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Original research article

Mental health stigma across healthcare levels: a mixed methods case study

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Abstract
Introduction: Stigma among healthcare professionals remains a major barrier to accessible, high-quality mental health care. This study explores attitudes of Slovenian healthcare workers across different care levels toward people with mental disorders.
Methods: Using a mixed methods design, the study combines a survey of 223 professionals, the Opinion of Mental Illness Scale, and qualitative data from three focus groups and 20 interviews.
Results: Primary and tertiary care workers report fewer social restrictions and greater openness to integration than those in secondary care. Primary care workers showed the strongest willingness to include individuals with mental disorders in everyday life, though systemic constraints limit these efforts. Secondary care workers act more cautiously in crises, while tertiary professionals tend toward emotional distancing. Despite progress, stigma continues to impede equitable care.
Discussion and Conclusion: Differences in attitudes toward marginalized groups (e.g., older adults, LGBTQ+, migrants) are not statistically significant, indicating a relatively uniform treatment approach. Across all care levels, there is a lack of continuous, reflective anti stigma education. Targeted cross level interventions – incorporating lived experience, reflective dialogue, and long-term curricula – are essential. Mixed methods designs help uncover underlying stigma dynamics and support responsive, evidence based strategies for change.

Keywords: Equity; Health care professionals; Marginalized or vulnerable groups; Mental health; Quality of health care; Stigma and discrimination

Introduction

Mental disorders represent a growing share of the global burden of disease, affecting one in eight people and accounting for 13% of years lived with disability (Doll et al., 2022; WHO, 2022). Despite therapeutic advances, stigma remains a major barrier to help seeking and quality care (Giebel et al., 2024; Rössler, 2016). Cultural and systemic factors shape how stigma manifests, and few societies have achieved full normalization of mental illness. Many individuals still conceal symptoms for fear of exclusion, with global surveys showing widespread fear of discrimination and frequent experiences of marginalization (Rössler, 2016; Sedić et al., 2024).

Healthcare professionals play a central role in either reinforcing or reducing stigma. Evidence indicates that clinicians often hold perceptions of dangerousness or poor prognosis, leading to diagnostic biases, reduced optimism, and weaker engagement (Domingo Espiñeira et al., 2024; Sedić et al., 2024). Slovenian data suggest similar patterns, with comparable social distance and misconceptions (James et al., 2020; Maina et al., 2018). Intersectional stigma further disadvantages older adults, LGBTQ+ people, migrants, and persons with disabilities, hindering equitable care and limiting the success of integrated models (Bickman, 2020; Flores et al., 2020; Petruželka and Walach, 2025; Vistorte et al., 2018).

Intervention studies show promising results: contact based programs, empathy training, and multicomponent education produce moderate to large improvements in attitudes (Porfyri et al., 2022; Yanos et al., 2020). A large RCT in Thessaloniki found that empathy training reduced social distance for at least one year (Martínez Zambrano et al., 2013). Systematic reviews emphasize that sustained attitude change is strongest when interventions are embedded in continuous professional development (Grandón et al., 2021; Griffiths et al., 2014; Iammarino et al., 2020). Nonetheless, even systems with established anti stigma policies continue to report persistent stigma (Vondroušová et al., 2025; WHO, 2016).

Existing research largely examines single levels of care, limiting applicability to integrated systems. Most studies isolate hospital specialists or community providers, overlooking differences between primary, secondary, and tertiary settings (Griffiths et al., 2014; WHO, 2016). Additionally, quantitative tools such as the Opinion of Mental Illness Scale (OMI) are

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rarely combined with qualitative approaches that reveal organizational and cultural drivers of stigma (Cohen and Struening, 1962; Oblak, 2025). While early OMI research explored multidimensional attitudes, few studies have applied it across the entire healthcare continuum (Madianos et al., 1987; von Elm et al., 2007).

To address these gaps, this study provides the first cross level comparison of mental health stigma among Slovenian healthcare professionals. Using a mixed methods case study, we combine OMI survey data from 223 practitioners with three focus groups and twenty interviews (Oblak, 2025). This approach allows us to identify variations in social restriction, care, and integration attitudes, and to examine systemic and cultural factors shaping stigma within each level of care.

Materials and methods

Study design

We conducted a cross-sectional mixed-methods case study, aligned with STROBE guidelines (Možina and Okorn, 2022), to compare attitudes toward mental disorders among healthcare professionals at primary, secondary, and tertiary levels in Slovenia. Quantitative data were collected using the Opinion of Mental Illness Scale (OMI), assessing five attitudinal domains, while qualitative data from focus groups and in-depth interviews explored contextual and experiential factors underlying these attitudes.

Setting and participants

Between January and March 2025, participants were recruited from three regional primary-care centres, two district hospitals, and the main Slovenian university medical centre. A priori power analysis (G*Power 3.1) indicated a required sample of 210 (70 per level) to detect medium effects (f = 0.25) at α = 0.05. Institutional leads distributed invitations to clinicians (physicians, nurses, allied health staff) with at least one year of clinical experience; administrative staff, trainees, and those on extended leave were excluded.

Of the 350 invited professionals, 223 participated (64% response rate). Responders did not differ meaningfully from non-responders based on available roster characteristics. The final sample included 51 primary, 111 secondary, and 61 tertiary care professionals. Efforts were made to ensure heterogeneity in professional roles, gender, and seniority (see Suppl. Table 1). Women represented 83% of respondents, and the largest age group was 31–50 years.

Since several OMI subscales violated assumptions of normality and homogeneity of variance, between-group comparisons were conducted using the non-parametric analogue of ANOVA (Kruskal–Wallis test) rather than classical parametric ANOVA. This approach allowed valid comparison of median scores across the three care levels, while accommodating the ordinal nature of Likert-type data.

Quantitative data collection

Participants completed a Slovenian translated and back-translated 51-item OMI scale (Madianos et al., 1987), rated on a 6-point Likert scale across five domains: Authoritarianism, Benevolence, Social Restrictiveness, Social Care, and Social Integration. Internal consistency (Cronbach's α) was assessed, and the instrument was pilot-tested with 15 practitioners. Demographics, professional data, and prior mental health training were also collected. Surveys were administered online via a secure platform.

Qualitative data collection

To contextualize survey patterns, we conducted three focus groups (one per care level; n = 18) and 20 semi-structured interviews using maximum-variation sampling. Participants included physicians, nurses, allied health professionals, mental health specialists, care coordinators, and patient representatives selected for diversity in role, experience, and prior mental health training. A pilot-tested guide explored experiences with mental health education, workplace stigma, and anti-stigma practices. Sessions (60–90 minutes) were recorded, transcribed, and anonymized. Two experienced mixed-methods researchers conducted data collection, maintained reflexive notes, and coded transcripts independently, with discrepancies resolved through discussion or involvement of a senior researcher.

Data analysis

Quantitative analysis was performed in SPSS 28. We calculated Cronbach's α for OMI subscales and compared mean scores across care levels using one-way ANOVA with Tukey *post-hoc* tests. Qualitative data collection and analysis proceeded iteratively until conceptual saturation, defined as three consecutive data sources producing no new codes. Two coders employed inductive thematic analysis, with weekly reconciliation meetings and senior review.

Mixed-methods integration used a convergence coding matrix comparing OMI subscale results with qualitative themes. Each cell was evaluated for convergence, complementarity, dissonance, or silence. Divergences were examined through re-review of transcripts and coding memos.

Ethical considerations

The study was implemented under project CRP 2023 (V3-2311) and approved by the Ethics Committee of the University of Novo Mesto (No. 32/2024). Participants received written information, provided informed consent, and could withdraw at any time. No incentives were offered. All qualitative data were anonymized, and quotations are reported using non-identifiable labels with contextual details generalized to ensure confidentiality.

Results

Quantitative results

The Opinion of Mental Illness Scale subscales reflect distinct attitudinal dimensions: Social Restriction refers to beliefs that people with mental disorders should be kept apart or limited in participation; Social Integration captures willingness to include them in everyday roles (e.g., work, community activities, friendships); Social Care measures supportive and compassionate attitudes; Authoritarianism denotes a preference for control or supervision over individuals with mental illness; and Etiology reflects beliefs about the causes of mental disorders.

Analysis of OMI subscales revealed significant group differences in three domains (Table 1).

Secondary level staff reported significantly higher social restriction, social care, and social integration scores than both primary and tertiary staff (all $p \leq 0.001$). No significant differences were found for authoritarianism (social discrimination) or etiology ($p > 0.8$). Item-level means and standard deviations for OMI subscales are provided in Suppl. Table 2.

Significant between-level differences in perceived discrimination were observed for Roma, immigrants/foreign language

speakers, socioeconomically disadvantaged individuals, and uninsured persons ($p < 0.05$), while no differences emerged for the elderly, LGBTQ+ individuals, or persons with disabilities. Detailed analyses are presented in Table 2 and Suppl. Table 3.

Table 1. Between level differences in perceived discrimination against marginalized groups among healthcare professionals (Kruskal–Wallis test, *N* = 223)

Factor	Healthcare professionals by level	*N*	Mean rank	Kruskal–Wallis H.	Sig.
Social discrimination	Primary	51	112.25	0.435	0.804
	Secondary	111	109.53		
	Tertiary	61	116.29		
Social restriction	Primary	51	86.76	33.020	0.000
	Secondary	111	136.90		
	Tertiary	61	87.80		
Social care	Primary	111	99.90	18.994	0.000
	Secondary	51	130.45		
	Tertiary	61	88.54		
Social integration	Primary	51	96.65	13.120	0.001
	Secondary	111	127.69		
	Tertiary	61	96.29		
Etiology	Primary	111	107.81	0.342	0.843
	Secondary	51	114.14		
	Tertiary	61	111.60		

Qualitative results

The qualitative findings provide an in-depth view of how healthcare professionals across care levels experience and interpret their attitudes toward mental health in clinical settings. Drawing on narratives from primary, secondary, and tertiary professionals, four interconnected themes emerged: limits of procedural support, tensions between empathic continuity and system pressures, the paradox of expertise and emotional distancing, and the widespread absence of sustained stigma-reduction education. These themes illuminate the complex dynamics underpinning the quantitative patterns observed.

Secondary-level professionals consistently praised referral protocols and multidisciplinary discussions for offering a structured framework in managing patients with mental disorders. Yet these same clinicians acknowledged that protocols could not fully address the emotional uncertainty present in escalating situations. As one neurologist noted, guidelines provide "a safety net", but when behaviour becomes unpredictable, "the protocol only covers so many scenarios". This highlights how procedural clarity reduces ambiguity but cannot eliminate personal responsibility or fear at the point of care.

In primary care, long-term therapeutic relationships emerged as a key facilitator of open mental-health conversations. Familiarity with patients' life contexts helped normalize discussions about mood or stress. However, this empathic continuity was frequently disrupted by systemic pressures such as tightly packed schedules and surges in urgent cases. A community nurse reflected, "I plan to explore their emotional well-being, but when I see the clock, I cut the conversation short or postpone it indefinitely."

Tertiary professionals – psychiatrists, psychologists, and allied specialists – described a paradox of advanced expertise paired with emotional distancing. Years of training and exposure to severe pathology encouraged a professional identity centred on objectivity. One psychiatrist admitted to "stepping back emotionally, as if maintaining a protective barrier", while a psychologist noted that high-intensity caseloads reinforced "a shell of detachment". These accounts help explain why tertiary professionals did not show the strongest Social Integration scores despite their knowledge.

Across all care levels, participants highlighted a notable absence of structured, long-term education on stigma and bias. Training on stigma was described as sporadic, superficial, or optional, often limited to communication-focused workshops without deeper reflection on personal prejudice or lived experience. As one primary care nurse put it, a half-day course "never challenged my own assumptions about mental illness", while a tertiary allied professional found existing sessions "superficial and without follow-up". This persistent educational gap aligns with the quantitatively stable Social Discrimination and Etiology scores.

Table 2. Between level differences in perceived discriminatory treatment of marginalized patient groups (Kruskal–Wallis test, *N* = 223)

		N	Mean score	Standard deviation	Mean rank	Kruskal–Wallis H.	Sig.
1. Elderly patients	Primary	51	2.22	0.832	121.49	1.795	0.408
	Secondary	111	2.01	0.667	109.02		
	Tertiary	61	2.10	0.943	109.48		
2. Roma	Primary	51	2.78	0.879	113.61	10.374	0.006
	Secondary	111	2.93	0.941	122.73		
	Tertiary	61	2.44	0.940	91.14		
3. Immigrants/foreign language speakers	Primary	51	2.43	0.70	105.77	8.935	0.011
	Secondary	111	2.71	0.948	123.72		
	Tertiary	61	2.30	0.863	95.89		
4. People with various forms of disabilities	Primary	51	2.08	0.688	115.45	4.148	0.126
	Secondary	111	2.11	0.705	117.50		
	Tertiary	61	1.92	0.862	99.10		
5. Socio-economically disadvantaged people	Primary	51	2.14	0.749	107.51	12.979	0.002
	Secondary	111	2.44	0.921	125.36		
	Tertiary	61	1.95	0.884	91.43		
6. Prisoners	Primary	51	2.69	0.860	121.43	3.593	0.166
	Secondary	111	2.59	0.867	114.08		
	Tertiary	61	2.39	0.900	100.33		
7. Homeless people	Primary	51	2.49	0.880	105.97	4.298	0.117
	Secondary	111	2.70	0.930	120.38		
	Tertiary	61	2.41	0.844	101.80		
8. Sex workers	Primary	51	2.63	0.871	120.82	2.101	0.350
	Secondary	111	2.50	0.990	112.38		
	Tertiary	61	2.38	0.969	103.93		
9. Homosexuals	Primary	51	2.41	0.898	116.59	1.546	0.462
	Secondary	111	2.35	0.827	114.34		
	Tertiary	61	2.23	0.883	103.91		
10. Drunks or alcoholics	Primary	51	2.71	0.855	109.46	2.420	0.298
	Secondary	111	2.82	0.855	117.98		
	Tertiary	61	2.59	0.864	103.24		
11. Drug addicts	Primary	51	2.84	0.857	116.98	0.601	0.740
	Secondary	111	2.78	0.857	111.91		
	Tertiary	61	2.70	0.901	108.01		
12. People without health insurance	Primary	51	1.86	0.722	102.05	7.332	0.026
	Secondary	111	2.12	0.760	122.67		
	Tertiary	61	1.85	0.792	100.90		

Discussion

The integrated analysis of quantitative and qualitative data shows that Slovenian healthcare professionals' attitudes toward mental disorders are context-dependent and shaped by organizational and emotional dynamics. Secondary-level professionals combined relatively strong support for social care and integration with persistent caution in acute situations – a tension explained qualitatively by reliance on multidisciplinary protocols that reduce ambiguity but do not eliminate uncertainty in unpredictable encounters. Primary healthcare professionals described long-term therapeutic relationships that lower social distance, yet heavy workload and rigid scheduling frequently curtailed mental-health conversations, revealing a gap between empathic intention and daily practice. Tertiary professionals, despite advanced expertise, reported emotional distancing and professional detachment as coping strategies, which aligned with their more reserved scores on social integration.

Across all levels, a pervasive lack of sustained, reflective anti-stigma education emerged. Training was typically sporadic, optional, or superficial, offering communication tools but not addressing deeper issues of prejudice, lived experience, or structural discrimination. This educational gap helps explain the stability of Social Discrimination and Etiology scores despite otherwise positive inclinations. These patterns reflect how organizational structures, interpersonal dynamics, and uneven training operate within a policy environment that promotes integrated community-based mental healthcare but has not translated intent into consistent professional capacity. Accordingly, secondary-level clinicians rely on procedural frameworks that support inclusion but leave affective uncertainty unresolved; primary-level staff face systemic barriers that limit reflective practice; and tertiary specialists often retreat into emotional distancing as a protective adaptation. These findings reinforce theoretical claims that institutional procedures cannot fully mitigate stigma's emotional burden (Rössler, 2016). They extend Link and Phelan's framework (2001) by showing how relational distance persists when contextual supports are insufficient, even among technically skilled professionals.

Relative to existing research, the cross-level mixed-methods design yields novel insights. While previous work validated the multidimensional structure of the OMI scale (Cohen and Struening, 1962; Madianos et al., 1987) and demonstrated the value of empathy-focused or multicomponent interventions (Griffiths et al., 2014; Martínez-Zambrano et al., 2013; Porfyri et al., 2022), our findings suggest that procedural clarity and isolated sessions do not adequately shift deeper biases. Participant accounts of superficial, one-off workshops underscore the need for continuous, theory-informed curricula, consistent with prior calls for longitudinal, system-embedded stigma-reduction efforts (Iammarino et al., 2020). Likewise, tensions found in primary care mirror broader arguments for genuinely integrated models that account for workload and system design constraints (Kroenke and Unutzer, 2017).

This study contributes a replicable framework for examining stigma across levels of care by pairing standardized measurement with qualitative depth to uncover emotional and structural drivers. By distinguishing secondary care as procedurally supported yet affectively uncertain, primary care as empathically oriented but systemically constrained, and tertiary care as technically expert yet emotionally distant, we refine existing models and identify targets for tailored interventions. From a practice perspective, the findings underscore the need to move beyond isolated workshops toward integrated programs that combine procedural clarity with sustained contact-based learning, reflective forums, and structured mentorship. Protected time in primary care for mental-health discussions, simulation-based crisis training in secondary settings, and peer-support mechanisms in tertiary environments could help translate positive intentions into consistent, compassionate practice.

Several limitations must be noted. Convenience sampling within a single national system limits generalizability, and the cross-sectional design precludes causal inference. Self-selection likely attracted professionals interested in mental health, and self-report measures introduce social desirability bias. We did not assess organizational culture or leadership climate, which may account for unobserved variation. Findings are embedded in the Slovenian healthcare context and may not fully transfer elsewhere. Future research should replicate this cross-level design in diverse systems, incorporate longitudinal or experimental components, triangulate self-report with observational data and patient outcomes, and explicitly model unit-level cultural factors.

Overall, addressing stigma in healthcare requires a coordinated, multilevel strategy that integrates procedural support with experiential learning and sustained reflective practice. Only by embedding comprehensive educational and relational scaffolds can healthcare systems consistently translate positive attitudes into equitable, compassionate care for people living with mental disorders.

Conclusion

This study addresses a major international gap by providing the first cross-level analysis of mental health stigma within a single healthcare system – a methodological contribution seldom used outside Slovenia. By integrating standardized attitude measures with qualitative narratives, we show how procedural structures, relational dynamics, and educational shortcomings jointly shape stigma across primary, secondary, and tertiary care. Our findings indicate that while formal protocols support inclusion, they leave clinicians uncertain in unpredictable situations; that long-term patient relationships promote empathic openness but are constrained by workload; and that advanced expertise can unintentionally lead to emotional distancing. The consistent absence of sustained stigma-reduction education highlights the global need for longitudinal, contact-based training.

By demonstrating a replicable mixed-methods framework, this study offers a template for international comparisons of stigma across care continuums. Integrated interventions – combining clear protocols with reflective practice, contact-based learning, and protected time for mental-health dialogue – show promise for translating positive attitudes into consistent, compassionate care across health systems. Future research should adopt this cross-level approach in diverse contexts and evaluate the long-term impact of multicomponent anti-stigma programs to advance more inclusive mental-health services.

Author contributions

Study conception and design: *VZ*; data collection: *VZ*; analysis and interpretation of results: *VZ, KE*; draft manuscript preparation: *VZ, KE*. All authors reviewed the results and approved the final version of the manuscript.

Institutional review board statement

The study was conducted in accordance with the Declaration of Helsinki. The Ethics Committee of the University of Novo Mesto approved the study (No. 32/2024).

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Conflict of interest

The authors have no conflict of interest to declare.

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