB HIV Care, for allowing access to this data, as well as the non-specialist health workers that completed the surveys.

Lastly, I'd like to thank my wife and the rest of my family for their constant encouragement, as well as for allowing me the time to complete this research project.

Format

This dissertation is being submitted in the format of a publication-ready manuscript. The manuscript has been submitted to *Stigma and Health* as an original research paper, and was formatted as per this journal's Submission Guidelines (see Appendices).

Contributions of authors

RPG, together with supervisors GS, BM and JFM, conceptualized and designed this study as part of his MMed (Psychiatry). GS was the principal investigator. RPG wrote the research protocol. RPG and JMB analysed the data. RPG was the main author of the manuscript. All authors contributed to the writing and editing of the manuscript. All authors approved the final version for MMed dissertation submission and for journal submission.

List of Tables

List of Figures

None

Abbreviations

CHW	Community Healthcare Worker
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
HIV	Human Immunodeficiency Virus
HREC	Human Research Ethics Committee
MDD	Major Depressive Disorder
NGO	Non-Governmental Organisation
NSHW	Non-Specialist Health Worker
SDS	Social Distance Scale
SAS	Statistical Analysis System
SUD	Substance Use Disorder
TB	Tuberculosis
UCT	University of Cape Town

Publication-ready manuscript, formatted for submission to *Stigma and Health*:

High levels of stigma towards substance use and depression amongst non-specialist health workers in South Africa

Richard P. Goncalves[1], Jennifer M. Belus[2,3,4], Alexandra L. Rose[4], Kristen S. Regenauer[4], Jessica F. Magidson[4*], Kim Johnson[5], Bronwyn Myers[1,5,6 *] and Goodman Sibeko[1*]

[1]Department of Psychiatry & Mental Health, University of Cape Town

[2]Department of Medicine, Swiss Tropical and Public Health Institute, Allschwil, Switzerland

[3]University of Basel, Basel, Switzerland

[4]Department of Psychology, University of Maryland, College Park, MD, USA

[5]Alcohol, Tobacco and Other Drug Research Unit, South African Medical Research Council

[6]Curtin enAble institute, Faculty of Health Sciences, Curtin University

*Co-senior authorship.

Author Note

Portions of these findings were presented at the Addictions 2021 Conference in South Africa, the South African Society of Psychiatrist's Annual Conference in 2021, and at the International Society of Substance Use Professionals Conference in 2022. We have no conflicts of interest to disclose.

Correspondence concerning this article should be addressed to Richard P. Goncalves, Department of Psychiatry & Mental Health, University of Cape Town. Email: gncric001@myuct.ac.za

Page count: 8

Number of tables: 4

Number of references: 45

Abstract

As mental health-related stigma is a significant barrier to seeking and receiving healthcare, stigma amongst non-specialist health workers (NSHWs) towards patients with major depressive disorder (MDD) and substance use disorder (SUD) could negatively affect mental health service provision. This study aimed to explore (1) the level of stigma towards MDD and SUD among NSHWs employed in primary care settings in South Africa, (2) the extent to which socio-demographic factors might be associated with stigma levels amongst these NSHWs, and (3) NSHWs' interest in receiving training for MDD or SUD. Overall, 81 NSHWs completed a culturally modified version of the Social Distance Scale (SDS) that assessed stigma towards a hypothetical patient with MDD and a hypothetical patient with SUD; higher cumulative SDS scores represented greater stigma. With a possible range of 6-24, we found a mean SDS score of 9.0 (*SD*=3.7) for MDD and 11.7 (*SD*=4.4) for SUD. Results show elevated levels of stigma towards both hypothetical patients, with significantly higher mean SDS scores for SUD compared to MDD (p <0.001). No socio-demographic variables were significantly associated with MDD or SUD stigma levels. When asked to rate their interest, more NSHWs were "very interested" in receiving training for MDD (90.0%) than for SUD (80.8%); this difference was statistically significant (p=0.027). High levels of self-reported stigma, coupled with a desire for further training, suggest that it would be prudent to incorporate stigma reduction measures into future MDD and SUD training programmes for NSHWs.

Keywords: stigma, non-specialist health worker, major depressive disorder, substance use disorder, social distance scale

High levels of stigma towards substance use and depression amongst non-specialist health workers in South Africa

Introduction

There is a substantial treatment gap for mental disorders in South Africa, that is close to 92% (Docrat et al., 2019), due to a severe shortage of specialist mental health providers. Task-sharing has been identified as a strategy for reducing the treatment gap in the context of chronic workforce shortages (Kakuma et al., 2011). This involves redistributing some mental health services from specialist mental health providers to non-specialist health workers (NSHWs) in primary care and community settings (Patel et al., 2007). NSHW refers to workers who provide health care without having received specialist mental health training, and can include doctors, nurses, and lay health workers (van Ginneken et al., 2013).

Global evidence demonstrates that task-sharing of psychological treatments to NSHWs is feasible, acceptable to patients and the broader health system, and effective for reducing rates and severity of common mental disorders such as depression, anxiety and posttraumatic stress, as well as substance use disorders (SUD) (Singla et al., 2017; van Ginneken et al., 2021). However, given limited formal training and exposure to individuals with mental health problems and/or SUD, there are concerns that some NSHWs may have stigmatizing and negative attitudes towards patients with mental disorders and/or SUDs (Magidson et al., 2019; Myers et al., 2018; Regenauer et al., 2020; Sorsdahl et al., 2019). Compounding this stigma further is the high prevalence of human immunodeficiency virus (HIV) and tuberculosis (TB) in South Africa (World Health Organization, 2019), and the fact that many patients are living with these co-occurring conditions, which are also stigmatized (Wouters et al., 2020).

In South Africa, previous studies have focused on internalized mental health or SUD stigma among patients (Anvari et al., 2022; Regenauer et al., 2022), enacted stigma in health facilities (Myers et al., 2019) or mental health and SUD stigma among community members (Sorsdahl & Stein, 2010; Sorsdahl et al., 2012). However, studies have not directly examined stigma related to major

depressive disorder (MDD) or SUD among the NSHW workforce. This is a critical evidence gap as it is well documented that stigma within health systems and amongst healthcare staff is a significant barrier to seeking and receiving appropriate healthcare (Henderson et al., 2013; Knaak et al., 2017; Nyblade et al., 2019; Vaccari et al., 2020). Prior research has demonstrated that health worker stigma impacts on the quality of treatment for physical illnesses (Mitchell et al., 2009; Molloy et al., 2021), patient adherence to treatment (Barney et al., 2006; Campbell et al., 2016; P. Corrigan et al., 2003; Sirey et al., 2001) and shorter life expectancies (Merrick & Merrick, 2007). Despite this, research measuring stigma amongst NSHWs towards people with MDD and SUD is limited. Insight into stigma amongst NSHWs, including whether stigma is more prevalent amongst specific groups of these workers, may assist in tailoring stigma reduction interventions aimed towards improving patients' experience of treatment and quality of care provided by NSHWs.

Within the stigma literature, social distance scales (SDS) are widely used to measure self-reported willingness to make contact with a described person (Corrigan et al., 2001) and have been used to measure mental health stigma (Corrigan et al., 2001; Link et al., 1999; Pescosolido et al., 2010). The primary aim of this study was to explore NSHWs' stigma levels towards people with MDD or SUD in primary care settings in South Africa. The secondary aims were to explore the extent to which socio-demographic characteristics of NSHWs were associated with stigma levels, and to measure NSHWs' willingness to receive future training on MDD or SUD.

Method

Study setting and design

Data were collected from November 2019 through June 2021, as part of two separate studies. The initial data collection took place in November 2019 as part of a mental health intervention trial in South Africa (Myers et al., 2018). In this phase, 66 participants based in Pietermaritzburg in the Kwa-Zulu Natal Province and Cape Town in the Western Cape Province who worked at a local Non-Governmental Organisation (NGO) were surveyed. This NGO trains and supervises NSHWs who provide TB and HIV health care in their communities. The final data

collection occurred between February and June 2021 as part of a study collecting formative data to guide the design of stigma reduction interventions among community healthcare workers (HCWs). In this phase, 15 CHWs completed an interviewer-administered questionnaire. Data collection in both studies involved completion of a cross-sectional survey. No participants received financial compensation for their involvement.

Ethical considerations

Data collection was approved by the Human Research Ethics Committee (HREC) at the South African Medical Research Council and the University of Cape Town (HREC 576/2018). Written or telephonic informed consent was obtained from all participants prior to data collection.

Participant Selection & Recruitment

This was a self-selected sample as the facility managers circulated consent documents and questionnaires to available NSHWs who were interested in participation, and the sample populations consisted of those that chose to participate. In total, 81 NSHWs were recruited. Any staff member who worked as a NSHW was eligible to participate, although those taking part were required to be able to complete the study procedures in English, Xhosa, or Afrikaans. There were no further exclusion criteria so as to not limit generalizability of findings.

Measurements

Socio-demographic data

Each participant was asked to provide the following data: gender, highest completed level of education completed, current job title and length of time in that role, and length of time working at the organisation. They were also asked if there were people with mental health or substance use problems in their family; this was used as a measure of familiarity with/exposure to these conditions. Participants self-identified the title of their current professional role.

Training experiences and interests

Participants were asked if they had received training that could help patients like the characters in the case vignettes, and how interested they would be to receive training in that area.

Participants self-rated their willingness to receive additional training to help the person in each vignette on a scale of 1-10. Scores of 1-2 reflected no interest in further training, 3-4 reflected limited interest, 5-6 reflected ambivalence about more training, 7-8 reflected some interest and scores of 9-10 reflected very high interest in further training.

Social distance scale

Each participant was asked to either self-complete or complete an interviewer-administered questionnaire, which included case vignettes and the use of a modified Bogardus Social Distance Scale. The two case vignettes within each questionnaire have previously been adapted for use in a South African setting (Sorsdahl & Stein, 2010; Sorsdahl et al., 2012). The vignettes each described an individual who was not labelled as having a mental disorder but was shown to possess the minimum Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnostic criteria for either MDD or SUD. The SUD vignette described an individual who had problematic use of alcohol, cannabis, and methamphetamine. Minor adaptations were made by our team to make these culturally relevant; these included changing the name of the person in the MDD vignette to “Vusi”, a common Nguni name in South Africa, and using colloquial terms for substances such as “Tik” (a term generally used to refer to methamphetamine) in the SUD vignette.

A modified Bogardus Social Distance Scale (Bogardus, 1925) was used to quantify stigma. This scale has previously been used in a low-income and middle-income countries (LMIC) setting, in Nigeria (Adewuya & Makanjuola, 2008). To complete this measure, participants rated their willingness to engage with someone across 6 different types of social interactions that vary in intimacy.

Participants were provided with the two vignettes and asked to consider these when answering the stigma-related questions. Each social interaction was rated on a 4-point scale with response options ranging from “Definitely not” (4) to “Definitely” (1). Scores were summed to create a cumulative SDS score ranging from a possible score of 6 to 24. Separate scores were created for

MDD and SUD stigma. Higher scores represent preferences for greater social distance, reflecting greater stigma.

SDS scores were also categorised into low, moderate, or high levels of social distance (Stuart & Arboleda-Florez, 2001). Participant responses to each item are dichotomized—responses of "unlikely"(3) or "definitely not" (4) are recoded as 1, other scores are coded as 0. Scores are summed and then classified as low stigma (score of 0), moderate stigma (score of 1), or high stigma (score of ≥2).

Data analysis

For Aim 1, descriptive statistics were generated in the form of means, standard deviations, and proportions to describe the socio-demographic characteristics of participants. A t-test was used to explore the difference between NSHWs' stigma level for MDD and SUD. For the secondary aims, we used Chi-square tests and correlations (depending on whether the variables were dichotomous or continuous) to explore associations between socio-demographic and training factors with stigma levels. Data analysis was conducted in SAS Version 9.4 (*SAS Institute*, 2010).

Results

Table 1 reflects the socio-demographic characteristics of the 81 NSHWs who were recruited and completed study procedures. Participants were on average 39.5 years old (*SD*=9.5) and the vast majority were female (90.1%, *n*=73), reflecting the typical demographic characteristics of NSHWs in South Africa. In addition, 22.2% of participants (*n*=18) reported never completing high school and 32.0% (*n*=24) reported that they had a family member with a mental health or SUD problem. NSHWs described their roles and titles in a variety of ways. The majority (74.7%, *n*=59) self-identified as "community health worker" and the remainder of NSHWs identified as working within the following broad categories: nurses, social work professionals, and administrators.

Social distance towards MDD and SUD

Table 2 shows the SDS scores for each question that was asked, for both the MDD and SUD vignettes, as well as the mean SDS continuous and dichotomous scoring towards both MDD and

SUD. The table demonstrates that social distance increased with questions that reflected higher levels of intimacy to the person in the vignette. Overall, the mean SDS score towards MDD was 9.0 (*SD* = 3.7) and towards SUD was 11.7 (*SD* = 4.4). There was significantly higher social distance observed towards the vignette with SUD, as opposed to MDD (mean difference = -2.7, $t(76) = -7.2$, $p < .001$). Roughly half (50.6%, *n*=41) of participants showed moderate or high stigma toward MDD, while more than three-quarters (77.8 %, *n*=63) showed moderate or high stigma towards SUD.

Associations between socio-demographic variables and stigma

We found no statistically significant associations between any of the socio-demographic variables and MDD or SUD stigma, as reflected in Table 3.

Interest in future mental health and SUD training

For the MDD vignette, 90.0 % (*n*=72) of participants indicated being "very interested" in further training (with scores of 9 or 10 on the scale). For the SUD vignette, 80.8% (*n*=63) of participants indicated being "very interested" in further training. Using McNemar's Test, when the responses were dichotomized into "very interested" or "not very interested", there was significantly more interest in future training to treat MDD as compared to SUD (*p*=0.013).

Discussion

This is the first study to our knowledge that focused exclusively on characterizing MDD and SUD stigma among NSHWs in South Africa. As a crucial resource in the task-sharing approach, NSHWs are strategically positioned to impact the care of patients with common mental disorders such as MDD and SUD. However, potential stigma amongst NSHWs towards patients with MDD and SUD must be understood and addressed, as it represents a barrier to help seeking and engagement in task-shared mental health and SUD interventions (Regenauer et al., 2022). Our key findings were that NSHWs showed high stigma towards both conditions, and even higher stigma towards SUD compared to MDD. This is evidenced by the finding that 50.6% of participants showed moderate or high levels of stigma towards MDD and 77.8% showed moderate or high levels of stigma towards

SUD. These high levels of stigma are concerning, as stigma from HCWs may impede patients seeking or staying in mental health counseling (Corrigan, 2004; Lannin et al., 2016; Lasalvia et al., 2013).

Indeed, stigma has been found to be a significant barrier to receiving appropriate healthcare (Henderson et al., 2013; Knaak et al., 2017; Nyblade et al., 2019; Vaccari et al., 2020) and adhering to treatment (Barney et al., 2006; Campbell et al., 2016; Corrigan et al., 2003; Sirey et al., 2001), including treatment for SUD in South Africa (Myers et al., 2009). With over half of NSHWs exhibiting moderate or high social distance towards MDD and over three-quarters towards SUD, our findings suggest that unaddressed stigma among NSHWs may negatively impact care of these common mental disorders.

The greater social distance towards SUD as opposed to MDD is concerning, even though it follows both international (Jorm & Oh, 2009) and previous South African trends (Myers et al., 2018; Sorsdahl & Stein, 2010). Previous research has explored the high levels of public stigma towards people who use substances in South Africa (Sorsdahl et al., 2012). A link has been drawn between the high prevalence of substance use (particularly alcohol) and the burdens that this places on communities in terms of injuries, violence and crime. It could be postulated, then, that a sample of NSHWs who are living in communities that have likely experienced the disruptive effects of substance use, will show increased social distance towards people who use substances (Myers et al., 2016, 2020).

Notably, we found that none of the socio-demographic variables were associated with increased stigma among NSHWs. This may be an important consideration when designing stigma reduction interventions, as there is no specific socio-demographic grouping that requires focused attention.

One particularly encouraging finding of this study was the high level of interest shown by NSHWs in receiving further training to support patients with either MDD or SUD. Over 91% of the sample signaled a willingness for further training on these topics. This is relevant, as exposure to people with lived experience of these conditions has been shown to reduce stigma (Thornicroft et

al., 2016) and could be included in NSHW training programs. A recent systematic review found at least 8 examples of where social contact with people with lived experience in training had been used to reduce mental health stigma in LMICs, but failed to examine the impact of this social contact and training on SUD stigma (Clay et al., 2020). Future work should therefore consider how training and stigma reduction efforts can most effectively shift NSHW attitudes towards both MDD and SUD, with the overall aim to improve treatment outcome in these patient groups.

The main limitations of this study relate to the small convenience sample which may not be representative of all NSHWs. Our method of convenience sampling did not allow for the recording of NSHWs that chose not to participate. Further, statistical power may be limited by the sample size and relative homogeneity of the sample; for example, the sample was over 90% female, reducing our ability to detect associations between stigma and certain demographic variables. Moreover, although the use of vignettes and the SDS are the most widely used methods of measuring stigma, this is still a proxy for stigma itself and there are numerous shortcomings. Firstly, these are self-report measures and are therefore at risk of self-report bias. Participants behaviour may not correlate with the answers that they have provided. Responses may also have been shaped by social desirability, which leads to an under-reporting of social distance scores.

Conclusion

This study is a first step towards quantifying levels of stigma towards MDD and SUD amongst NSHWs in South Africa, particularly towards patients with SUD, and willingness on the part of NSHWs to receive further training on MDD and SUD. With a focus on decentralizing mental health care in South Africa and a move towards relying more on NSHWs to deliver task- shared mental health counselling, it would be prudent to conduct more research to understand changes in stigma over time and evaluate efforts to reduce stigma in this important cadre of care providers. With the overall goal being to improve treatment outcomes, future research may focus on interventions to provide opportunities for NSHWS to have social contact with people with lived experience of MDD and SUD during the course of training as a strategy for decreasing stigma.

Disclosure

The author has disclosed no conflicts of interest.

Funding

This work was funded in part by the joint funded initiatives of the British Medical Research Council, Wellcome Trust and DFID (MR/M014290/1 (PI: Myers), ; the National Institute of Drug Abuse (NIDA): R21DA053212 (PIs: Magidson, Myers) and the National Institute of Mental Health (NIMH): R34MH122268 (PIs: Magidson, Myers). Alexandra Rose's time on this manuscript was funded by NIMH: F31MH123020 (PI: Rose). The content is solely the responsibility of the authors and does not necessarily represent the official views of any of the funding agencies.

References

Adewuya, A., & Makanjuola, R. (2008). Social distance towards people with mental illness in southwestern Nigeria. *Australian and New Zealand Journal of Psychiatry*, *42*(5), 389–395. https://doi.org/10.1080/00048670801961115

Anvari, M. S., Belus, J. M., Regenauer, K. S., Myers, B., Joska, J., & Magidson, J. F. (2022). The combination of HIV and alcohol use internalized stigmas are associated with greater symptoms of depression in a South African sample living with HIV. *Stigma and Health*. https://doi.org/10.1037/sah0000394

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry*, *40*(1), 51–54. https://doi.org/10.1111/j.1440-1614.2006.01741.x

Bogardus, E. S. (1925). Measuring social distances. *J Appl Sociol*, *1–2*, 216–226.

Campbell, D. G., Bonner, L. M., Bolkan, C. R., Lanto, A. B., Zivin, K., Waltz, T. J., Klap, R., Rubenstein, L. V., & Chaney, E. F. (2016). Stigma Predicts Treatment Preferences and Care Engagement Among Veterans Affairs Primary Care Patients with Depression. *Annals of Behavioral Medicine*, *50*(4), 533–544. https://doi.org/10.1007/s12160-016-9780-1

Clay, J., Eaton, J., Gronholm, P. C., Semrau, M., & Votruba, N. (2020). Core components of mental health stigma reduction interventions in low- A nd middle-income countries: A systematic review. *Epidemiology and Psychiatric Sciences*. https://doi.org/10.1017/S2045796020000797

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614

Corrigan, P., Thompson, V., Lambert, D., Sangster, Y., Noel, J. G., & Campbell, J. (2003). Perceptions of discrimination among persons with serious mental illness. *Psychiatric Services*, *54*(8), 1105–1110. https://doi.org/10.1176/appi.ps.54.8.1105

Corrigan, P. W., Edwards, A. B., Green, A., Diwan, S. L., & Penn, D. L. (2001). Prejudice, Social Distance, and Familiarity with Mental Illness. *Schizophrenia Bulletin*, *27*(2), 219–225. https://doi.org/10.1093/oxfordjournals.schbul.a006868

Docrat, S., Besada, D., Cleary, S., Daviaud, E., & Lund, C. (2019). Mental health system costs, resources and constraints in South Africa: A national survey. *Health Policy and Planning*, *34*(9), 706–719. https://doi.org/10.1093/heapol/czz085

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health*, *103*(5), 777–780. https://doi.org/10.2105/AJPH.2012.301056

Jorm, A. F., & Oh, E. (2009). Desire for social distance from people with mental disorders: A review. *Australian and New Zealand Journal of Psychiatry*, *43*(3), 183–200. https://doi.org/10.1080/00048670802653349

Kakuma, R., Minas, H., Van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., Saxena, S., & Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. *The Lancet*, *378*(9803), 1654–1663. https://doi.org/10.1016/S0140-6736(11)61093-3

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, *30*(2), 111–

116. https://doi.org/10.1177/0840470416679413

Lannin, D. G., Vogel, D. L., Brenner, R. E., Abraham, W. T., & Heath, P. J. (2016). Does self-stigma reduce the probability of seeking mental health information? *Journal of Counseling Psychology*, *63*(3), 351–358. https://doi.org/10.1037/cou0000108

Lasalvia, A., Zoppei, S., Van Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K., Bacle, S. V., Van Audenhove, C., Van Weeghel, J., Reneses, B., Germanavicius, A., Economou, M., Lanfredi, M., Ando, S., Sartorius, N., Lopez-Ibor, J. J., Thornicroft, G., Treacy, S., Brohan, E., … Laguado, A. (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: A cross-sectional survey. *The Lancet*, *381*(9860), 55–62. https://doi.org/10.1016/S0140-6736(12)61379-8

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health*, *89*(9), 1328–1333. https://doi.org/10.2105/AJPH.89.9.1328

Magidson, J. F., Joska, J. A., Regenauer, K. S., Satinsky, E., Andersen, L. S., Seitz-Brown, C. J., Borba, C. P. C., Safren, S. A., & Myers, B. (2019). "Someone who is in this thing that I am suffering from": The role of peers and other facilitators for task sharing substance use treatment in South African HIV care. *International Journal of Drug Policy*, *70*(2019), 61–69. https://doi.org/10.1016/j.drugpo.2018.11.004

Merrick, J., & Merrick, E. (2007). Equal Treatment: Closing the Gap. A Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities and/or Mental Health Problems. In *Journal of Policy and Practice in Intellectual Disabilities* (Vol. 4, Issue 1). Disability Rights Commission. https://doi.org/10.1111/j.1741-1130.2006.00100.x

Mitchell, A. J., Malone, D., & Doebbeling, C. C. (2009). Quality of medical care for people with and without comorbid mental illness and substance misuse: Systematic review of comparative studies. *British Journal of Psychiatry*, *194*(6), 491–499. https://doi.org/10.1192/bjp.bp.107.045732

Molloy, R., Brand, G., Munro, I., & Pope, N. (2021). Seeing the complete picture: A systematic review of mental health consumer and health professional experiences of diagnostic overshadowing. *Journal of Clinical Nursing*, *September*, 1–12. https://doi.org/10.1111/jocn.16151

Myers, B., Fakier, N., & Louw, J. (2009). Stigma, treatment beliefs, and substance abuse treatment use in historically disadvantaged communities. *African Journal of Psychiatry (South Africa)*, *12*(3), 218–222. https://doi.org/10.4314/ajpsy.v12i3.48497

Myers, Bronwyn, Breuer, E., Lund, C., Petersen Williams, P., van der Westhuizen, C., Brooke-Sumner, C., Naledi, T., Stein, D. J., & Sorsdahl, K. (2019). Assessing capability for implementing mental health counselling within primary care facilities in a middle-income country: A feasibility study. *Journal of Psychiatric and Mental Health Nursing*, *26*(5–6), 163–174. https://doi.org/10.1111/jpm.12519

Myers, Bronwyn, Carney, T., Johnson, K., Browne, F. A., & Wechsberg, W. M. (2020). Service providers' perceptions of barriers to the implementation of trauma-focused substance use services for women in Cape Town, South Africa. *International Journal of Drug Policy*, *75*(2020), 102628. https://doi.org/10.1016/j.drugpo.2019.102628

Myers, Bronwyn, Carney, T., & Wechsberg, W. M. (2016). "Not on the agenda": A qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa. *International Journal of Drug Policy*, *30*, 52–58. https://doi.org/10.1016/j.drugpo.2015.12.019

Myers, Bronwyn, Joska, J. A., Lund, C., Levitt, N. S., Butler, C. C., Naledi, T., Milligan, P., Stein, D. J., & Sorsdahl, K. (2018). Patient preferences for the integration of mental health counseling and chronic disease care in South Africa. *Patient Preference and Adherence*, *12*, 1797–1803. https://doi.org/10.2147/PPA.S176356

Myers, Bronwyn, Lund, C., Lombard, C., Joska, J., Levitt, N., Butler, C., Cleary, S., Naledi, T., Milligan, P., Stein, D. J., & Sorsdahl, K. (2018). Comparing dedicated and designated models of integrating mental health into chronic disease care: Study protocol for a cluster randomized

controlled trial. *Trials*, *19*(1), 1–13. https://doi.org/10.1186/s13063-018-2568-9

Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., Lean, R. M., Mitchell, E. M. H., Nelson, L. R. E., Sapag, J. C., Siraprapasiri, T., Turan, J., & Wouters, E. (2019). Stigma in health facilities: Why it matters and how we can change it. *BMC Medicine*, *17*(1), 1–15. https://doi.org/10.1186/s12916-019-1256-2

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., Hosman, C., McGuire, H., Rojas, G., & van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet*, *370*(9591), 991–1005. https://doi.org/10.1016/S0140-6736(07)61240-9

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). "A disease like any other"? a decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry*, *167*(11), 1321–1330. https://doi.org/10.1176/appi.ajp.2010.09121743

Regenauer, K. S., Kleinman, M. B., Belus, J. M., Myers, B., Joska, J. A., & Magidson, J. F. (2022). Effects of intersecting internalized stigmas and avoidance on HIV and alcohol-related outcomes among people living with HIV in South Africa. *Drug and Alcohol Dependence*, 109364. https://doi.org/10.1016/J.DRUGALCDEP.2022.109364

Regenauer, K. S., Myers, B., Batchelder, A. W., & Magidson, J. F. (2020). "That person stopped being human": Intersecting HIV and substance use stigma among patients and providers in South Africa. *Drug and Alcohol Dependence*, *216*(September), 108322. https://doi.org/10.1016/j.drugalcdep.2020.108322

SAS Institute (Version 9.4). (2010). SAS Institute.

Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological Treatments for the World: Lessons from Low- and Middle-Income Countries. *Annual Review of Clinical Psychology*, *13*(1), 149–181. https://doi.org/10.1146/annurev-clinpsy-032816-045217

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S.

(2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry*, *158*(3), 479–481. https://doi.org/10.1176/appi.ajp.158.3.479

Sorsdahl, K., Morojele, N. K., Parry, C. D., Kekwaletswe, C. T., Kitleli, N., Malan, M., Shuper, P. A., & Myers, B. (2019). 'What will it take': addressing alcohol use among people living with HIV in South Africa. *International Journal of STD and AIDS*, *30*(11), 1049–1054. https://doi.org/10.1177/0956462419862899

Sorsdahl, K. R., & Stein, D. J. (2010). Knowledge of and stigma associated with mental disorders in a South African community sample. *Journal of Nervous and Mental Disease*, *198*(10), 742–747. https://doi.org/10.1097/NMD.0b013e3181f4b2d7

Sorsdahl, Katherine, Stein, D. J., & Myers, B. (2012). Negative attributions towards people with substance use disorders in South Africa: Variation across substances and by gender. *BMC Psychiatry*, *12*. https://doi.org/10.1186/1471-244X-12-101

Stuart, H., & Arboleda-Florez, J. (2001). Community attitudes toward people with schizophrenia. *Canadian Journal of Psychiatry*, *46*(3), 245–252. https://doi.org/10.1177/070674370104600304

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C., & Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, *387*(10023), 1123–1132. https://doi.org/10.1016/S0140-6736(15)00298-6

Vaccari, P., Ramírez-Vielma, R., Saldivia, S., Cova, F., Vielma-Aguilera, A., Victoriano, V., Ulloa-Vidal, N., & Grandón, P. (2020). Stigma towards people with a diagnosis of severe mental disorder in primary healthcare centers: Perspectives of service users and health teams in Chile. *International Journal of Mental Health Systems*, *14*(1), 1–11. https://doi.org/10.1186/s13033-020-0340-5

van Ginneken, N., Chin, W. Y., Lim, Y. C., Ussif, A., Singh, R., Shahmalak, U., Purgato, M., Rojas-García, A., Uphoff, E., McMullen, S., Foss, H. S., Thapa Pachya, A., Rashidian, L., Borghesani, A.,

Henschke, N., Chong, L. Y., & Lewin, S. (2021). Primary-level worker interventions for the care of people living with mental disorders and distress in low- and middle-income countries. *Cochrane Database of Systematic Reviews*, *2021*(8). https://doi.org/10.1002/14651858.CD009149.PUB3

van Ginneken, N., Tharyan, P., Lewin, S., Rao, G. N., Meera, S., Pian, J., Chandrashekar, S., & Patel, V. (2013). Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. *The Cochrane Database of Systematic Reviews*, *2013*(11). https://doi.org/10.1002/14651858.CD009149.PUB2

World Health Organization. (2019). *Global Tuberculosis Report*.

Wouters, E., Sommerland, N., Masquillier, C., Rau, A., Engelbrecht, M., Van Rensburg, A. J., Kigozi, G., Ponnet, K., & Van Damme, W. (2020). Unpacking the dynamics of double stigma: how the HIV-TB co-epidemic alters TB stigma and its management among healthcare workers. *BMC Infectious Diseases*, *20*(1), 1–12. https://doi.org/10.1186/S12879-020-4816-3/TABLES/3

Tables 1-4:

Table 1: Demographic characteristics of the sample (Total participants = 81)

Demographic characteristics	Total sample (*N*=81)
Age, *M* (SD)	39.5 (SD=9.5)
% Women (n)	90.1 (73)
% Completed high school or above (n)	77.8 (63)
Current job title (*N*=79)	
% Community health worker (n)	74.7 (59)
% Nurse or Social work professional (n)	12.7 (10)
% Administrator (n)	12.7 (10)
% Familiarity (family member with mental illness) (n), *N*=75	32.0 (24)
% Any previous training in mental health (n), *N*=71	47.9 (34)

Table 2: Social distance scores for Major Depressive Disorder & Substance Use Disorder

	MDD	SUD
1. Would you have a conversation with the person in the vignette (x)?	1.15 (*SD*=0.53)	1.30 (*SD*=0.77)
2. Would you work on the same job as x?	1.63 (*SD*=1.02)	1.96 (*SD*=1.20)
3. Would you make friends with x?	1.35 (*SD*=0.76)	1.68 (*SD*=1.03)
4. Would you share a room or a house with x?	1.41 (*SD*=0.82)	2.10 (*SD*=1.14)
5. Would you be ashamed if people knew someone like x was in your family?*	1.41 (*SD*=0.95)	1.70 (*SD*=1.07)
6. Would you date or marry someone like x?	2.06 (*SD*=1.21)	2.90 (*SD*=1.23)
Total continuous SDS score	9.0 (*SD*=3.65)	11.7 (*SD*=4.37)
Categorical SDS score		
% Low SDS (n)	49.4% (40)	22.2% (18)
% Moderate SDS (n)	29.6% (24)	32.1% (26)
% High SDS (n)	21.0% (17)	45.7% (37)

* As this item was worded in the opposite direction, the response was reverse coded

Table 3: The associations between socio-demographic variables and Major Depressive Disorder & Substance Use Disorder stigma

Demographic factor	MDD stigma		SUD stigma	
	X^2	*p* value	X^2	*p* value
Age	r = 0.032*	*0.82*	r = -0.091*	*0.55*
Gender	0.611	0.43	0.040	0.84
Education	*0.226*	*0.63*	*0.413*	*0.52*
Current job title	0.004	1.00	0.359	0.90
Familiarity (family member with mental illness)	1.510	0.21	*0.552*	0.53
Any previous training in mental health	0.131	*0.71*	*0.474*	0.49
Willingness for further training	2.988	0.15	0.413	0.53

* Correlations were conducted because both variables are continuous

Table 4: The associations between socio-demographic variables and dichotomized interest in receiving training for Major Depressive Disorder & Substance Use Disorder

Demographic factor	Interest in receiving MDD training		Interest in receiving SUD training	
	X^2	*p* value	X^2	*p* value
Age	r = 0.162*	0.36	r = 0.174*	0.25
Gender	1.734	0.18	0.040	0.84
Education**	0	0.32	0	0.25
Current job title	5.066	0.07	2.860	0.23
Any previous training in mental health	0.390	0.53	0.474	0.49

* Correlation, ** Required Fisher's Exact Test

Health worker survey: Opinions about mental health and substance use

We are interested in your views about people with mental health and substance use problems and training to work with people who have these conditions. This form will ask you a few questions about your background. Then you will read two short descriptions of patients and answer a few questions about your reactions to each of these patients. Lastly, you will answer a few questions about your interests in training. To complete the form, please mark your answers by completely filling in the appropriate circles.

1. **What gender do you identify as?**
   - Male
   - Female
   - Other

2. How old are you?

   Response: _____

3. **Do you identify as? [MARK ONE]**

   - Black African
   - Asian/Indian
   - White
   - Coloured
   - Other (specify) _____

4. **What is the highest level of education you completed?? [MARK ONE]**

   - Did not complete high school
   - Completed High school
   - Some tertiary education, but no degree
   - Diploma in health care
   - University/Technicon degree
   - Master's degree
   - Doctoral degree or equivalent
   - Other (specify) _____

5. **What is your title in your current professional role?**

   Response: _____

6. **How long have you been working in your current role? [MARK ONE]**
   - 0-6 months
   - 6-11 months
   - 1 to 3 years
   - 3 to 5 years
   - Over 5 years

7. How long have you been working at this clinic and/or organisation? [MARK ONE]
   - 0-6 months
   - 6-11 months
   - 1 to 3 years
   - 3 to 5 years
   - Over 5 years

Please read the following passage and imagine Vusi. After reading this passage, please fill in the following questions about your responses to Vusi.

Vusi is a 36-year-old married man who was has been on ARVs for about 10 years. Recently he has been feeling down and irritable most of the time. He keeps on thinking about his life and all the things he could have achieved – to him it feels like his life has no meaning. He often thinks that he is worthless and a failure. Because of these thoughts, he believes that people will not like him and so he has stopped socialising with his friends and family. This has made him feel even worse. He is struggling to sleep at night and has no appetite. It is hard for him to think clearly and recently he has missed two ARV appointments because he did not have the energy to go and stand in the clinic queue.

8. **SDS-1*: Would you have a conversation with Vusi?**
   a. Definitely Not
   b. Unlikely
   c. Likely
   d. Definitely

9. S**DS-2: Would you work on the same job as Vusi?**
   a. Definitely Not
   b. Unlikely
   c. Likely
   d. Definitely

10. **SDS-3: Would you make friends with Vusi?**
   a. Definitely Not
   b. Unlikely
   c. Likely
   d. Definitely

11. SDS-4: Would you share a room or a house with Vusi?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

12. SDS-5: Would you be ashamed if people knew someone like Vusi was in your family?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

13. SDS-6: Would you date or marry someone like Vusi?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

14. **On a scale of 1 to 10, with 1 being not at all interested and 10 being very interested, how interested are you in getting training to learn how to help/assist someone like Vusi with problems with depression and thinking too much?** Please circle your response.

1 2 3 4 5 6 7 8 9 10

15. Please write briefly why you selected the number that you did from to 1 to 10 for Vusi.

Response: _____

<u>Please read the following passage and imagine Andile. After reading this passage, please fill in the following questions about your responses to Andile.</u>

Andile started drinking and using dagga when he was still in school. He thought it was cool, but soon he started missing classes and it started to impact on his school work. He ended up dropping out of school and, after that, his whole life focused on hanging out with his friends and getting drunk and high. When he was 24, his girlfriend at the time became pregnant and he found out that both he and his girlfriend had HIV. Andile felt like his life was over and coped with these feelings by starting to use stronger drugs like tik. He thought he was in control of his drug use, but his appearance and behaviour changed. He got thinner and stopped taking care of himself. Although his brother managed to find him some part-time work in a construction job, he got fired because of inconsistent attendance on the job. He began stealing from his mother and sometimes from people in the community to pay for his drugs. His mother and brothers

have tried to make him stop using drugs, but it often leads to arguments and conflict. Sometimes he gets into physical fights with his brothers. Andile's family does not know how to help him and are frustrated and aware that their neighbours are talking about what is going on in their home. Andile's mother is worried it is a matter of time before he gets arrested or killed.

16. SDS-1*: Would you have a conversation with Andile?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

17. SDS-2: Would you work on the same job as Andile?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

18. SDS-3: Would you make friends with Andile?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

19. SDS-4: Would you share a room or a house with Andile?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

20. SDS-5: Would you be ashamed if people knew someone like Andile was in your family?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

21. SDS-6: Would you date or marry someone like Andile?

a. Definitely Not
b. Unlikely
c. Likely
d. Definitely

22. **On a scale of 1 to 10, with 1 being not at all interested and 10 being very interested, how interested are you in getting training to learn how to help/assist someone like Andile with drug problems?** Please circle your response.

    1 2 3 4 5 6 7 8 9 10

23. Please write briefly why you selected the number that you did from to 1 to 10 for Andile.

Response: _____

24. Is there anyone like Andile or Vusi (or with other mental health problems) in your family?

a. Yes
b. No
c. Don't want to say

25. If someone in your family is like Andile or Vusi or has another mental health problem, what type of problems does this person have?

Response: _____

26. Have you ever received any training to help you know how to provide treatment to someone like Andile or Vusi?

a. Yes
b. No
c. Unsure

27. If you have received or think you may have received some previous training on how to provide treatment to someone like Andile or Vusi, please answer the following:

a. How long ago did you receive this training: _____years ____months
b. How long was the training: _____days of training _____hours of training
c. Briefly: What was the content of the training: _____
   _____
   _____
   _____
d. Who provided this training: _____
   _____

Thank you for taking the time to complete our survey!

Participant information sheet and consent form: health provider survey

Strengthening South Africa's health system through integrating treatment for mental illness into chronic disease care (Project MIND)

Introduction.
Hello. I am from the South African Medical Research Council (SAMRC). We are asking you to complete a survey about your opinions about people with mental health and substance use problems and training you may have received to help people with these issues. You qualify for this study because you are a health provider that works with patients who have HIV or other chronic diseases. Before you agree to take part you should understand what it involves. This pamphlet is to help you decide if you would like to take part in this study. If you have any questions, which are not fully explained in this pamphlet, please ask the project team. You should not agree to take part unless you are happy about all that is involved.

Why are we doing this?
The purpose of this study is to improve access to mental health services for chronic disease patients. Before we implement the project MIND counselling programme, we would like to understand health workers' views of patients who have mental health or substance use problems and their previous training. This will help us decide whether we should train health workers to deliver these services.

What We're Asking of You.
If you agree to complete this survey, you will be one of up to 350 health providers we interview. You will be asked a series of questions about yourself, your training and how you feel about patients with mental health and substance use problems. It will take about fifteen minutes to complete the survey. We value your input, because the information you provide will help us make decisions about what we need to include in our training materials when implementing the MIND programme.

Potential Risks and Discomforts.
We do not foresee any risk with participating in this study; however, some of the questions may make you feel uncomfortable. You can choose not to answer any questions.

Potential Benefits of Taking Part in the Study.
Your participation will help us gain a better understanding of the mental health training needs of health workers. The information and feedback you provide will help us develop better training programmes.

Confidentiality and Privacy.
Any information obtained during the consent processes and this survey will remain confidential. These consent forms will be stored in double-locked file cabinets. The South African MRC ethics committee will however have access to all data. Your name will not be recorded anywhere on the survey questionnaire and your answers cannot be linked back to you.

Who is funding the study?
The study is being conducted by the South African Medical Research Council, University of Cape Town and University of Oxford in collaboration with the Western Cape Department of Health. It is funded by the Medical Research Council in the U.K.

Reimbursement
There will be no reimbursements for participating in this activity.

Participation and Withdrawal.
Participation is voluntary. You can choose not to participate. If you decide to participate, you may choose to stop your participation at any time. There will be no consequences. You may also refuse to answer any questions you do not want to answer.

Who to Contact with Questions.
This study has been approved by the South African MRC Ethics Committee (EC 004-2/2015), the University of Cape Town's Ethics Committee (089/2015), and University of Oxford's Ethics Committee (567-15). The study will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, and the South African Guidelines for Good Clinical Practice.

If you have any questions or concerns about the research, please contact Dr. Bronwyn Myers (Principal Investigator) at +021 938 0993 or write to bmyers@mrc.ac.za, or Medical Research Council (MRC) P.O. Box 19070, Tygerberg 7505, South Africa.

Rights of Research Participants.
You can decide you do not want to complete this interview at any time. If you have any questions about your rights as a participant, you can contact the chairperson of the MRC ethics committee, Prof Danie du Toit at 021 938 0687 or email: adri.labuschagne@mrc.ac.za.

Indicating Consent.
Please let us know if you have any questions before signing this consent form. Please initial next to each item to show that you agree to what is required:

	Agree	
1.		I agree to take part in the study, which has been fully described to me, by participating in this survey today
2.		I agree to complete this survey which has been described to me
3.		I understand that my participation in this study is completely voluntary, and there will be no penalty if I choose not to participate.

DECLARATION BY PARTICIPANT

By signing below, I, _____ ***(Participant's Full Name)*** agree to take part in the Project MIND Study.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressured to take part. I also understand that I do not give up any rights by signing below.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Participant's Signature	**Date (DD/MM/YYYY)**	**Signed at (Place)**

DECLARATION BY PROJECT STAFF

I, _____ ***(Project Staff's Full Name***) declare that:

- I explained the information in this document to _____ _____

(Participant's Full Name)

- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that s/he adequately understands all aspects of the research

Project staff's Signature	**Date (DD/MM/YYYY)**	**Signed at (Place)**

Witness (only if participant is illiterate)

HUMAN RESEARCH ETHICS COMMITTEE

14 November 2019

Prof Bronwyn Myers
Alcohol, Tobacco & Other Drug Research Unit
SAMRC Cape Town

Dear Prof Myers

Protocol ID: EC004-2/2015
Protocol title: Strengthening South Africa's health system through integrating treatment for mental illness into chronic disease care (Project MIND): a cluster randomised trial, version 6.1
Meeting date: 30 October 2019

Thank you for your application to the Committee for an amendment, dated 30 September 2019, and your response dated 13 November 2019. Ethics approval is hereby granted for the amendment.

Wishing you well with your research.

Yours sincerely

Signed by candidate

Prof Danie du Toit
Chairperson: SAMRC Human Research Ethics Committee

Members present at the meeting: Prof D du Toit (Chairperson), Ms S Behardien, Adv J Early, Dr H Etheredge, Ms M Ledwaba, Prof C Lombard, Dr A Loxton, Dr E Nicol

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room G50- Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-enquiries@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

17 November 2020

HREC REF: 720/2020

Dr G Sibeko
Department of Psychiatry & Mental Health
Room 10, North Wing, Education Centre
Valkenberg Hospital
Email: goodman.sibeko@uct.ac.za
Student: richgoncalves21@gmail.com

Dear Dr Sibeko

PROJECT TITLE: STIGMATISING VIEWS TOWARDS PATIENTS WITH SUBSTANCE USE DISORDER AND MAJOR DEPRESSIVE DISORDER AMONGST NON-SPECIALIST TB & HIV CARE PROVIDERS: AN EXPLORATORY STUDY. (SUB-STUDTY LINKED TO: 576/2018) (MASTERS CANDIDATE: DR R GONCALVES)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee (HREC) for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

This approval is subject to strict adherence to the HREC recommendations regarding research involving human participants during COVID -19, dated 17 March 2020 & 06 July 2020.

Approval is granted for one year until the 30 November 2021.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: Dr Richard Goncalves will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
PROFESSOR M BLOCKMAN

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
NHREC-registration number: REC-210208-007

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use: Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines. The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

Form FHS006: Protocol Amendment

HREC office use only (FWA00001637; IRB00001938)		
☐ Approved	☑ Type of review: Expedited	☐ Full committee
This serves as notification that all changes and documentation described below are approved.		
Signature HREC Chairperson / Designee	Date	1/2/21

Note: All major amendments must include a local **PI Synopsis** justifying the changes for the amendment. Please note that incomplete amendment submissions will not be reviewed.

Please email this form and supporting documents (if applicable) in a combined pdf-file to hrec-enquiries@uct.ac.za.

Please clarify your plan for research-related activities during COVID-19 lockdown.

Comments from the HREC to the Principal Investigator:
Note: The approval of this protocol amendment does not grant annual approval. Please complete the FHS016 / FHS017 form for annual approval at least one month before study expiration.

Principal Investigator to complete the following:

1. Protocol Information

Date (when submitting this form)	29/01/2021	
HREC REF Number	720/2020	
Protocol title	Stigmatising views towards patients with substance use disorder and major depressive disorder amongst non-specialist TB & HIV care providers: an exploratory study.	
Protocol number (if applicable)		
Principal Investigator	Dr Goodman Sibeko	
Department / Office Internal Mail Address	goodman.sibeko@uct.ac.za	
1.1 Is this a major or a minor amendment? (see FHS006hlp) Major (tick box) Minor (tick box)	☐ Major	☐✓ Minor
1.2 Does this protocol receive US Federal funding?	☐ Yes	☐✓ No

1.3 If the amendment is a major amendment and receives US Federal Funding, does the amendment require full committee approval? **Note: Any protocol amendments for Full Committee review MUST be submitted on the monthly HREC submission dates. (Please email an electronic copy to hrec-enquiries@uct.ac.za)**	☐ Yes	☐ No N/A

2. List of Proposed Amendments with Revised Version Numbers and Dates

Please itemise on the page below, all amendments with revised version numbers and dates, which need approval.
This page will be detached, signed and returned to the PI as notification of approval. Please add extra pages if necessary.

Project MIND, of which this MMed is a sub-study, have expanded their data collection beyond the initial planned period, in order to obtain a larger sample. Data collection is therefore ongoing and is expected to be complete by late February 2021. As such, we would like to please request an amendment to our ethical approval, to include the additional data. Prof Myers (Principal Investigator of project MIND, and co-supervisor of this MMed project) supports this application and I submit the amended research protocol, for your consideration. We have attached the slightly modified research protocol, reflecting this proposed change to the data collection.

The changes that have been made may be found in the modified Research Protocol(with Tracked Changes) and entail:

Page 1, Line 17 Changed date to reflect this current amendment submission.
Page 5, Line 1- 2. Added a sentence noting that HREC approval was previously granted in Nov 2020.
Page 19, Line 14-15 Modified to reflect the requested change of dates of data collection.
Page 22, Line 6-8. Modified to reflect the requested change of dates of data collection.
Page 26. A new Gantt Chart was designed to reflect the change in timeline due to change of data collection dates.

3. Protocol status (tick ✓)

☐✓	Open to enrolment
☐	No participants have been enrolled
☐	Closed to enrolment (tick ✓)
☐	Research-related activities are ongoing
☐	Research-related activities are complete, long-term follow-up only
☐	Research-related activities are complete, data analysis only

4. Proposed changes will affect: (tick ✓ all the categories that apply)

	Protocol
☐	Study objectives, design (including investigator's brochure, clinical activities, study length)
☐	Study instruments, questionnaires, interview schedules
☐✓	Sample size
☐	Recruitment methods
☐	Eligibility criteria (inclusion and exclusion criteria)
☐	Drug/device (composition, amount, schedule, route of administration, combination with other drugs/devices, safety information)

☐	Data collection/ analysis
☐	Principal Investigator. (Please attach revised conflict of interest and PI declaration statements. Refer: sections 7 and 8.4 in the New Protocol Application Form FHS013)
☐	Consent form and information sheet
☐	Recruitment materials (e.g. advertisements)
☐	Administrative (e.g. change in sponsor's name, change in contact information)
☐	Other. Please specify:

4.1 In your opinion, will there be any **increase** in risk, discomfort or inconvenience to participants?	☐ Yes	☐✓ No
If yes, please provide a detailed justification/explanation:		

4.2 What follow-up action do you propose for participants who are already enrolled in the study?	
☐	Inform current participants as soon as possible
☐	Re-consent current participants with revised consent/assent forms (append)
☐✓	No action required
☐	Other. Please describe:

5. Detailed description of the change(s)

Please attach, for each amendment, a summary of all changes which clearly indicates:

i. Old wording (e.g. ~~strikethrough~~ text, CHANGED FROM and CHANGED TO)

ii. New wording (e.g. *italicized*, **bold**, tracked)

iii. Detailed rationale/ justification/ explanation for each change

6. Ethics Review Levy – cost including vat

Cost for Major Amendments - R3 691.20

(Protocols funded by UCT (e.g. departmental funding / student research) and by certain grant funding organizations (e.g. MRC, NRF, CANSA,) are exempt from charges)

For invoicing purposes, please provide:

Sponsor's name	N/A
Contact person	

Address	
Telephone number	
Email Address	

7. Signature

My signature certifies that I will maintain the anonymity and/ or confidentiality of information collected in this research. If at any time I want to share or re-use the information for purposes other than those disclosed in the original approval, I will seek further approval from the HREC.			
Signature of PI		Date	29 January 2021

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938)			
This serves as notification of annual approval including any documentation described below.			
☑ Approved	Annual progress report	Approved until/next renewal date	30.11.22
☐ Not approved	See attached comments		
Signature Chairperson of the HREC/ Designee		Date Signed	5/12/22

Note: Please email this form and supporting documents (if applicable) in a combined pdf-file to hrec-enquiries@uct.ac.za.
Please clarify your plan for research-related activities during COVID-19 lockdown.
Please use the latest form found on our website:
http://www.health.uct.ac.za/fhs/research/humanethics/forms

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol Information

Date when submitting this form	22/11/2022		
HREC REF Number	720/2020	Current Ethics Approval was granted until	30/11/2021
Protocol title	Stigmatising views towards patients with substance use disorder and major depressive disorder amongst non-specialist TB & HIV care providers: an exploratory study.		
Protocol number if applicable			
Are there any sub-studies linked to this study?	☐ Yes	✓ No	
If yes, could you please provide the HREC Reference number for all sub-studies? Note: A separate FHS016 must be submitted for each sub-study.	N/A		
Principal Investigator	Prof Goodman Sibeko		

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

Department / Office Internal Mail Address	goodman.sibeko@uct.ac.za

1.1 Does this protocol receive US Federal funding?	☐ Yes	✓ No
1.2 If the study receives US Federal Funding, does the annual report require full committee approval? **Note:** Any annual approvals for **Full Committee** review MUST be submitted on the monthly HREC submission dates. (Please send electronic copy for full committee review to hrec-submission@uct.ac.za)	☐ Yes	☐ No N/A

If yes in 1.2 please complete section 1.3 below for invoicing purposes

1.3 Ethics Renewal Fee

Please **(tick ✓)** appropriate box for billing purposes:

Submission Type	***Description***	***New fee (Vat Incl.)***	***tick ✓***
Research funded solely from UCT departmental/ divisional/group budget	Annual evaluation of research progress report for re-certification	**R0,00**	☐
Non-sponsored student research for degree purposes at UCT/Other Universities & Colleges	Annual evaluation of research progress report for re-certification	**R0,00**	✓
Annual re-certification / Progress report (FHS016 Form)	Clinical Trial & International Grant Funded Research - Annual evaluation of research progress report for re-certification for Full Committee Approval	**R7000,00**	☐
Annual re-certification / Progress report (FHS016 Form)	Clinical Trial & International Grant Funded Research - Annual evaluation of research progress report for re-certification for Expedited review	**R3 710.00**	☐
Annual re-certification / Progress report (FHS016 Form)	National grant funded research - Annual evaluation of research progress report for re-certification for Full Committee Approval	**R6000.00**	☐
Annual re-certification / Progress report (FHS016 Form)	National Grant funded research for Annual evaluation of research progress report for re-certification for Expedited review	**R1 500,00**	☐

NB: Protocols funded by UCT (e.g. departmental funding / student research) and by certain grant funding organizations (e.g. MRC, NRF, CANSA,) are exempt from these charges.

Please provide details for invoicing, either complete section 1 or 2 :

1. Invoice billing – Directly to Sponsor

Sponsor's name	N/A
Billing Address of Sponsor:	
Vat Number:	

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Contact person	
Telephone number	
Email Address	
2. Internal Journal Billing:	
Fund Number:	
Cost Centre Number:	
Account Holder Name:	
Division of Account Holder:	

2. List of documentation for approval

3. Protocol status (tick ✓)

☐	Open Enrolment
✓	Closed to enrolment (tick ✓)
☐	Research-related activities are ongoing
☐	Research-related activities are complete, long-term follow-up only
✓	Research-related activities are complete, data analysis only
☐	Main study is complete but sub-study research-related activities are ongoing
☐	Study is closed → Please submit a Study Closure Form (FHS010)

4. Enrolment

Number of participants enrolled to date	81
Number of participants enrolled, since last HREC Progress report (continuing review)	81
Additional number of participants still required	0

5. Refusals

Total number of refusals (participants invited to join the study, but refused to take part)	0

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

6. Cumulative summary of participants

Total number of participants who provided consent	**81**
Number of participants determined to be ineligible (i.e. after screening)	0
Number of participants currently active on the study	0
Number of participants completed study (without events leading to withdrawal)	0
Number of participants withdrawn at participants' request (i.e. changed their mind)	0
Number of participants withdrawn by PI due to toxicity or adverse events	0
Number of participants withdrawn by PI for other reasons (e.g. pregnancy, poor compliance)	0
Number of participants lost to follow-up. Please comment below on reasons for loss of follow-up.	0
N/A	
Number of participants no longer taking part for reasons not listed above. Please provide reasons below:	
N/A	

7. Progress of study

Please provide a brief summary of the research to date including the overall progress and the progress since the last annual report as well as any relevant comments/issues you would like to report to the HREC:
HREC approval was granted on 17/11/2020 (HREC 720/2020). HREC also approved a Protocol Amendment on 01/02/2021 – this was to allow for additional participants to be enrolled, in order to increase the sample size of the study. 81 participants have been enrolled. Formal data collection was completed as of July 2021 and there will be no further participants enrolled in the study. The data is currently being analysed, with the intention to submit findings for degree purposes and publication in early 2022. This is the first annual review. A FHS010 (Study Closure Form) will be submitted once the data has been analysed.

8. Protocol violations and exceptions (tick ✓ all that apply)

✓	No prior violations or exceptions have occurred since the original approval
☐	Prior violations or exceptions have been reported since the last review and have already been acknowledged or approved
☐	Unreported minor violations that have occurred since the last review, as well as significant deviations not yet reported, are attached for review

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

9. Amendments (tick ✓ all that apply)

☐	No Prior amendments have been made since the original approval
✓	Prior amendments have been reported since the last review and have already been approved
☐	New protocol changes/ amendments are requested as part of this continuing review (See note below)

Note: If new protocol changes are being requested in this review, please complete an amendment form (FHS006).
Specific changes in the amended protocol and consent/assent forms must be **bolded**, *italicised* or tracked and all changes must include a rationale.

10. Adverse events

10.1 Please provide below or attach a narrative summary of serious adverse events and/ or unanticipated problems since the last progress report. Please indicate changes made to the protocol and informed consent document(s) as a result (if not already reported to the HREC). Please comment on whether causality to any study procedure or intervention could be established.
Nil adverse events.

10.2 Have participants received appropriate treatment/ follow-up/ referral when indicated (e.g. in the case of abnormal or incidental clinical findings, distress or anxiety)?		
☐ Yes	☐ No	✓ Not applicable
If yes, please describe:		

11. Summary of Monitoring and Audit Activities (tick ✓)

11.1 Was this study monitored or audited by an external agency (e.g. SAHPRA, FDA)?		
☐ Yes	✓ No	☐ Not applicable

11.2 Did a Data and Safety Monitoring Board publish a report?		
☐ Yes	☐ No	✓ Not applicable

11.3 If yes, please identify the agency and attach a summary of the findings.					
Agency Name		Report attached	☐ Yes	☐ No	✓ Not applicable
		DSMB report attached	☐ Yes	☐ No	✓ Not applicable

11.4 Has there been any agency, institutional or other inquiry into non-compliance in this study, or any finding of non-compliance concerning a member of the research team?

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

☐ Yes	✓ No
If yes, please explain:	
N/A	

12. Level of risk (tick ✓)

12.1 In light of your experience of this research, please indicate whether the level of risk to participants has:	
☐	Increased
☐	Decreased
✓	Shown no change
If there has been a change, please explain:	
N/A	

12.2 Please provide a narrative summary of recent relevant literature that may have a bearing on the level of risk.
N/A

13. Insurance

Please confirm that valid no fault insurance is still in place? (tick ✓)			
☐ Yes		✓ No	
If yes, please complete the following:			
Insurer's name:	N/A		
Policy no.	N/A	*Coverage Period:	N/A
For UCT sponsored studies please liaise the insurance office via fhs.sponsorship@uct.ac.za regarding the required documentation and information required obtain a renewed UCT No-fault Insurance Certificate.			

14. Statement of conflict of interest

Has there been any change in the conflict of interest status of this protocol since the original approval? (tick ✓)	
☐ Yes	✓ No
If yes, please explain and if necessary, attach a revised conflict of interest statement (Section #7 in the New Protocol Application Form FHS013):	

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

N/A

15. Signature

My signature certifies that the above is complete and correct.			
Signature of PI		Date	30 November 2021

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Stigma and Health Submission Guidelines

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission electronically through the Manuscript Submission Portal in Microsoft Word format

To submit to the Editorial Office of Patrick W. Corrigan, please submit manuscripts (.doc) or LaTex (.tex) as a zip file with an accompanied Portable Document Format (.pdf) of the manuscript file.

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.

SUBMIT MANUSCRIPT

Editor: Patrick W. Corrigan
Illinois Institute of Technology

Manuscript types and length

Stigma and Health accepts both regular articles and brief reports.

Articles should not exceed 20 pages inclusive of the introduction, methods, results, and discussion. Tables, figures and references may be outside of this page limit; however, the combined number of tables and figures should not exceed 5. Authors should include the page count, number of figures/tables, and number of references on the title page of the manuscript.

Authors are encouraged to move tables and figures not directly pertinent to the understanding of the manuscript text into the online-only supplemental material. Please see Supplementing Your Article With Online Material for more details.

Brief reports should be a maximum 1,800 words (excluding abstract, references, and table/figure), plus no more than 15 references and one table or figure.

Authors may request consideration of longer papers or additional tables/figures by providing clear justification in a cover letter to the editor.

Manuscripts based in the following realms are also encouraged:

- Qualitative studies
- Survey research
- Quantitative tests of hypotheses about the form and impact of stigma
- Theoretical reviews and pioneering reports on innovations
- Research studies on methods meant to erase the stigma of mental and physical illnesses
- First person essays about experience with stigma

The journal will likewise consider lengthier theory-based papers with permission from the editor.

Masked review

This journal has adopted a policy of masked review for all submissions. The title page should include all authors' names and institutional affiliations and full contact information for the corresponding author. The first page of text should omit this information but should include the title of the manuscript and the date it is submitted. Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Manuscript preparation

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.
For authors interested in additional resources on manuscript writing, APA Style's Journal Article Reporting Standards offer guidelines on what information should be included in all manuscript sections for qualitative, quantitative, and mixed-methods research. For more information, including checklists and flowcharts, visit the APA Style JARS website.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.
Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In online supplemental material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the text of the article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic writing and English language editing services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting supplemental materials

APA can place supplemental materials online, available via the published article in the PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.

Examples of basic reference formats:

Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.
The minimum line weight for line art is 0.5 point for optimal printing.
For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.
When possible, please place symbol legends below the figure instead of to the side.
APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.
The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.
For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure;
- an additional $600 for the second figure; and
- an additional $450 for each subsequent figure.

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).
On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.
APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK
  Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK
  Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).
In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).
APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.
Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

STG - Submission Confirmation for High substance use and depression stigma amongst non-specialist health workers in South Africa - [EMID:8b3d31cb91d0eac8]

Inbox ×

Stigma and Health <em@editorialmanager.com> 8:50 PM (0 minutes ago)

to me

Dear Dr Goncalves,

Your submission "High substance use and depression stigma amongst non-specialist health workers in South Africa" has been received by Stigma and Health.

You will be able to check on the progress of your submission by logging on to Editorial Manager as an author. The URL is https://www.editorialmanager.com/stg/.

Your manuscript will be given a reference number once an Editor has been assigned.

Please note that you may also confirm or Authenticate your ORCID iD by clicking here Your ORCID iD: 0000-0003-1340-3215 is already linked and Authenticated..

Best regards,
Editorial Office
Stigma and Health

APA asks that you please take a moment to give us your feedback on the submission process, by completing a short survey, available at http://goo.gl/forms/vKXxocF4Jk.