Gabriel Obukohwo Ivbijaro

NOVA Medical School | Faculdade de Ciências Médicas

Mental Health in Primary Care

Stigma and Social Distance for Schizophrenia in Psychiatrists, General Practitioners and Service Users

A Doctoral Thesis submitted to NOVA University Lisbon|
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ABSTRACT

THE PROBLEM

Patients who suffer from mental illness do not make best use of standard medical facilities such as general practice facilities, and other primary care services. This puts them in a disadvantaged position when it comes to their health needs, especially as there is evidence that primary care is effective, more accessible and produces more positive long-term outcomes leading to a reduction in mortality and morbidity (B. Starfield et al 2005; WHO 2008; M. Funk and G. Ivbijaro 2008).

It has been postulated that a reason for this lack of progress is stigma and discrimination which can be assessed by measuring social distance. The concept of social distance is a generic concept that can relate to any form of distancing (E. S. Bogardus E.S. 1925).

To tackle the stigma associated with a Serious Mental Illness (SMI) such as schizophrenia and reduce the disparity in physical and mental health in people with serious mental illness so that patients can reap the benefits of a primary care transformation process, there is a need to have a deeper understanding of the barriers patients face in accessing primary care either from the community or from secondary care mental health services.

WHY THIS IS IMPORTANT

The 2012 Mental Health Case for Change for London noted that mental ill health was a significant barrier to social inclusion in London and limited access to health. This was worse in those people with mental and physical health co-morbidity.

Patients with schizophrenia consult general practitioners more often than the average patient, often with somatic complaints rather than symptoms of mental illness and receive very little specific evidence based practice for either their physical or mental health condition (I. Nazareth et al 1993). This could be related to poor knowledge, skills and confidence in general practitioners to manage the health of patients with schizophrenia.

A 1997 review noted a low detection rate of physical health problems in those with a mental health diagnosis and linked this to a lack of self-confidence characteristics in patients with a diagnosis of schizophrenia (T. Burns and T. Kendrick 1997).

This review also found that patients with schizophrenia present more often to general practitioners for a variety of reasons, including collection of repeat prescriptions, but will rarely talk about their physical or mental health spontaneously.

The authors suggested that a reason for the lack of confidence of general practitioners in managing patients with schizophrenia is the low numbers of such patients that they see in their daily practice because the prevalence of this disorder is 0.9%.

KEY FINDINGS

i. There is a non-significant relationship between psychiatrists social distance for schizophrenia and their confidence in the ability of general practitioners to manage schizophrenia in general practice

ii. There is a significant relationship between psychiatrist's social distance for schizophrenia and their belief that general practitioners should be confident in managing schizophrenia in general practice.

iii. There is a significant relationship between psychiatrist's social distance for schizophrenia and their belief that general practitioners should not manage patients with schizophrenia in general practice.

iv. There is a significant relationship between general practitioner's social distance for schizophrenia and their belief that general practitioners should be confident in managing patients with schizophrenia in general practice.

v. There is a significant relationship between general practitioner's social distance for schizophrenia and their belief that general practitioners should be confident in managing schizophrenia in general practice.

vi. There is a significant relationship between general practitioner social distance for schizophrenia and their belief that general practitioners should not manage patients with schizophrenia in general practice.

vii. There is no relationship found between mental health service users social distance for schizophrenia and their belief that their general practitioner is confident in managing their mental health

viii. There is no relationship found between mental health service users social distance for schizophrenia and their belief that their general practitioner is confident in managing their other health problems

ix. There is no relationship found between mental health service users social distance for schizophrenia and their belief that their general practitioner should be confident in managing their mental health problems

The literature review showed that mental health stigma and discrimination occurs in mental health service users, mental health service providers, the population at large and policy makers. We therefore require innovative ways of addressing stigma, discrimination and social distance in mental health in order to change attribution and behaviour and the research presented here is part of a larger study.

We need to identify new ways to tackle the malignancy of stigma and discrimination in mental health and find a new lens to re-examine the concepts and constructs. We will use the information from the overall study to inform the development of an assessment tool to assess social distance for mental health service users as part of the routine assessment of people with a mental health problem managed in primary care that is sensitive to change over time.

INTRODUCTION

Patients who suffer from mental illness do not make best use of standard medical facilities such as general practice facilities, and other primary care services. This puts them in a disadvantaged position when it comes to their health needs, especially as there is evidence that primary care is effective, more accessible and produces more positive long-term outcomes leading to a reduction in mortality and morbidity (B. Starfield et al 2005; WHO 2008; M. Funk and G. Ivbijaro 2008).

My thesis brings together the common thread of my work, which is how to provide improved access to healthcare for people who suffer from mental health conditions irrespective of race, gender, social and economic status.

I have reviewed three of my publications that bring together the role of policy in mental health access, skills training in primary care and treatment options and collaborative care:

i. Integrating mental health into primary care: A global perspective
ii. Companion to primary care mental health
iii. Informing mental health policies and services in the Eastern Mediterranean Region: cost-effective deployment of human resources to deliver integrated community based care

In 1978 the WHO made the Alma Ata Declaration stating that primary care should be the vehicle for global and individual access to health to improve general health outcomes. Discrimination and social exclusion contribute to the difficulty in achieving mental health integration in Primary Care, and new ways of dealing with this problem are needed (Bowling 1997, De Vaus 2013, Winter & Munn-Giddings 2001, Bogardus 1925).

It has been postulated that a reason for this lack of progress is stigma and discrimination which can be assessed by measuring social distance (M. C. Angermeyer & H. Matschinger H. 2004, M. King et al 2007). The concept of social distance is a generic concept that can relate to any form of distancing (E. S. Bogardus E.S. 1925).

When considered in mental health put simply, increased social distance means that people do not want people with a mental illness as a neighbour, or to associate with them socially when compared to other people (M. C. Angermeyer & H. Matschinger H. 2004, M. King et al 2007).

A consequence of social distance is that patients who suffer from mental illness may not receive the care they require when presenting at health facilities such as general practice surgeries and other primary care services. This puts them in a disadvantaged position when it comes to their health needs.

I have reviewed the literature about the concept of social distance and how this relates to access to primary care services by service users who suffer from mental disorder. I have also studied stigma and discrimination about schizophrenia in psychiatrists, general practitioners and mental health service in East London, UK.

The results presented in this thesis compare social distance for schizophrenia in psychiatrists, general practitioners and mental health service users as measured using a validated social distance questionnaire and the confidence of each group in the general practice management of schizophrenia.

I will use the result of this literature review and the findings of the comparison of social distance for schizophrenia in psychiatrists, general practitioners and mental health service and confidence in the general practice management of schizophrenia.

I will relate this to access to health care so that people with mental health problems can share the benefits of good quality primary care in line with the population who does not suffer from mental disorder.

The World Organisation of Family Doctors (Wonca) and the World Health Organisation (WHO) published a document on Primary Care Mental Health in 2008 (Funk &Ivbijaro 2008). This concluded that integration of mental health service users into primary care provides the best option for mental health service users. However there remain a lot of barriers to achieving this aim.

CHAPTER ONE

1. LITERATURE REVIEW

1.1. DEFINITIONS OF STIGMA

Erving Goffman (1963) defined stigma as the mark that distinguishes someone as discredited.

The work of Goffman has been cited by many social scientists, people working in the legal field and economists and has been very useful in providing a framework for understanding (E. Goffman 1963, E. Goffman 2006, L. M. Coleman 2006, C. B. Bracey 2003, S. Raphael 2002).

Goffman enabled us to understand that every human has the potential to be stigmatised as they move from one social context to another and postulated that stigma is associated with negative attributes and a sign that distinguishes that individual from others for instance their gender, religion or race.

He noted that the history of stigma dates to the Ancient Greeks who were very strong on visual images and used the word stigma to refer to bodily signs designed to expose something unusual and bad about the moral status of the individual. These signs were cut or burnt into the individual to show that they were blemished, polluted or should be avoided in public places.

In his earlier work, Goffman (E. Goffman 1963) noted that society has a way of categorising people. In the chapter Selections from Stigma Goffman noted that stigma possesses a relationship between attribute and stereotype (ed. J. L. Davis 2006).

To understand this relationship, I will refer to the work of B. G. Link and J. C. Phelan (2001) who agreed with Goffman’s view that stigma can occur in all circumstances and further developed the explanatory construct for mental health stigma (K. Sheldon and L. Caldwell 1994; J. Lewis 1998).

1.2. EXPLANATORY CONSTRUCTS FOR MENTAL HEALTH STIGMA

To understand stigma and define it appropriately requires one to understand the Goffman's original proposal that stigma occurs within a relationship where attributes and stereotypes have a dynamic interaction.

Link and Phelan (2001) have elaborated on Goffman's three constructs and describe four components that they believe allow a deeper understanding of the meaning of stigma. These are:

- Distinguishing and labelling,
- Associating human differences with negative attributes,
- Separating "us" from "them"
- Loss of status and discrimination.

I will expand upon these four components and, in addition consider two psychodynamic concepts, the concept of the collective unconscious (C. G. Jung 1936) and projective identification (M. Klein 1946) to explore how they may relate to the explanatory constructs listed above.

In their studies of stigma Link and Phelan (2001) examined cognitive processes and behaviours to explain the structure of stigma, but this does not fully explain why stigma persists and how it is transmitted between cultures and individuals. This transmission and acceptance may be better explained by the psychodynamic theories of the collective unconscious and projective identification.

The contribution of the collective unconscious and projective identification was not part of the original construct postulated by Goffman (1963) and Link and Phelan (2001) however, these two additional psychological concepts enable us to have a deeper understanding of why mental health stigma and discrimination is so malignant and persistent and persist at a global level at all levels of society.

Considering these psychodynamic concepts may also enable us to understand why people with mental illness stigmatise themselves, and why short lived mental health de-stigmatisation campaigns are ineffective.

1.2.1. Components of Stigma I - Distinguishing and Labelling

Link and Phelan (2001) propose that no two human beings are the same but many of the differences between individuals are often ignored and considered irrelevant or unimportant.

Some differences, such as skin colour and handicap begin to come to the forefront and create the concept of labelling and categorisation. Examples include black people and white people and blind people and sighted people. Looking at these two examples, one label brings social disadvantage and the other label does not. The label associated with social disadvantage leads to real or perceived stigma.

According to Goffman (1963), labelling that brings social disadvantage is the one that subsequently leads to stigma. J. Crocker et al (1998) stated that stigmatised individuals possess a social attribute that conveys a social identity that is devalued in a particular context.

What often comes to people’s mind when considering stigma and discrimination is its relationship to race (C. R. Lawrence III 2008; A. Mentovich and J. T. Jost 2008) and I will start by considering this to illustrate some of the disadvantages of labelling.

As a result of labelling due to their skin colour, African Americans are found to earn less money, are less likely to be in employment than their white counterparts and earn less per hour than their white counterparts (S. Raphael 2002, C. A Bracey 2003). This is not because of education but simply because they are labelled as black.

Some studies have shown that in the United States of America the average net wealth of a black household is 25% less than the average net wealth of a white household (M. L. Oliver & T. Shapiro 1997).

Labelling is a cognitive process that leads to a series of pathways that can result in an individual being stigmatised, irrespective of characteristic, whether race, sexuality, physical or mental health, and I will explore this in more detail in relation to mental health in a later chapter.

1.2.2. Components of Stigma II - Associating Human Differences with Negative Attributes

Giving a person a label is not in itself damaging however, linking a label with a negative connotation or value leads to stigma. Link and Phelan's (2001) second component of stigma, highlighted in Goffman's original 1963 work is another cognitive process, commonly known as stereotyping.

Stereotyping can be understood by considering that individuals have an automatic negative image of an object or individual for instance "most Irish people are drunks." This serves as a collective representation of a particular group of people, possibly related to the collective unconscious (C. Jung 1936) and leads individuals to make a cognitive leap and draw a generalised conclusion about a particular group with no scientific basis for the decision making, especially as we know that it is not true that most Irish people are drunks. An example from mental health may be the assumption that "most people with mental illness are dangerous," especially as we know that this is not true (B. Link & F. T. Cullen 1987). This results in a group of people being tarnished because of an experience of some (D. L. Hamilton & J. W. Sherman 1994, R. S. Biernat & J. F. Dovidio 2003).

The research shows that the process of associating human differences with negative attributes happens very quickly. Individuals reach a judgement and conclusion very quickly and the conclusion is often faulty (D. L. Hamilton & J. W. Sherman 1994).

In making judgements about people with mental ill health this decision-making style is thought to result from poor health literacy at an individual and community level (A. F. Jorm et al 1999, W. Gaebel et al 2002, G. Thornicroft 2007).

There have been many mental health anti-stigma campaigns to educate the public such as the World Federation for Mental Health's World Mental Health Day on 10th October annually, the 1992 to 1996 UK National Defeat Depression Campaign, but these campaigns are not often as successful as intended as awareness does not translate into effectiveness (M. Orrell et al 1996). This means that we need to find new techniques and ways to align public education with positive outcomes for those currently stigmatised as a result of mental ill health.

1.2.3. Components of Stigma III - Separating “Us” From “Them”

According to Goffman (1963), Link and Phelan (2001) this component of stigma occurs in the behavioural domain and is the active process of separating “them” from “us.”

This can be understood as the people who are being stigmatised being clustered together and separated from those people that are stigmatising them. This means that labels are being linked to an active process of separating people into groups so that people in one group have an advantage compared to people in the stigmatised group. Goffman described this process by saying that a group of people who carry the stigma are thought to be the stigmatised group whilst the other people are thought to be normal.

Language is very important in separating “them” from “us” (S. E. Estroff 1989). Language associated with stigma turns the attribute to a noun, no longer a person with schizophrenia but “schizophrenic,” no longer a person with epilepsy but “epileptic.”

1.2.4. Components of Stigma IV - Loss of Status and Discrimination

This construct was not part of Goffman’s original description (1963) and was added by Link and Phelan (2001) to link the theoretical concept with the practical outcome of stigma on an individual’s life, because stigmatised people suffer a lot of negative consequences.

As already stated, African Americans are found to earn less money, are less likely to be in employment than their white counterparts and earn less per hour than their white counterparts. In the USA, the average net wealth of a black household is 25% less than the average net wealth of a white household (M. L. Oliver & T. Shapiro 1997).

People with mental illness sometimes do not use standard medical facilities, such as general practice surgeries and other primary care services because of labelling, stigma and discrimination. This puts them in a disadvantaged position when it comes to their health needs. People with a mental health condition do not have access to the appropriate help that they need and deserve and for the individual themselves, compliance with treatment is reduced (P. Corrigan 2004). This may be contributing to the poor life expectancy that people with mental health conditions have.

As previously stated a great deal of evidence has accrued demonstrating that people with mental health conditions such as schizophrenia and bipolar affective disorder have a mortality rate two to three times higher than the general population (C. W. Colton, R. W. Manderscheid 2006; T. M. Lauren et al 2012; E. E. McGinty et al 2016), and the majority of the excess mortality in this group of people can be attributed to preventable conditions.

1.3. EXPLANATORY CONSTRUCTS FOR MENTAL HEALTH STIGMA: ADDITIONAL CONSIDERATIONS

We require innovative ways of thinking to develop a clearer understanding of why stigma and discrimination in mental health continue to persist despite over 50 years of research. Stigma needs to be conceptualised on the individual level as a target for treatment interventions, and at a societal level as a target for interventions to change attribution and behaviour. Psychodynamic concepts and principles may hold some of the answers.

We need to identify new ways to tackle the malignancy of stigma and discrimination in mental health and find a new lens to re-examine the concepts and constructs because stigma and discrimination are part of relationships and connectedness to others.

Perhaps the constructs of the collective unconsciousness and projective identification may provide another perspective to advance research and understanding in this field especially as this has been extensively studied in stigma and discrimination and race (S. L. Bielock et al 2007; J. P. Jamieson and S. G. Harkins 2007).

1.3.1. The Collective Unconscious

Labelling, stereotype and prejudice occur in all parts of society, and in all age groups. These are all cognitive processes which can be considered part of the collective unconscious.

Carl Jung, a Swiss psychiatrist, put forward the concept of the collective unconscious stating “The collective unconscious is a part of the psyche which can be negatively distinguished from a personal unconscious by the fact that it does not, like the latter, owe its existence to personal experience and consequently is not a personal acquisition.” Jung further said, “Whereas personal unconscious consists for the most part of complexes the content of the collective unconscious is made up essentially of archetypes.”

Jung proposes that the collective unconscious is something that is handed down in stories or behaviours and stigma can be considered using this lens because, since Ancient Greece, stigmatised individuals are seen negatively. This may account for why stigmatising attitudes and behaviours are so resistant to change. If we accept this argument them we may need to look for psychodynamic approaches to tackle individual and collective stigma and not just holding routine public campaigns.

Jung thought of the collective unconscious as a collective memory, the collective memory of humanity and human experience however, not everybody agrees with this view.

Sheldrake provides a different explanation and understanding about the role of the collective unconsciousness and the relationship to stigma in his essay entitled Mind, Memory, and Archetype Morphic Resonance and the Collective Unconscious (1987).

Sheldrake proposed that society should be seen as a superorganism, and that collective human behaviour can be understood as that of a flock, drawing on crowd behaviour studies of social psychologists who describe “collective behaviour” in fashion fads, rumours, football hooliganism and lynch mobs.

Applying this to mental health stigma we can understand how people think badly about people with mental health problems without questioning their beliefs because it is already held within their collective memory. If a member of a family voices negative beliefs about people with mental illness then that is held within the collective memory of that family group.

At a societal level, newspapers coverage of mental illness is predominantly negative (J. Pirkis & C. Francis 2012) and this is kept in the collective memory of the group and enters the collective unconsciousness of that society.

The understanding of components I to III of stigma were described by Goffman, and later developed by Link and Phelan (2001) who added component IV. Ideas related to the collective unconsciousness and society as a superorganism can be used to further understand why many of the efforts made to address stigma, particularly mental health stigma, have been largely ineffective thus far. We need new research and innovative approaches to address the role of the collective unconsciousness in maintaining and sustaining mental health stigma at a community and societal level. Individuals experiencing mental health problems, psychiatrists and family doctors have an important role to play in this.

The idea that the collective unconscious can contribute to the understanding of stigma is not new, it is just that it has not been included as part of the explanatory theory especially as Hamilton and Sherman proposed that there is a collective agreement when it comes to the issue of stigma (1994) supporting the notion of the role of collective unconscious.

Unconscious motives are thought to drive prejudice, and it is postulated that prejudice held within a group is used as a tool to enforce order (G. W. Allport 1954). Although this sounds simplistic, one can see how a group of people will hold a shared negative view about another group of people to create an advantage for themselves.

Unconscious bias has been demonstrated in experiments based on the Stroop Test which measures implicit attentional bias (C. M. MacLeod 1991). Unconscious bias starts at a very early age, even before a child might be expected to be developmentally capable of making such a judgement (A. Mentovich and J. T. Jost 2008).

Prejudice in racial settings can be understood as a systemic issue that goes beyond the individual and infects almost everyone in contact with it and unconscious motives play a role in perpetuating stigma and stereotype (C. R. Lawrence III 2008).

With regards to mental health stigma, one can extrapolate this concept and that there is a collective unconscious process that continues to perpetuate stigma in mental health. A potential intervention might be to develop a methodology to enable what is unconscious to be brought to the surface and made conscious so that it can be directly addressed.

Some of the evidence to support the role of the collective unconscious in perpetuating or inducing mental health stigma comes from social and experimental psychology research. The concept of stereotype threat can help to shed some light onto this.

Stereotype threat is defined as the phenomenon that occurs when and individual performs more poorly on a task that is relevant to a stereotype or stigmatised social identity that acts as a distraction (T. Schmader and M. Johns 2003; C. M. Steele 1997, C. M. Steele and J. Aronson 1995).

The theory of stereotype threat is that when a negative stereotype about a group is introduced into a task it leads to performance difficulty in members of that group who asked to complete the task (C. M. Steele 1997). This would suggest that a collective memory is kept within that stereotype group that then affects their cognitive performance. An example is that if African Americans are asked to perform a task that assesses their intelligence and negative information about intelligence in African Americans is introduced their performance on that task reduces as a group effect (C. M. Steele and J. Aronson 1995).

People have tried to explain this group phenomenon. The explanation put forward is that, because of the collective memories held by the group related to the stigma, when the required task is suggested, the performance of the group declines because of an activation process of negativity about oneself.

This is a cognitive process that leads to doubt in an individual or group of individuals which would suggest the concept of the collective unconscious being attacked by the stereotype threat.

1.3.2. Projective Identification

There is evidence that self-stigmatisation occurs in mental health (A. C. Watson et al 2007). One explanation put forward is that the stigmatised individual has internalised the prevailing cultural stereotype about mental illness (B. G. Link 1987, B. Link et al 1989). The question one asks is why do some people with a mental illness internalise negative societal attributes about mental illness to the extent that they decide to accept this negative societal attitude as true whilst others reject the negative connotations and feel empowered, energised and unaffected by this (J. Chamberlain 1978, P. E. Deegan 1990). The explanation for this may lie in another psychodynamic theory, Melanie Klein's theory of projective identification (1952).

Projective identification is a term used to refer to a type of projection on the one hand and from identification on the other leading to a situation where the person projecting fells 'at one' with the person receiving the projection (the object). A way to understand this in relation to mental illness is that society has a fantasy that for instance an individual with mental illness is dangerous and should be avoided. The person with mental illness accepts this, reinternalizes the whole process and accepts that he or she is dangerous. This process may explain why some individuals with mental illness self-stigmatise because they have accepted society's fantasy about mental illness.

A helpful insight is provided by Michael Feldman's 1997 article on projective identification where he states that the process of projective identification is an unconscious phenomenon that can be used to understand the past and to predict future behaviour. For projective identification to happen more than one person must be involved, and this can also involve a group projecting into an individual who accepts the group think (L. Horwitz 2015). This also relates to the collective unconscious for instance the belief that 'people with mental illness are dangerous' and the individual also accepts this through the process of projective identification.

Klein tells us that projective identification is an asymmetrical influence in which one person pressurises another to experience a part of him or herself that they are unable to accept (S. Seligman 1999). Applying this concept to the stigma associated with mental illness one can postulate that society is so afraid of mental illness and its consequences that it projects this unacceptable part of itself onto an individual with mental illness who accepts this feeling and owns it. This provides an understanding of how projective identification can explain why self-stigma occurs in individuals with mental illness. We therefore need to develop specific strategies to target self-stigma in people with mental illness (C. R. Lawrence III 2008; A. Mentovich and J. T. Jost 2008).

1.4. STIGMA, HEALTH AND MENTAL ILLNESS

A contributory factor for poor outcome for people who suffer from serious mental health conditions such as schizophrenia is access to effective, evidence based health care. Public attitudes to people with mental health conditions are often negative. This affects how people engage with health care services and contributes to poor outcomes resulting from poor engagement with physical and mental health care interventions, delayed physical and mental health diagnosis and poor ongoing engagement with longer term treatment interventions (G. Schomerus and M. C. Angermeyer 2008; G. Schomerus et al 2009; P. Corrigan 2004). In this research I will focus on schizophrenia as the archetypal serious mental illness.

People who suffer from severe mental illness, are frequently perceived as dangerous, incompetent and unpredictable. These attitudes have been found to be related to a preference for social distance a measure of stigma and discrimination often used in this field. Put simply, using the example of schizophrenia social distance means the degree to which people do not want a person with schizophrenia as a neighbour, or to associate with them socially. (E. S. Bogardus 1925; M. C. Angermeyer & H. Matschinger 2004; M. King et al 2007).

Social distance is used as a proxy measure for behaviour or intentions for one to distance oneself from a person who suffers from mental illness including schizophrenia (M. C. Angermeyer & H. Matschinger 2004, B. Link et al 1987, E. S. Bogardus 1925, B. Schulze, and M. C. Angermeyer 2003).

The measurement of social distance looks at the intention or actions taken as a result of stigma in the relationship with a person with mental illness such as schizophrenia. The measure of social distance as a proxy measurement for stigma and discrimination is made by examining a relationship intention or action with a person who has mental illness by exploring the desire, or not, to be a neighbour, a landlord, a co-worker, being a member of the same social circle, being a personal job broker, an in-law or child care provider to a person with a mental illness.

This proxy measure is how mental health stigma is assessed in an objective way and allows comparison between individuals and systems on either the intent to stigmatise or actual stigma. The less likely you are to be positive in any of the situations above, the greater your social distance.

One of the observations that has sometimes been made in research is a gender difference in the measure of social distance. A gender bias has been found when assessing mental health stigma using social distance questionnaires or case vignettes.

A systematic review found that in Western countries females tend to be more positive and show lesser social distance to people with a mental illness such as schizophrenia. Whilst both men and women were equally happy to seek help in mental illness, women are more likely to recommend approaching a professional for help. Women are more likely to have a psychosocial explanation for mental illness than me and are more likely than men to suggest psychotherapy as a treatment (A. Holzinger et al 2012).

A landmark event organised by the World Health Organization in 1978 resulted in the Alma-Ata Declaration (WHO 1978) stating that primary care should be the vehicle for global and individual access to health to improve general health outcomes. Although the discussion documents that led to the Alma-Ata Declaration included mental health as a key component of primary care mental health was excluded from the final declaration despite objections from countries such as Panama (N. Sartorius 2008; G. Ivbijaro et al 2008, D. A. Tejada de Rivere 2003).

Stigma and discrimination contributes to this lack of prioritisation of mental health. As stated by Norman Sartorius (N. Sartorius 2008), even though mental health was originally included in the original discussion as an essential part of health, institutional stigma may have contributed to mental health being excluded from the final Alma-Ata Declaration.

Research has shown that patients who suffer from mental illness sometimes do not use standard medical facilities such as general practice facilities, and other primary care services. This puts them in a disadvantaged position when it comes to their health needs, especially as there is evidence that primary care is effective, more accessible and produces more positive long-term outcomes leading to a reduction in mortality and morbidity (B. Starfield et al 2005; WHO 2008; M. Funk and G. Ivbijaro 2008).

The World Organisation of Family Doctors (Wonca) and the World Health Organisation (WHO) published a document on Primary Care Mental Health in 2008 (M. Funk & G. Ivbijaro 2008). This publication concluded that integration of mental health service users into primary care provides the best option for mental health service users, similar to the findings of Barbara Starfield (2005).

There remain a number of barriers to achieving this aim of integration including inadequate training, discriminatory policies, poor accountability and poor mental health governance. Discrimination and social exclusion contribute to the difficulty in achieving mental health integration in Primary Care and new ways of dealing with this problem are needed particularly as mental illness contributes to the increasing costs of hospitalisation (A. Bowling 1997; D. De Vaus 2002; R. Winter & C. Munn-Giddings 2001; G. Ivbijaro et al 2014).

In the United States public stigma about mental illness is widespread and leads to many negative consequences for the individuals concerned, irrespective of age (A.M. Parcepese et al 2013). The 1999 US Surgeon General's Report noted that public stigma and negative attitudes to mental health significantly contribute to poor engagement for people who use mental health services, poor retention of those people who engage with mental health services, poor treatment adherence and subsequent poor outcomes (US Department of Health and Human Services 1999).

Mental health stigma is not limited to the general public. It occurs in people who offer treatment to people with mental health difficulties, and in people that use mental health services (A. C Watson et al 2007; S. Wrigley et al 2005; S. H. A. Hernandez et al 2014; A. C. Iversen et al 2011; C. Nordt et al 2006). Families and carers are stigmatised because of their relationship to people with a mental illness a concept known as courtesy stigma (E. Goffman 1963), or stigma by association.

1.5. STIGMA AND LIFE EXPECTANCY IN SERIOUS MENTAL ILLNESS

The majority of people are living to an older age, and it has been said that this is one of humanity's major achievements (UN 2002). Not only are people living longer but there are also many initiatives to ensure that they are having a healthier life that is fulfilling and enriching (NIA/WHO 2011; D. P. Rice and J. J. Feldman 1983). This dramatic increase in average life expectancy in the 20th Century is not shared by people who suffer from mental health conditions.

According to the 2006 Global Burden of Disease estimates, by 2030, the three leading causes of burden of disease would be HIV/AIDS, mental illness, particularly unipolar depressive disorder and ischaemic heart disease (C. D. Mathers and D. Lonca 2006). The authors noted that unipolar depressive disorder was ranked 4th as a leading cause of disability in 2002 and would rise to the 2nd most common cause of disability by 2030. They also projected that self-inflicted injury would rise from a rank of 17 in 2002 to 14 in 2030. This burden of mental health disability needs to be addressed and the burden arrested or reversed.

A great deal of evidence has been accrued looking at the life expectancy of people with a serious mental illness. People with mental health conditions such as schizophrenia and bipolar affective disorder have a mortality rate two to three times higher than the general population (C. W. Colton, R. W. Manderscheid 2006; T. M. Lauren et al 2012; E. E.

McGinty et al 2016, M. Funk and G. Ivbijaro 2008). The majority of excess mortality in this group of people can be attributed to preventable conditions. One wonders if the people concerned were not experiencing a stigmatising mental health condition if the outcome would be the same (N. Sartorius 2008; G. Ivbijaro et al 2008, D. A. Tejada de Rivere 2003).

A major cause of excess mortality in people with a severe mental health condition is the result of cardiovascular disorders (E. E. McGinty et al 2016; N. H. Liu et al 2017). People with severe mental illness have a high prevalence of metabolic syndrome including obesity, hyperlipidaemia, hypertension, diabetes mellitus and other high-risk behaviours such as tobacco smoking, physical inactivity and risky sexual behaviours (J. W. Newcomer, C. H. Hennekens 2007; J. W. Newcomer 2005; N. H. Liu et al 2017; WHO 2010; WHO 2014).

Not only do people with mental illness suffer from co-morbidity and premature morbidity and mortality, they also earn less than the general population. A WHO survey carried out in ten high income countries and nine low to medium income countries assessed earnings by people with a serious mental illness and found that having a mental illness resulted in a 30% reduction of earnings irrespective of region or country (D. Levinson et al 2010). We know that income contributes to the social determinants of health and general health outcomes (S. O Irwin 2010).

The evidence tells us that there is a group of people who do not benefit from the improved technology, global wealth and advances in medical science. For example, if a person suffers from schizophrenia, that person is at risk of poorer health access and poorer health outcomes than other people. This is partly because of the labelling of the mental health condition, resulting in prejudice (A. Farina 1998; R. Imhoff 2016).

In many health care systems classification systems such as ICD 10 (WHO 1992) and DSM V (APA 2013) are often used for administrative purposes and research. This can be very helpful in many medical conditions, but in mental health conditions the introduction of a diagnosis can cause result in the negative connotation of labelling which can produce negative consequences for the affected individual.

It has been stated that diagnosis is more than just identifying a disorder of separating one disorder from another. Diagnosis is also used to understand what is going on in the mind and body of the individual (P. Lain-Entralgo 1982) The label itself does not cause the mental disorder but it does have negative consequences for the individual who is labelled (R. Imhoff 2016). In addition, the current classification systems used in mental health, such as ICD 10 and DSM V, do not reflect the complexity of the kind of patients seen in the community and in primary care (L. Gask et al 2008; G. M. Reed 2010).

Efforts are being made to find a more functional and useful classification for mental disorder that is more likely to be acceptable to primary care doctors, that will be able to support the management of the burden of diseases that individuals suffer from and that will allow treatment to be better tailored to the multi-morbidity that many people with a mental illness suffer from (G. M. Reed 2010; J. E. Mezzich and I. M. Salloum 2007; D. J. Stein et al 2013; H. Lamberts and M. Wood 2002).

This is illustrated by a large-scale study of 2265 people who were given two case vignettes with similar signs and symptoms, one labelled as schizophrenia and the other not. The results showed that when symptoms of psychosis were described, but not labelled as schizophrenia, the attitude of the population studied was more positive than when the same symptom cluster was labelled schizophrenia. The people given the label of schizophrenia were considered untrustworthy and aggressive (R. Imhoff 2016) replicating previous findings in other studies (I. F. Brockington et al 1993; B. G. Link 1999).

We need to understand the psychological processes behind this negative effect towards people with a mental illness, especially people who suffer from a diagnosed mental illness, and the psychiatrists and general practitioners who treat them, so that we can decrease the risk of people with schizophrenia dying 10 to 20 years earlier than the general population (S. Saha et al 2007).

Another readily available intervention for improving physical and mental health is exercise. The World Health Organization highlighted that inactivity contributes to approximately 27% of the burden in diabetes, and 30% of the burden in ischaemic heart disease, conditions that are both commonly co-morbid with schizophrenia (WHO 2009).

A comprehensive review of interventions for people with schizophrenia and co-morbid physical health conditions shows that there are many effective interventions that can address conditions such as obesity and tobacco smoking in schizophrenia however many people who would benefit do not receive these interventions (E. E. McGinty et al 2016; N. H. Liu et al 2017).

Many of the medications used in the treatment of schizophrenia lead to an improvement in symptoms of mental illness, but are known to have significant side effects such as weight gain and metabolic syndrome (S. Mukherjee et al 1996; J. P. Lindenmeyer et al 2003).

A systematic review and meta-analysis concluded that an exercise programme of at least 30 mins per day on three days a week, for a minimum of 12 weeks has a robust positive effect on quality of life and functioning for people with schizophrenia, and also leads to an improvement in cognition (M. Dauwan et al 2016).

There is evidence that many people globally, irrespective of country, receive little or no treatment for their mental disorder. This is called the science to service gap (A. F. Lehman 2009; R. E. Drake and S. M. Essock 2009; R. E. Drake et al 2009) or treatment gap. The treatment gap in low and middle-income countries is approximately 70%, and can be up to 90% in some countries in Africa. The treatment gap in high income countries is between 52% to 74% (J. Alonso et al 2004; WHO 2004; G. Thornicroft 2007; M. Funk. and G. Ivbijaro 2008). Stigma and discrimination makes a significant contribution to this global treatment gap.

A literature review looking at unmet needs in individuals with schizophrenia in the United States of America and longitudinal studies of first admission patients showed that epidemiological studies found that 40% of people with schizophrenia had not received treatment for their mental illness in the six to twelve months prior to the study. The review also found that there was a high rate of disengagement from treatment and the majority of those who remained in treatment had ineffective non-evidence based care. This resulted in over 50% of people with schizophrenia who remained engaged in care having active psychotic symptoms. Of those people with schizophrenia and a co-morbid physical or dental health problem the majority did not receive the medical interventions that they were entitled to and if they did, interventions were often not evidence based. People on inadequate treatment for schizophrenia were found to be significantly more likely to require repeated hospitalisation (R. Mojtabai et al 2009; S. Leucht et al 2007).

A commentary from the United States of America noted that, although there are effective treatment interventions for serious mental illness such as schizophrenia, many people who have this condition do not receive evidence based treatment because of stigma, dissatisfaction with previous services and a lack of awareness of the benefits of treatment (R. E. Drake and S. M. Essock 2009).

The commentators advocated for an active engagement process with the individuals and community to tackle these factors. They suggested that this requires a change in the way psychiatrists think because they need to learn how to manage complex situations through trade-offs and suggested that many of the current work force are not skilled in this technique. The commentators suggested that re-training of some workers may be necessary to embrace this new way of thinking and interacting.

A systematic review of 144 quantitative and qualitative studies looking at the impact of mental health related stigma on help-seeking concluded that stigma had a small to moderate effect on the help seeking behaviour of people with mental health problems (S. Clement et al 2015).

Corrigan noted that, although the quality and effectiveness of treatment for mental health conditions has significantly improved, many people with a mental health condition choose not to afford themselves the available effective treatment. He postulated that mental health stigma is one of the reasons that people with a treatable mental health condition make this choice (P. Corrigan 2004). Many other studies support this view (B. Link, & J. C. Phelan 2001; R. Kohn 2004), and the USA Surgeon General highlighted this as an issue in his 1999 Report.

Stigma and discrimination is also a significant reason from many people from ethnic minorities in the U.S.A. not seeking help for mental health problems, even when effective treatment is available (F. A. Gary 2005).

A review of the implementation of evidence based practice in schizophrenia also found that people with a diagnosis of schizophrenia are unlikely to receive evidence based practice for schizophrenia (R.E. Drake et al 2009).

This review found that up to 95% of people with schizophrenia receive either no treatment, or suboptimal treatment for their mental illness and, when they have co-morbid chronic physical illness they do not receive evidence based practice for the management of their physical disorder either.

The authors noted that public policies and public health systems are not geared up to effectively tackle issues presented by those people who have a mental illness and regulations were often found not to align with expected standards of good practice.

These consistent findings of poor practice and funding across a range of systems designed to address mental health need resulting from stigma and discrimination would lead one to suggest that mental health advocates should be routinely employed by all mental health service providers and those with lived mental health experience may be able to advocate very effectively (S. Clement et al 2009)

Emerging research and evidence shows that people with severe mental health conditions such as schizophrenia die ten to twenty years earlier than the general population. There has been some progress in addressing this problem, such as improved primary care access and improved training at a population level such as the mhGAP training devised by the WHO (WHO 2016).

Despite this evidence many such treatment interventions are not routinely included as part of evidence based treatment guidelines for schizophrenia. When they are included in evidence based treatment guidelines for schizophrenia, patients often do not receive evidence based interventions. In contrast, patients with other physical health conditions such as chronic obstructive airway disease and cardiovascular disease are routinely provided with non-pharmacological treatment interventions such as pulmonary rehabilitation for chronic obstructive airway disease (B. McCarthy et al 2015; Y. Lacasse et al 1996) and cardiac rehabilitation (L. Anderson and R. S. Taylor 2014; G. F. Fletcher et al 1992; G. J. Balady et al 2007).

The question we must ask ourselves is why patients with schizophrenia are not receiving effective treatment interventions for co-morbid physical ill health in secondary mental health services or primary care.

Even if the treatments are available and effective, mental health stigma and discrimination continue to be significant barriers to health access and the provision of evidence based care for people with mental health conditions. The consequence of social distance and stigma and discrimination in mental health is early disengagement from services.

One of the reasons cited for early disengagement from services by people with schizophrenia is the belief that services are ineffective. Clinicians also have the wrong impression of what it might feel like to a patient in the community because many of the people that they see are the most unwell. Many people with a mental illness who live in the community do not think they need help, or they believe the help given will be ineffective. Some people perceive the treatments offered as unhelpful (J. Kreyenbuhl et al 2009). These authors suggested the importance of hospital staff being able to provide psychosocial education that focussed on recovery and ways of engagement including an improvement of primary and secondary mental health care collaboration.

We therefore need a new approach to embedding anti-stigma campaigns into day to day life and clinical practice. To do this one needs to first understand the psychology behind and structure of mental health stigma.

1.6. COURTESY STIGMA, OR STIGMA BY ASSOCIATION, IN MENTAL ILLNESS,

Although stigma in relatives and people who work in mental health was well described, and called courtesy stigma by Goffman in 1963, courtesy stigma, also known as stigma by association is not terminology that is regularly used in day to day practice.

It is important to understand the concept of courtesy stigma in order to support people who are familiar with or care for people with a mental illness.

Research evidence shows that many health professionals discriminate against mental illness including psychiatrists, general practitioners, psychologists, social workers and nursing staff discriminate. Families also discriminate against people with mental illness. This is different from courtesy stigma.

Courtesy stigma, or stigma by association, is defined as the prejudice and discrimination experienced by parents, siblings, spouses, children, friends, care givers and co-workers of people who have a mental illness (Goffman 1963). This type of stigma is specifically due to having a relationship with a person who has a mental illness. The relationship can be as a relative, spouse or partner, carer, friend, co-worker or as a health professional.

One review of courtesy stigma found that the key elements of courtesy stigma include the stereotypes of blame, shame and contamination (J. E. Larson and F. J. Lane 2006). The review suggested that the general public may attribute incompetence to the families of those people with a mental illness.

One can link this to the psychological construct of the collective unconscious that has already been considered, insofar as the family members assimilate and internalise the negative projections about the family mental illness and start to believe that they themselves are incompetent. They may even begin to act on this, for example avoiding neighbours and friends (J.E. Larson & F. J. Lane 2006).

An Ethiopian study of 178 relatives of people who had a diagnosis of schizophrenia or affective disorder interviewed using the Family Interview Schedule reported that 75% of family members perceived themselves as stigmatised due to the presence of mental illness in their family. 42% expressed concern about being treated differently by others because of the family history of mental illness and 37% were willing to conceal the fact that there was somebody in their family with a diagnosis of mental disorder (T. Shibre et al 2001). This is another example of the internalisation of the mental health stigma and discrimination experienced by family members of people with a mental disorder.

Courtesy stigma occurs across a range of mental health conditions including substance misuse. In a United States of America study of 968 relatives of people with a diagnosis of mental illness, including substance misuse parents, siblings and spouses described courtesy stigma by agreeing that family members bear some responsibility for the person originally falling ill, for their subsequent relapses and described feeling incompetent (P. W. Corrigan et al 2006).

The concept of courtesy stigma is not only associated with mental illness. It has been reported in the families of people with other disabilities. The explanation is related to Goffman, Phelan and Links concepts of distinguishing and labelling, associating human differences with negative attributes and separating them from us (S. Green et al 2005).

Courtesy stigma also referred to as ‘stigma by association’ has been reported in people who provide health services to sex workers (R. Phillips et al 2012), people with HIV, AIDS (M. Snyder et al 1999) and dementia (H. MacRae 1999). The research identifies courtesy stigma in many long-term health conditions and the methodology to address and decrease courtesy stigma can be generalised across different illnesses and conditions (A.

Birenbaum 1970; E. Goffman 1963; J. W. Schneider & P. Conrad 1980; C. Sigelman et al 1991).

A Canadian report entitled 'Fighting stigma and discrimination is fighting for mental health' (H. Stuart 2005) was produced because of the absence of stigma reduction efforts from the 2004 report of the Standing Senate Committee on Social Affairs, Science and Technology. Fighting stigma and discrimination is fighting for mental health noted that policy makers give lowest priority to mental health issues and persistently underfund mental health activities and research and reminded the Standing Senate Committee that courtesy stigma, or stigma by association, can lead to fear in families, loss, lowered family esteem, shame, secrecy, distrust, anger, inability to cope, hopelessness and helplessness quoting the work of M. Gullekson (1992) and H. P. Lefley (1992).

The report also noted that mental health professionals are seen as mentally abnormal, corrupt or evil as a result of courtesy stigma and psychiatric treatment interventions are seen as suspicious, and sometimes horrible (R. E. Kendell 2004). This is an example of courtesy stigma or stigma by association, leading to a negative connotation just because the person has a relationship with another person who has a mental illness.

These type of negative beliefs about the efficacy and acceptability of psychiatric treatment interventions may be a contributory factor to poor engagement with psychiatric treatments and access to mental health.

A review of courtesy stigma in families found that parents are often blamed for causing their child's mental illness, siblings and spouses are often blamed for non-adherence to treatment plans by mentally ill relatives and children are often afraid of being contaminated by the mental illness of their parent (P. W. Corrigan & F. E. Miller 2004).

It is important to distinguish courtesy stigma from negative care giving experiences. A helpful insight is provided from a United States of America study of 437 adult relatives of people with a mental illness using a battery of questionnaires including the Experiences of Caregiving Inventory (ECI), the Family Empowerment Scale (FES), the Brief Symptom Inventory-18 (BSI-18), the Family Assessment Device (FAD) and the Family Problem-Solving and Communication (FPSC) questionnaire (A. Muralidharan et al 2014).

This study reported that two thirds of participants reported thinking about stigma-related care giving experiences and that this contributed to the total caregiver burden that they experience. This means that courtesy stigma leads to care giver distress and burden and can result in care giver disempowerment and the study suggested that care giver strategies should be developed and implemented as part of the overall package to address mental health stigma.

A Belgian survey of 543 mental health professionals and 707 mental health service users using multilevel analysis provides a useful insight into the relationship of courtesy stigma in mental health professionals to burnout, job satisfaction and self-stigma (M. Vernhaeghe and P. Bracke 2012). This survey showed that courtesy stigma in mental health professionals is associated with more depersonalisation, more emotional exhaustion and less job satisfaction. Departments with higher scores on courtesy stigma in professionals had higher self-stigmatisation scores in their patients with a metal health diagnosis.

Although mental health professionals reported feeling exhausted with low rates of job satisfaction they did not feel a sense of failure in their personal accomplishments. However, it was the patients of these health professionals that reported higher levels of self-stigma. This illustrates the importance of addressing courtesy stigma in professionals in order to decrease levels of self-stigma in patients with a mental health diagnosis so that they can achieve better outcomes.

Public mental health knowledge and mental health literacy contributes to courtesy stigma (R. L. M. Van Der Sanden et al 2013). This reinforces the need to address public mental health stigma if we are to successfully decrease courtesy mental health stigma in families and mental health professionals.

In a qualitative study from Belarus that interviewed twenty relatives of people with a diagnosis of schizophrenia using a semi-structured interview found that relatives in Belarus also experienced discrimination which resulted in non-disclosure of their relatives illness and concealment resulting in families of people with mental illness not encouraging them to seek help (D. Krupchanka et al 2016).

A study from The Netherlands noted that female relatives are more likely to internalise negative attributes of mental health stigma than male relatives and suggested that tailored education programmes should routinely be made available to family members and carers to support them so that they can develop stigma resilience. They also proposed that mental health professionals should be provided with regular social skills training and opportunities to learn about stigma and how to tackle it as part of the training offered by their employers (R. L. M. Van Der Sanden et al 2015).

Taking these findings into account addressing public mental health stigma is likely to decrease the burden of stigma on families and mental health professionals.

Many families and caregivers often find solace in non-medical settings to address the stigma and personal distress that they are burdened with. A survey in the United States of America of caregivers of people with a serious mental illness such as schizophrenia found that caregivers often found support from religious organisations and 37% reported that they had received spiritual support to help them to cope with the burden associated with caring for a relative with a mental illness in the three months prior to the survey (A. B. Murray-Swank 2006).

It was suggested that closer collaboration between mental health providers and religious and spiritual communities may go some way to reducing the burden on those caring for a relative with a mental illness.

Distress and courtesy stigma in the families of people with a mental disorder appears to be related to the severity of the illness experienced by the person receiving care. A secondary analysis of baseline data collected during a study of family to family peer driven education in the United States of America found that where the relative with a diagnosis of mental illness has been severely ill or there is a perceived risk of self-harm families report more negative experiences of care giving, carers report poorer mental health and higher burden associated with being a carer (J. Katz et al 2015).

Courtesy stigma, or associated stigma in professionals as previously stated can worsen outcomes in their patients with a mental health diagnosis and has a similar effect in relatives because they may not seek help early and may conceal the illness. A Swedish multi-centre study of 162 relatives of patients in acute in-patient psychiatric wards found that the majority of relatives' experiences psychological factors of stigma by association (courtesy stigma), 18% though that it would be better for their relative to be dead and 10% reported experiencing suicidal thoughts (M. Östman & L. Kjellin 2002). In contrast to the findings of Katz et al in the United States of America (2015) severity of mental illness did not play a part, rather it was the presence of mental illness in the carer that was associated with a more negative outcome.

There is a need to develop strategies to tackle courtesy stigma (stigma by association) in order to reduce its prevalence and it consequences. Psycho-education and evidence based practices such as family education have been put shown to be effective in achieving this aim but unfortunately evidence based interventions are often not made available in clinical settings (L. Dixon 2001). The effectiveness of psychoeducation to address courtesy stigma is also supported by the Larson and Lane review (J. E. Larson & F.J. Lane 2006).

An Iranian clinical trial that included 60 relatives of people with schizophrenia showed that psychoeducation for carers and relatives can reduce self-stigma in the people with a mental illness that the care for (S. Vague et al 2015).

In addition to psychoeducation, it has been suggested that families and carers should be engaged with care planning and services offered to support them in a more meaningful way and mental health services should be more family friendly (B. Dausch et al 2012; I. D. Glick & L. Dixon 2002). Evaluation of family education programmes have demonstrated that the positive effects of such interventions last over time especially the families ability to cope. A study in the United States of America found that when family and carers received a family education programme about mental illness that were peer-taught the benefits persisted at six month follow up (A. Lucksted et al 2013). In an earlier study of a 12-week peer taught family to family education programme for severe mental illness families that participated reported a reduction in the burden of distress that they were experiencing, they felt that they understood the mental health system better and their own self-care improved (L. Dixon et al 2004).

1.7. PUBLIC ATTITUDES, SOCIAL DISTANCE AND MENTAL HEALTH

I have already highlighted some important key points relevant to this section. I have looked at some key challenges facing people with mental health conditions, using the work of Mathers and Lonca (2006) including early mortality and increasing morbidity. I have also started to consider the co-morbidity common in mental health conditions, particularly metabolic syndrome, tobacco use, diabetes mellitus, hypertension, infectious diseases and risky sexual behaviour. Many of these conditions can be managed effectively however stigma and discrimination continues to be an obstacle to obtaining and delivering the best treatment.

I have already defined stigma and, drawing on the work of Goffman, Link and Phelan, considered some explanatory models that describe how stigma develops. I have also explored the psychodynamic mechanisms of the collective unconscious and projective identification and how they may contribute to maintaining mental health stigma and discrimination at an individual and population level.

Research carried out to date has established the role of stigma and the relationship to mental health and wellbeing. I will now explore this further.

It is important to have a definition in mind to understand public mental health stigma. A useful conceptualisation is that public stigma is a set of negative attitudes and beliefs held by the population which lead to fear, rejection, avoidance and discrimination against people who suffer from mental illnesses (P. W. Corrigan and D. L. Penn 1999; B. A. Pescosolido 2013).

Public mental health stigma leads to consequences including discrimination, poor opportunities for housing and an impact on recruitment and retention of employment. In the long run, this hampers recovery (N. Sartorius and H. Schulze 2005; D. B. Feldman and C. S. Crandall 2007).

A detailed global review about public beliefs and attitudes about mental health from 1992 to 2004 found that attitudes towards people with mental illness had improved over this period but misconceptions about mental disorder continue to prevail in the general public (M. C. Angermeyer and S. Dietrich 2006). The review included 29 local and regional studies, the majority from Europe but despite this the findings are robust enough to generalise. The authors noted that there was a need to develop a more robust approach to the integration of mental health to other health platforms and the public required education about evidence based practice in mental health. Many of the studies reviewed fund that the public preferred psychotherapy as the primary form of treatment for the whole spectrum of mental disorder including schizophrenia. Very few respondents in the studies reviewed considered pharmacological intervention as the best form of treatment for illnesses such as schizophrenia despite this having the best evidence base for efficacy. Another finding was that there was very little difference between social demographic groups in attitude, opinion and knowledge when canvassed for their views about mental illness. The only difference found between social demographic group was with regard to treatment preferences.

Some studies have also shown cultural variation when it comes to types of stigma (M. C. Angermeyer and S. Dietrich 2006). This 2006 review found that French speaking Swiss were more reluctant to seek support from a specialist mental health team for a serious mental illness such as schizophrenia when compared to German speaking Swiss. French and Italian speaking Swiss were more likely to accept restrictive practices in mental illness than German speaking Swiss. The review highlighted that Italians living in South Italy were more likely to agree to restriction of civil rights for people with mental illness than Italians living in Northern Italy.

A limitation of this review, as with many other reviews in this field is that the studies reviewed although focussed on mental health stigma all used different measuring instruments and different methodologies.

A trend analysis from Germany examined beliefs about schizophrenia and beliefs about causation in two German towns (M. C. Angermeyer & H. Matschinger 2005). The authors noted that knowledge was poor and there was a need to improve mental health literacy in the general population. Surprisingly an increased tendency among the general public to endorse a biological causation for schizophrenia was found however embracing a biological causation was related to an increased desire for social distance.

This study found that the % of the German population who would accept person with schizophrenia as a neighbour was 19% in 1990, and this rose to 35% in 2001. In 1990 44% of people surveyed said that they would not rent a room to a person with schizophrenia, and this rose to 63% in 2001. These findings support the need to better understand the range of factors that need to be considered to better understand the construct driving social distance in schizophrenia. If a person with schizophrenia cannot be your neighbour or rent a room in a house where will they live?

1.7.1 Government Policy, Law and Mental Health Stigma

Public stigma and discrimination occurs at all levels of society, including at government level and is either intentional or unintentional. This means that policy makers need to do more to decrease discrimination in this field, improve rates of recognition of mental illness and improve access to care (WHO, 2013).

The 2013-2020 Mental Health Action Plan rightly noted that many individuals and their families suffer from poverty because of mental health conditions and their human rights are often violated because of mental health stigma and discrimination. People with mental disorder are often denied political rights and the right to participate in society.

The 2013-2020 Mental Health Action Plan argues that health systems do not adequately respond to people with mental disorders and that in low income countries 76%-85% of people with mental disorder receive no treatment and that this figure is between 35% - 50% in high income countries.

There have been some positive initiatives to deliver mental health interventions to more people using policy as a tool for instance the Improving Access to Psychological Therapies (IAPT) programme in the UK (D. Clark et al 2009). Although a very successful programme this is not enough. A review of access to evidence based interventions by children and young with mental disorders globally showed that young people, particularly in low and middle-income countries do not have access to the right care, and this can be seen as a failure of government policy (V. Patel et al 2013). A systematic review of access to mental health care in young people noted that young people are often excluded from the planning and delivery of services resulting in their voice being unheard and recommended that those who plan and fund health need to have a comprehensive approach that includes young people in planning and delivery to improve access and compliance (J. E. Allen & C. A. Lowen 2010).

Language is very important when dealing with stigma (S. E. Estroff 1989) and many governments use the word dangerousness when referring to some mental health conditions. The use of the word ‘dangerousness’ in government documents about mental health can lead to negative connotations.

A review of mental health legislation globally concluded that the dangerousness criterion is a feature of many mental health laws which results in people with mental health problems being detained and treated without their consent (M. M. Large et al 2008). A government’s use of such emotive language about a group of people who suffer from mental illness perpetuates mental health stigma and discrimination. The authors noted that the use of the word dangerousness was initially the result of good intentions based on the false belief that a psychiatrist can accurately predict future risk and danger (J. Monahan 2001). Even when predicting the risk of the suicide, which many physicians think they are good at, the research evidence shows that prediction rates are inaccurate (A. D. Pokorny 1983).

The argument here is, could the widespread adoption of the dangerousness criteria in mental health law by governments and legislators be contributing to and perpetuating the collective unconscious that results in the stereotyping of people with mental disorder as dangerous a judgement that is of no clinical value.

Large et al argue that the dangerousness criterion is providing a legal framework to detain many mentally ill people who will never become dangerous therefore contributing to component I of stigma, labelling (E. Goffman 1963), component II, associating human differences with negative attributes in this case “you have mental illness therefore you will be dangerous” (E. Goffman 1963, B. Link 1997), component III separating “them” from “us,” in this case classifying those with mental illness as abnormal, dangerous with a need to be detained and the rest as normal and autonomous (B. Link & J. C. Phelan 2001).

A UK study of people detained in mental services showed that people detained in hospitals felt that their dignity was violated and felt stigmatised (M. Chambers 2014). The service user interviewed in this study wanted to be respected, to be treated as human and not stigmatised.

There are several reasons why the legal definition of dangerousness about mental health patients is frowned upon by patients and carers. Using a legal definition of dangerousness can lead to drastic consequences for an individual. This may include indeterminate length of involuntary confinement and in the law courts (A. D. Brooks 1978) or an offender who is thought to be dangerous being given a harsher sentence (D. Wexler 1976; H. J. Steadman 1978).

With the negative consequence of the term “dangerous” one would expect there to be clarity with regard to the legal definition of “dangerousness” when dealing with mental illness, unfortunately, this is not the case. The concept of “dangerousness” has been described as being used in a very elastic way by psychiatrists (D. Jacobs 1974; A. D. Brooks 1978). Research on psychiatric risk assessment by psychiatrists found no statistical difference in future prediction of violence between patients in the community who psychiatrists believed to be dangerous compared to patients in the community psychiatrists thought were not dangerous. The legal use of dangerousness therefore does not appear to be useful (R. H. Kuh 1963; H. Steadman 1978).

This suggests that mental health law based on the concept dangerousness is not helpful in helping us to tackle the stigma and discrimination that patients with mental health disorders suffer from. There is a need to have new criteria for the application of mental health law that will be less stigmatizing because the current labelling of people with mental illness as dangerous will continue to contribute to the collective unconscious perpetuating stigma.

1.8. SOCIAL DISTANCE AND SERIOUS MENTAL ILLNESS

The construct often used in the field of mental health stigma to assess discrimination or the desire to discriminate against others is called social distance (B. Link and J. C. Phelan 2001: M. C. Angermeyer and H. Matschinger 2003; A. E. Baumann 2007; P. W Corrigan et al 2001). The narrower the social distance between people the more those people feel they belong. The wider the social distance between people the less those people feel they belong (A. E. Baumann 2007). This maps on to component three of Goffman, and Link and Phelan's schema of 'Us and Them.'

I began this thesis by first considering the effect of stigma on mental illness and looked at how mental health stigma contributed to poor access to health care services generally using Goffman's definition of stigma because this is the most widely used definition in social science, medicine and law.

I explored the classic mental health stigma construct proposed by Goffman and further refined by Link and Phelan who proposed an additional construct leading to the current understanding of stigma as a four component process. These components are:

1. The distinguishing and labelling process
2. The association of differences with negative attributes
3. Separation of 'us' from 'them'
4. Loss of status and discrimination

I considered the role of the Collective Unconscious as part of this process and suggested that the recognition of the role of Projective Identification and the Collective Unconscious may help us to deepen our understanding of mental health stigma that is endemic in all societies.

I have now introduced another well-recognised concept used in this field, that of social distance and mental health. I will explain this in more detail including the methodology used to assess social distance in the section of the thesis that describes this research.

The starting point for considering this concept is by posing a series simple questions:

- "How willing are you to be physically or emotionally close to a person who has a mental health problem?"
- "Do you understand what it feels like to have a mental health problem?"
- "Would you be willing to be there for a person with mental health problems?"

The degree of your response to each of these questions is a measure of your social distance with a person who has mental health problems.

Early research into social distance relied on peoples' responses to case vignettes presented to them (M. C. Angermeyer and H. Matschinger 1977; B. G. Link et al 1987; D. L. Penn et al 1994). Other researchers have developed and used validated questionnaires to assess public and individual stigma (M. C. Angermeyer and H. Matschinger 1977; B. G. Link et al 1987). Irrespective of the methodology chosen to measure social distance all have been found to be useful and scientifically valid. I have chosen to use a validated social distance questionnaire for my research presented in this thesis.

The literature suggests that high levels of social distance for people with mental health problems occurs in all societies whether in Europe, Africa, Asia or high middle or low income countries.

A cross-sectional survey in 27 countries by use of face-to-face interviews with 732 participants with schizophrenia measured experienced and perceived anticipated discrimination and showed that negative discrimination was experienced by 47% of participants in making or keeping friends, by 43% from family members, by 29% in finding a job, 29% in keeping a job, and by 27% in intimate or sexual relationships. Positive experienced discrimination was rare. Anticipated discrimination affected 64% in applying for work, training, or education and 55% looking for a close relationship and 72% felt the need to conceal their diagnosis. Over a third of participants anticipated discrimination for job seeking and close personal relationships when no discrimination was experienced (G. Thornicroft et al 2009). These findings could be related to the concept of the Collective Unconscious driving negative attitudes globally and to the important contributory factor to negative attitudes to people with a mental health problem is the contribution of public stigma and labelling (M. C. Angermeyer and H. Matschinger 2003) and relates to Component One of the Stigma Constuct.

Angermeyer and Matschinger (2003) surveyed 5025 people of German nationality living in Germany and concluded that labelling as mental illness has an impact on public attitudes towards people with schizophrenia, and that negative effects clearly outweighed the positive effects.

Endorsing the stereotype of dangerousness had a strong negative effect on people's emotional reactions to people with schizophrenia, and increased a preference for social distance. Perceiving a person with schizophrenia as being in need of help resulted in mixed feelings from members of the public with positive and negative effects on the desire for social distance. The study found that labelling a person as suffering from major depression had almost no effect on public attitudes.

A 1994 study used six case vignettes to explore social distance in undergraduate students in the United States of America and found that one contribution to degree of social distance in this group of people was experience of previous contact with somebody who had experienced mental illness (D. L. Penn et al 1994). Those with previous contact with people with a mental illness were less likely to perceive those with a mental disorder as dangerous. In contrast, those people who had no previous contact with somebody who had experienced mental illness were more likely to believe that people with a mental illness are dangerous. The outcome of this research was in keeping with previous findings that suggest familiarity reduces stigma (B. G. Link and F. T. Cullen 1986; P. W. Corrigan 2001). This suggests that increasing opportunities to enable people to meet those who have been labelled as suffering from a mental illness will decrease stigma. More positive labelling of people with a diagnosis of schizophrenia is also likely to decrease the stigma towards people with schizophrenia.

An influential study measured the effect of familiarity on social distance in serious mental illness such as schizophrenia in 208 Community College students in the United States of America (P. W. Corrigan et al 2001). The outcomes showed that people who were already familiar with people who have a serious mental illness were less likely to say that the people with serious mental illness were dangerous or disabled. This supports the notion of enabling young people to meet those with a serious mental illness as early as possible to decrease social distance and stigma and discrimination in serious mental illness.

A study of 1835 people in 14 European countries found that people with a mental illness who live in European countries with less stigmatising attitudes to mental illness had higher rates of help seeking behaviour from health services than those living in countries with higher levels of mental health stigma (R. Mojtabai 2010; S. Evans-Lacko et al 2012). This is consistent with global findings and also supports the role of the collective unconscious of perpetuating levels of social distance in mental health.

I have already highlighted that increased social distance and stigma in mental health can lead to poorer health outcomes and health service utilisation. There is also emerging evidence that increased social distance and stigma in mental health leads to a loss of social skills in people with a mental disorder (J. D. Henry et al 2010). In this Australian study patients did not self-stigmatise but were aware of their mental illness. It was suggested that this awareness contributed to the loss of social skills, particularly in the areas of conversation, speech and switching between topics.

This social skills difficulty is not limited to schizophrenia and also occurs in other severe long term mental health conditions such as bipolar affective disorder. Patients with bipolar disorder who showed concern about mental health stigma during the acute phase of their illness had higher levels of impaired social functioning seven months later when they were outside their family setting compared with those who did not show concern about mental health stigma during the acute phase of illness (D.A. Perlick et al 2001).

Attitudes of the general public towards mental health stigma and social distance have been extensively studied and published in the United States of America. A systematic review of the the literature on mental health stigma in the United States general public concluded that public stigma about mental health is pervasive in the United States of America, and is a deterrent to engagement with mental health treatment and therefore can slow recovery (A. M. Parcesepe and L. J. Cabassa 2013). This review also noted that Phelan et al (2000) found increase in the perception of mental health stigma in the general public between 1950 and 1996 because the general public were 2.3 times more likely to describe a person with mental illness as dangerous in 1996 compared to 1950.

The public perception of dangerousness being associated with mental illness has now stabilised and the authors hypothesised that increasing knowledge about genetics and chemical imbalance in the aetiology of schizophrenia could be a significant contributory factor to this stabilisation (B. A. Pescosolido 2010). This is consistent with the familiarity concept in mental health stigma.

The detailed 2013 Parcesepe and Cabassa systematic review examined many areas of public mental health stigma including in children, major depression, substance misuse, attention deficit disorder and schizophrenia. I am only highlighting the systematic review findings in relation to schizophrenia however it is worth noting that the finding that people with a mental illness are dangerousness was found across all age groups and all the mental illnesses included in this review. There was also cultural variation in the perception of mental illness. For example African Americans were more likely to believe that mental illness will improve spontaneously and were more likely to seek help than Hispanic Americans. This association appears to be a paradox.

Although the authors of the 2013 systematic review postulated that the biological explanation for the aetiology schizophrenia prevented increased levels of stigma in the general population Angermeyer et als work in Germans is at odds with this (2005). Angermeyer’s findings are supported by a review that states that thirty five out of thirty nine studies showed that a psychosocial explanation for mental illness reduced social distance more effectively than a biological explanation (J. Read 2007).

Stigma and social distance in the general public occurs in all settings. A 1999 United States of America survey of 1301 mental health consumers that was followed up with an interview with 100 of the respondents showed that the experience of mental health stigma and discrimination occurred in a variety of settings including the community, the family, churches, the workplace and mental health care givers (O.F. Wahl 1999). About 30% of respondents felt that they had been turned down for employment because of their mental health problems. Relatives were the second most common source of mental health stigma in this population which is surprising given the findings that familiarity with mental illness decreases social distance. About 25% of respondents felt that those charged to care for them had stigmatised them in the past.

The effect of labelling people with a mental health diagnosis on social distance has been measured and the link remains unclear. The majority of studies have found some evidence that labelling affects mental health stigma but findings have not been significant enough across all measures (B. J. Link 1987). Angermeyer and Matschinger's German study concluded that labelling had a specific negative impact on public attitude towards schizophrenia particularly regarding dangerousness but this was not the case for depression (Angermeyer and Matschinger (2003). They also found that when the German population were confronted with the fact that somebody with schizophrenia needed help their reaction was mixed consistent with the work of Link (B. J. Link 1987).

A study that investigated what type of information reduces stigmatisation in schizophrenia concluded that the severity of acute symptoms made a more significant contribution to increased social distance than labelling alone (D.L. Penn et al 1994). Therefore contact with people who are floridly psychotic results in more negative attitudes towards people with schizophrenia. This may explain why people in regions with good access to health care and to early intervention services for mental illness tend to have a better understanding of mental illness and reduced social distance (B. G. Link and F. T. Cullen 1986; B. G. Link et al 1987).

Mental health stigma in the general public can be challenged, especially as we are beginning to understand the dynamics involved and the underlying explanatory models. A meta-analysis noted that education has a positive effect in reducing stigma in mental illness and in adults, contact with people who are or have experienced mental illness was more beneficial than education (P. W. Corrigan et al 2012). This is consistent with the familiarity principle already discussed.

1.9. FAMILIARITY AND SOCIAL DISTANCE IN MENTAL HEALTH

Familiarity with mental illness has been shown to be a factor in reducing social distance in the general public so one would expect this to apply to those people who have experienced a mental illness themselves. There is however evidence that people with mental illness self-stigmatise, and desire social distance from other people with mental health problems and that people with a mental illness such as schizophrenia also internalise the mental health stigma that is present in the community and this leads to low self-esteem and lowered self-efficacy (A. C. Watson et al 2007).

The theory proposed to explain self-stigma in those people with a mental illness is that the person with a mental illness assimilates the prevailing public stereotype. The person then endorses and subsequently agrees with the prevailing public stereotype (A. C. Watson et al 2007).

This can also be explained using the construct of the collective unconscious in psychodynamic theory. The person with the mental illness is living in a society where the collective unconscious about mental illness is negative. This negative construct is then projected onto the person with mental illness and the person with mental illness accepts this through a process of projective identification. I have mapped these concept from psychodynamic theory onto Watson et als 2003 theoretical model of self-stigma in Figure No.1.

Figure No. 1: Mapping Psychodynamic Concepts onto Stepped Model of Self-Stigma

Self-Stigma (Watson et al 2003)	**Psychodynamic Theory**
1. Group identification and legitimacy	Collective unconscious (Jung)
2. Stereotype awareness	Collective unconscious (Jung)
3. Stereotype agreement	Projective identification (Klein)
4. Self-concurrence	Projective identification (Klein)
5. Low self-esteem and low self-efficacy	Collective unconscious (Jung) & projective identification (Klein)

Support for this psychodynamic mapping onto the model of self-stigma can be found in work completed by a range of different authors (H. Tajfel and J. C. Turner 1979; D. S. Whitaker 1989; J. Farnsworth and B. Boon 2010). These researchers hypothesise that it is important for people to belong to a group, and belonging to the group means that group members consciously or sub-consciously identify with the group process and the groups thinking. This then results in people acting and abiding by the group process and by the collective unconscious of that particular group. For example, if the group process and thinking is based on the belief that mental illness equates to dangerousness members of the group adopt this.

It is important to note that self-stigma does not affect all people with mental illness. Some people with a mental health problem use the familiarity concept in order to decrease the social distance associated with mental ill health. Rather than adopting the psychological defence mechanism of projective identification it is postulated that people with mental illness who do not suffer from self-stigma have adopted a different method whereby they develop resistance to stigma, and reject the negative stereotypes associated with mental ill health. This is referred to as the Rejection-Identification Model (Branscombe et al 1999) and enables people with a mental illness to use this label positively and become mental health advocates on behalf of the group of people who have a mental illness (D. S. Whitaker 1989; Van Zomeren et al 2008).

The Rejection-Identification Model is a potential catalyst for empowering people with mental illness to address negative stereotypes in society. A helpful model to improve understanding of the process underpinning stereotype rejection and stigma resistance has been provided by J.W. Crabtree et al (2010) who postulate that in individuals who do not self-stigmatise group identification is met by stereotype rejection, stigma resistance, and combined with external social support that raises self-esteem. These authors suggest that belonging to a mental health support group can help to increase resistance to the stigma associated with mental illness and the rejection of mental health stereotypes resulting in a reduction in the social distance associated with mental ill health. They also suggest that membership of a mental health support group can help people to create a more positive about mental health which then has the potential to enter the collective unconsciousness.

As already noted, people who live in regions with low levels of mental health stigma are less likely to self-stigmatise and seek help than those living in regions with high levels of mental health stigma (R. Mojtabai 2010). This is also found in the 14 European Countries study about public views and self-stigma (S. Evans-Lacko et al 2012).

As previously found in Wahl’s survey (O. F. Wahl 1999) people with a mental illness who felt that they had been stigmatised stated that it resulted in them feeling angry, hurt, sad, discouraged and had a lasting effect on their self-esteem. As previously stated, the stigma towards people experiencing mental ill health can occur within families, churches, the workplace, health settings and in the general public.

In trying to shed light on familiarity and social distance in people with a serious mental illness such as schizophrenia (P. W. Corrigan et al 2001) 208 college students in the United States of America were studied. Over 90% had previous contact with people with a mental illness through films, two thirds had previous contact with people with a mental illness through documentaries, one third had friends or family members with a mental illness, 25% had worked alongside somebody with a mental illness and 2% disclosed a diagnosis of serious mental illness. The findings were that familiarity resulted in decreased social distance towards people with a serious mental illness.

A recent study of mental health stigma in university college students in the United States of America assessed social distance and beliefs about illness causation (A. E. Lydon et al 2016). The findings were consistent with previous studies that had shown that most students have had contact with a person who has had a diagnosis of a serious mental illness (M.C.Angermeyer and Matschinger 1996; B. Link and Cullen 1996) although the finding that the more contact a student has had with a person with mental illness the less the desire for social distance was less robust in this US sample.

1.10. SOCIAL DISTANCE IN THE HEALTH CARE SETTING

Research shows that within the spectrum of mental illness, those who suffer from psychosis are the most stigmatized (M. C. Angermeyer and H. Matschinger 2004, A. H. Thompson et al 2002).

Studies have also shown that early interventions can reduce the consequences of psychosis and studies have suggested that the early phase of psychosis is a critical period and we therefore need to provide early treatment interventions to prevent deterioration (M. Birchwood et al 1998; T. H McGlashan; S. M. Harrigan et al 2003; M. S. Keshavan and A. Amirsadri 2007; P. D. McGorry et al 2009).

The studies of first episode psychosis suggest that both pharmacological and psychological interventions help to reduce morbidity. Studies suggest that one of the reasons for delay in early intervention is the stigma and nihilism that sometimes occurs in the treatment of schizophrenia (P. D. McGorry et al 2009).

A review of the literature in early intervention from 2009 to 2011 noted that early interventions are now an established part of therapeutic approach in America, Europe and Australasia and concluded that there is evidence to support early specialised intervention services (M. Marshall and J. Rathbone 2006).

If the evidence is strongly in favour of early detection, and early intervention to improve overall outcome for psychosis the impact of stigma and discrimination in preventing people from accessing services early or service provides commission for such services then we need to find innovative ways to tackle this.

A Canadian survey of people diagnosed with a psychosis in the previous 12 months found that one of the internal reasons for individuals not seeking help was stigma and in some cultures, individuals will either go to traditional faith healers rather than clinical settings (D. Fikretoglu and A Liu 2015).

Taking this into account, it may be that primary care could transform and find appropriate ways to link up with traditional healers and faith healers in low and medium income countries, especially as these regions have a shortage of man power and therefore will not have the capacity to deal with early onset psychosis and therefore reduce the barrier to care. (V. Patel et al 1997; V.Patel et al 1995).

There has been much research into how people with a mental illness seek help and how professionals in health provide help to people illness and their families and specific research focussed on the relationship between decision making and health seeking behaviour in people with mental disorder (S. G. Reidel-Heller et al 2005; G. Schomerus and M. C. Angermeyer 2008)

A 2001 German study of 5015 participants found that when faced with a scenario which included a person with symptoms of schizophrenia 76.7% of the general public would seek help from a health care professional, 34.6% of the general public surveyed advocated seeking help from a psychiatrist, 24.7% from a psychotherapist and only 17.4% advocated seeking help from a family doctor (S. G. Reidel-Heller et al 2005).

There is evidence of mental health stigma and discrimination amongst health professionals (C. Lauber et al 2006, B. Schulze 2007, C. Nordt et al 2006) and I will specifically focus on the role of the psychiatrist and general practitioner on mental health stigma and discrimination.

An international survey carried out in 12 countries included Belarus, Brazil, Chile, Denmark, Egypt, Germany, Japan, Kenya, New Zealand, Nigeria, Poland and the Unites States of America examined the stigmatization of psychiatrists and general practitioners using a validated questionnaire completed by 1893 psychiatrists and 1238 general practitioners. Findings were that psychiatrists and general practitioners experienced stigma and self-stigma in their work dealing with people who have a diagnosis of serious mental illness. Psychiatrists reported significantly higher levels of perceived stigma and discrimination than general practitioners. Both professional groups considered stigma and discrimination as a serious issue when managing people with serious mental illness (W. Gaebel et al 2014). The international nature of this survey increases confidence when generalising results.

A United States of America study of 74 people with a diagnosis schizophrenia receiving community care interviewed using the Consumer Experience Stigma Questionnaire (CESQ) (O. Wahl 1999) found that almost all participants reported some experiences of stigma including the worry about being viewed negatively by others. Other participants reported hearing people say negative things about them (F. B. Dickerson et al 2002). The most frequently reported concern in 70% of patients surveyed was worry about other people making unfavourable comments about them. As a result of this worry 58% of the population surveyed said that they would not disclose their mental health status. 55% of participants confirmed hearing negative comments made about them by other people and 43% confirmed hearing negative comments about schizophrenia in the media. These finding are consistent with other studies (B. G. Link et al 1999; B. G. Link et al 1997) and it is suggested that we need to do more to enhance the positive experience of people with mental illness such as schizophrenia.

Taking account the concept of familiarity and mental health literacy which I have already discussed one would predict that there should be less stigma and discrimination from professionals that work with mental health patients. However research and empirical evidence does not support this hypothesis.

A survey, one of the first of its kind compared 1073 mental health professionals with 1737 members of the public in regard to stereotype and attitudes about restrictions toward people with mental illness and found that, when it came to schizophrenia, there was no difference in the degree social distance in mental health professionals and the general public (C. Nordt et al 2006).

It is important to understand the impact of levels of mental health stigma and discrimination in health professionals in order to be able to develop appropriate plans and strategies to reduce this because mental health stigma and discrimination has a significant effect on patient care. There is evidence that the stigma related to mental illness can be an important factor affecting health seeking behaviour in people with a mental health condition because it reduces health seeking behaviour (B. Link & J.C. Phelan 2001).

One of the first detailed reviews to look at mental health stigma and health seeking behaviour is a 2015 systematic review of 144 qualitative and quantitative studies. This concluded that stigma had a small to moderate sized negative effect on health seeking behaviour in people diagnosed with a mental disorder. The review showed that people with mental disorder adopt a range of coping mechanisms which include selective disclosure of their mental health status, non-disclosure of mental health status when seeking help, emphasising the somatic aspects of their symptoms rather than the psychological aspects or re-framing their mental health problem. (S. Clement et al 2015). This systematic review provides robust evidence that mental health stigma has a direct effect on help seeking behaviour in people with a mental health diagnosis.

A survey comparing attitudes of the Swiss general public and Swiss mental health professionals found that mental health professionals do not have consistently less negative or more positive stereotypes against people with a mental illness compared with the general public and concluded that mental health professionals should improve their attitudes towards people with mental illness suggesting education or regular supervision as potential mechanisms to achieve this aim (C. Lauber et al 2006).

It is difficult to be a patient with mental health problems seeking help irrespective of locality, country or region (M. Funk & G. Ivbijaro 2008; WHO 2007). The relationship between mental health professionals and mental health stigma is complex because they themselves can be stigmatised because of their profession, they can stigmatise others and they can also be agents of positive change by addressing mental health stigma by becoming anti-stigma champions fighting for he rights of their patients, promoting mental health literacy and supporting collaborative care in order to improve access to general health (B. Schulze 2007).

Mental health stigma and discrimination has also been well documented in the nursing profession and the same model applies; nursing staff can be stigmatised, they can stigmatise others and they can be anti-stigma advocates (N. Sartorius & B. Schulze 2005). Studies have shown that nurses have the same level of mental health stigma as the general population particularly with regards to dangerousness, unpredictability, violence and bizarre behaviour (S. R. Bailey 1994; M. Hardcastle & B. Hardcastle 2003).

One of the explanations put forward to explain the levels of mental health stigma and discrimination in nursing staff is lack of knowledge and skills to manage mental health conditions (S. R. Bailey 1994; J. Scott 2001). In addition, negative attitudes towards people with mental health problems is much more common in general medical settings (S. R. Bailey 1994) and an explanation may be the lack of familiarity as already described.

A 2009 literature review about mental health stigma and the nursing profession concluded that nursing staff, just like other health professionals can perpetuate stigma and can also be stigmatised (C. A. Ross & E. M. Goldner 2009). We need to do more to support and educate nurses so that they can develop insight into this and the effect it can have on their work and on patient care.

Social distance has also been measured in mental health counsellors, social workers, psychologists and non-mental health staff using a social distance questionnaire (A. L. Smith & C. S. Cashwell 2011). This study found that professional counsellors and psychologists desired less social distance than social workers and non-mental health professionals and it was postulated that training and familiarity accounted could account for this.

Evidence is emerging that stigma and discrimination in the mental health setting can lead to harmful catastrophic effects such as poorer life expectancy, premature mortality from long term conditions such as metabolic syndrome, hyperlipidaemia, hypertension, obesity and many other preventable health conditions known to be associated with serious mental illness (D. Ben-Zeev et al 2010; E. E. McGinty et al 2016; M. Funk & G. Ivbijaro 2008; N. H. Liu et al 2017). Family doctors and psychiatrists can play a significant role in tackling this but the evidence remains that many doctors discriminate just like other health professionals. Even the classification system used in mental health can promote social distance (D. Ben-Zeev et al 2010). In some developing countries individuals can sometimes go to traditional healers because of fear of mental health stigma and discrimination which can sometimes lead to them receiving ineffective and sometimes dangerous treatment (A. Kleinman & A. Cohen 1997)

Mental health stigma and discrimination in psychiatrists and family doctors starts from medical school, if not before (V. Menon et al 2015) and psychiatrists also have the potential to and continue to discriminate (N. Sartorius 20030 Medical students enter medical school with levels of mental health stigma and discrimination that is similar to the general population and it is well recognised that medical training globally is a period of considerable stress (M. Dahlin et al 2005). Medical students are also known to worry about mental health stigma which leads to them being reluctant to seek help. A 2015 cross sectional study of 461 Indian medical students showed that fear of mental health stigma affected medical student health seeking behaviour and there was a statistically significant difference when compared to help seeking behaviour in physical illness (V. Menon et al 2015). This group of medical students believed that mental health treatment was of minimum benefit and seeking mental health treatment would be seen by their peers as a sign of weakness.

An Australia survey of 655 first year medical students attending six Australian universities showed that medical students viewed psychiatry as a less attractive career option compared with other medical specialties (G. S. Malhi et al 2003). This may reflect the public stigma that people working in mental health experience from others. A 2007 Danish survey of 222 senior medical students showed that medical students did not see a career option in psychiatry as attractive although completing a four-week placement in psychiatry tends to improve (C. Holm-Peterson et al 2007). This is consistent with the concept of social distance reducing as a result of familiarity.

A study that investigated the impact of exposing medical students and psychology students to different aetiological explanations for schizophrenia, one biological and the other psychological and assessed their social distance using a validated questionnaire found that medical and psychology students expressed significant levels of explicit stereotype (T. M. Lincoln 2007). Surprisingly there was no significant difference in the pre-existing explanations for the aetiology of schizophrenia in both groups however, psychology students were more likely to have pre-existing knowledge of psychosocial explanations for this disorder.

Social distance towards people who have a diagnosis of schizophrenia has also been demonstrated among pharmacists. This has been addressed by using peer level patient presenters as a method to reduce social distance (A. V. Buhler et al 2007). It has been found that exposing pharmacy student to patients with schizophrenia and clinical depression in the first year of their studies reduces social distance as measured on graduation. Students who were introduced to people with a diagnosis of schizophrenia early in their pharmacy training were less likely to endorse the statement that “people with schizophrenia cannot bring up children” and the statement that “people with schizophrenia are dangerous” and this finding was statistically significant. The students who worked with people with schizophrenia from the first year of training were also significantly more likely to believe that people with a diagnosis of schizophrenia were likely to take their medication.

It is not only the level of stigma in psychiatrists and family doctors that affects access to mental health care. The design of the health care system also makes a significant contribution to social distance. A review examining access to mental health care for people with mental health problems concluded that many people with mental illness, especially those in developing countries, will eventually access the type of help they require but this may be after a delay of nine years or longer in some cases (G. Thornicroft 2008). When people develop mental health symptoms that they recognise require treatment they are often reluctant to share their concerns with health professionals and seek help because fearful of the anticipated stigma once diagnosed (R. Kohn et al 2004).

Attitudes of doctors and healthcare providers towards people with a mental health condition can result in people with mental health problems not receiving the kind of physical health care that they need. A study of 130,088 women in Ohio in the United States of America aged 50-64 years enrolled in Ohio's Medicaid program during the years 2002-2008 showed that women with mental illness were 32% less likely to undergo at least one screening mammography. Among those who received at least one screening mammography, fewer women with mental illness received screening mammography on an annual basis (S. M. Koroukian et al 2012).

There is evidence that people with a mental illness are more likely to use episodic care from Accident and Emergency departments when they have physical health co-morbidity rather than using primary care services even in regions where primary care is universally provided and easily accessible (G. Ivbijaro et al 2014; C. Naylor et al 2012).

An effective treatment for myocardial infarction is cardiac catheterisation. The stigma associated with mental illness also extends to this effective cardiovascular procedure. (B. G. Druss et al 2000) When access to other common elective surgical procedures was reviewed in the United States of America people with a mental health diagnosis were between 30% to 70% less likely to be referred to a surgical team for the necessary procedure (Y. Li et al 2011). Once referred, people with mental illness who undergo a surgical procedure are more likely to suffer from post-surgical complications (B. G. Druss et al 2001). One of the theories to explain this discrepancy in access to physical health care in those people with a mental disorder is the mental health stigma that occurs in physicians and other health care providers (C. Lauber et al 2006; H. Schulze 2007). These findings may help us to understand and inform how we might start to address stigma in health professionals.

The Contact-Based Stigma Change Process suggests a five-step approach to addressing stigma at both community and professional level and has been developed using a community-based participatory research (CBPR) methodology (P. W. Corrigan et al 2014). The first step of the process is the design stage when you think about what you want to target, what materials you intend to use and the size of the population you intend to cover. This results in the identification of specific target groups and the goals for this group are planned. You then identify the people who will deliver the anti-stigma to the target group often working with somebody who has lived experience. The intervention needs to have a clear message which emphasises the core values of anti-stigma and it is essential to have a follow up, often within a month. This methodology has been successfully applied in California in the United States of America (P. W. Corrigan et al 2013)and can also help to improve the quality of primary care provision for people with a serious mental illness (P. W. Corrigan 2011).

There are other effective methods to address mental health stigma in health professionals. A Swiss study assessed the mental health literacy of mental health professionals to determine if there was agreement between professional groups about knowledge of individual mental health conditions and compared this to that of the general public. The authors concluded there is a need to have regular initiatives to promote knowledge about mental health in order to improve health literacy in professionals because they found that although psychiatrists and psychologists valued their profession they sometimes did not believe in the treatment that they were offering (C. Lauber et al 2003).

It is established that stigma and discrimination against patients with a mental health problem occurs in health and mental health professionals (C. Lauber et al 2006). This has a significant impact on the mental and physical health care that people with a mental illness receive from mental health professionals and reduces access to both mental and physical health care (G. Thornicroft 2008; P. W. Corrigan 2004). It is therefore essential to develop a strategy for addressing mental health stigma to improve access to mental and physical health interventions. Investing in primary care and training the primary care work force to be able to identify mental illness and promote mental health literacy can be a useful tool for decreasing the social distance in relation to people with a mental illness. Having a clearer pathway that supports increased collaboration between primary and secondary care is essential and there is evidence to support the effectiveness of such an approach.

A recent systematic review and meta-analysis about public attitudes towards psychiatry and psychiatric treatment at the beginning of the 21st century noted that it is difficult to be a psychiatrist because many psychiatrists fell that they are losing autonomy, feel undervalued, have concerns about the poor public image of their discipline and feel increasingly stigmatised and discriminated against (M.C. Angermeyer et al 2017).

This latest systematic review examined attitudes of help seeking behaviour by the general public for severe mental illness from specialists showed that 85% of the general public would seek treatment for schizophrenia from a psychologist or psychotherapist, 83% from a psychiatrist and 68% from a family doctor. When these results were analysed by geographical region members of the general public in Asia were less likely to recommend seeking help for mental illness from a family doctor. Self-stigma was identified as a significant factor in members of the general public refusing to seek help from health professionals in general (M.C. Angermeyer et al 2017).

1.11. PRIMARY CARE TRANSFORMATION

There are good examples demonstrating that easy access to primary care is an initiative that can be utilised to decrease social distance in mental health. A 2008 WHO report noted that primary care mental health can enhance access to appropriate mental health care and promote human rights whilst remaining cost effective and provided eleven good practice primary care case examples from around the globe to show the effectiveness of primary care transformation and reduction of stigma (M. Funk & G. Ivbijaro 2008). These examples support the assertion that we can improve mental health access and decrease mental health stigma by service re-design in primary care. The 2012 Mental Health Services Case for Change for London noted that, London a rich city in a high-income country with a 7.6 million population representing 12.5% of UK population, who have universal access to high quality primary care continued to have poor access to health care for patients with a mental health condition and that mental health stigma and discrimination persists (London Health Programmes 2011 a; London Health Programmes 2011 b).

In 2008/9 the UK Office of National Statistics recorded that 37% of the in-patient mental health population in London were detained against their wishes. As I have already described, people detained under the UK Mental Health Act believe that their human rights are violated, they are coerced into treatment and do not feel that they are offered information about their treatment (M. Chambers et al 2014). It was also noted that in 2008 29% of people experiencing a severe mental health condition were likely to be separated or divorced compared with 8% of the general population, 43% of people with a severe mental health condition were likely to be living alone compared with 16% of the general population and 70% of people with a severe mental health condition were economically inactive compared with 30% of the general public.

The 2012 Mental Health Case for Change for London noted that mental ill health was a significant barrier to social inclusion in London and limited access to health. This was worse in those people with mental and physical health co-morbidity. It was also noted that a 2010 survey of patients under secondary care mental health services stated that they did not receive the type of care that they expected including not having a mental health worker to speak to, not receiving enough support with finding or keeping accommodation and not receiving enough help with getting financial advice or benefits. Only 20% of secondary care mental health providers in London were able to satisfy all three conditions.

This report also showed that people with severe mental illness such as schizophrenia had a lack of coherent pathways to appropriate care, poor integration between mental and physical health and sometimes received poor quality primary and secondary care services despite spending over £1.4 billion pounds per annum in London to support mental health.

Taking this into account having accessible good quality primary care with appropriately skilled staff is likely to reduce the number of people requiring specialist secondary care services and is likely to be able to decrease physical health morbidity and mortality in people with mental health conditions.

The London Mental Health Case for Change also highlighted a mental health skills gap in primary care because, although general practitioners in primary care are the first port of call for the majority of people seeking health care, many of them have little or no skills in mental health assessment and management of mental health conditions. This may lead to the provision of non-evidence based interventions when people for people with a mental illness. The proposed model of care for the management of people with long term mental health conditions such as schizophrenia living in London recommended that there should be a programme to improve the competence of primary care teams in the management of long-term mental health conditions, to improve partnership working across the primary/secondary care and other interfaces, to promote and support the provision of evidence based interventions, recovery -orientated practice and active efforts to reduce mental health stigma and discrimination.

A cross-sectional study of 395 primary health care workers in China completed a questionnaire about their attitude to psychiatric patients. The authors concluded that it was important for primary care health workers to have contact with people with mental health conditions and better quality contact contributed to a reduction in mental health stigma (Y. Wang et al 2017).

Using people with mental health lived experience to train professionals who work with people with a mental illness has also been shown to be an effective tool to decrease social distance. Pharmacists have also been shown to have increase social distance for people with schizophrenia, just like other health professionals. Studies have found that pharmacists have a poor understanding of the biological and chemical aetiology in illnesses such as schizophrenia. Some also demonstrate poor knowledge about the efficacy of psychotropic medication in mental illness and social distance has been recognised in pharmacists (V. Phokeo et al 2004; K.K. Vainio te al 2002; D.M. Kirking 1982; M.E. Cates et al 2005).

1.12. CONFIDENCE IN THE ABILITY OF GENERAL PRACTITIONERS IN THE MANAGEMENT OF SCHIZOPHRENIA

To tackle the stigma associated with a serious mental illness (SMI) such as schizophrenia and reduce the disparity in physical and mental health in people with serious mental illness so that patients can reap the benefits of a primary care transformation process, there is a need to have a deeper understanding of the barriers patients face in accessing primary care either from the community or from secondary care mental health services.

There has been a great deal of research to highlight the obstacles that may impede people's ability to obtain the services that they need including the Goldberg and Huxley filter-model for access to mental health care (1980) depicted in Figure No. 2.

Figure No. 2: The Goldberg and Huxley Filter-Model for Access to Mental Health Care

Level	Setting	Rate (per 1000)
1	Community (total)	250
FIRST FILTER – ILLNESS BEHAVIOUR ⬇		
2	Primary care (total)	230
SECOND FILTER – ABILITY TO DETECT ⬇		
3	Primary care (identified)	140
THIRD FILTER – WILLINGNESS TO REFER ⬇		
4	Mental illness services (total)	17
FOURTH FILTER – FACTORS DETERMINING ADMISSION ⬇		
5	Mental illness services (admissions)	6

(Reproduced with permission from David Goldberg)

This original model proposed by Goldberg and Huxley (1980) describes four filters which represent obstacles to accessing mental health care.

At the first filter, between community and primary care, there are people with a mental illness who do not present to their general practitioner/family doctor for a variety of reasons, including fear of the consequences and mental health stigma.

At the second filter, there are people with a mental illness whose illness is not recognised by the general practitioner/family doctor.

At the third filter, there are people with a mental illness who are identified as having a severe mental illness but are not referred to secondary care mental health services, or are not willing to be referred to secondary care mental health services by their general practitioner/family doctor for a variety of reasons, including fear of the consequences and mental health stigma.

At the fourth filter, there are people with a mental illness who are referred to secondary care mental health services and are unwilling to have an in-patient admission for a variety of reasons, including fear of the consequences and mental health stigma.

The original Goldberg and Huxley filter-model was designed to describe the pathway to psychiatric care, and points for decision making. The decision points are the filter points. This model describes how patients move from the community, through primary care and into the psychiatric service. It also provides a framework for research into why patients meet obstacles in their journey to mental health care (P. F. M. Verhaak 1995).

A great deal of research has been carried out on the second filter in this model, the ability of staff working in primary care to recognise mental illness (R. Gater et al 1991). A filter that has not had much attention is what determines when psychiatrists think it is appropriate and necessary to refer patients with a mental illness back to primary care where they can receive holistic health care (M. Funk and G. Ivbijaro 2008) and an additional filter to consider is access to physical health care for those patients with a diagnosis of mental illness.

There is therefore a reverse direction to the original Goldberg and Huxley Model (1980) for access from secondary to primary which is driven by the psychiatrist and their team. As already noted in the Mental Health Services Case for Change for London (2012a) many psychiatrists continue to keep patients with mental health problems on their case-loads when they could be better managed in primary care by their general practitioner.

If we generalise this to the general population then we begin to see the emergence of another barrier to care which need to be addressed if we are to address access to general health care for patients with a diagnosis of mental illness.

Consideration should be given to the suggestion that the psychiatrist does not have confidence in the general practitioner/family doctor’s competence to manage mental illness.

Patients with schizophrenia consult general practitioners more often than the average patient, often with somatic complaints rather than symptoms of mental illness and receive very little specific evidence based practice for either their physical or mental health condition (I. Nazareth et al 1993). This could be related to poor knowledge, skills and confidence in general practitioners to manage the health of patients with schizophrenia.

A 1997 review noted a low detection rate of physical health problems in those with a mental health diagnosis and linked this to a lack of self-confidence characteristics in patients with a diagnosis of schizophrenia (T. Burns and T. Kendrick 1997).

This review also found that patients with schizophrenia present more often to general practitioners for a variety of reasons, including collection of repeat prescriptions, but will rarely talk about their physical or mental health spontaneously.

The authors suggested that a reason for the lack of confidence of general practitioners in managing patients with schizophrenia is the low numbers of such patients that they see in their daily practice because the prevalence of this disorder is 0.9%.

Confidence has been used as a proxy marker for performance, competence and skills in many fields including health care.

A study of how inner city General Practitioners in London, UK improve their clinical skills in mental health found that many used a lack of confidence in a mental health related topic to include this in their Continuing Medical Education (CME). Once the lack of confidence in the particular topic area was addressed through training general practitioners considered themselves as more competent in managing the conditions associated with that particular subject area (S. Kerwick et al 1997).

A cross-sectional survey of general practitioners in Australia showed that self-professed interest and prior training in mental health was associated with self-professed confidence, skills acquisition and continuing medical education (CME) in the mental health field (M. O. Browne et al 2007).

Nursing staff who work in general health services have demonstrated that training in mental health also leads to an increased confidence in their ability to assess and manage patients with mental health conditions (F. Payne et al 2002).

These studies support the use of confidence in this study as a proxy marker for knowledge and skills in health professionals.

In sports medicine self-confidence has been shown to improve performance in sports people. A meta-analysis of 42 studies of performance in sportsmen and sports women found that self-confidence in a sports person was associated with a significant improvement in their performance (T. Woodman and L. Hardy 2003).

Confidence has also been shown to predict employee productivity in management and employment, and is linked to efficacy, performance and leadership (A. de Jong et al 2006). A study of physics student's problem solving skills in mechanics found that confidence was an important factor and indicator for high levels of performance (M. Potgeiter et al 2010).

All these examples support the use of confidence as a proxy for assessing skills in health.

A qualitative study of patients with a mental illness, using depression as a model, found that the desire to seek help for mental health treatment was based on a series of assumptions. These included the patient's beliefs about what the service is likely to offer, their expectations about what they are likely to get and their confidence in the service that that are attending. The authors concluded that seeking psychiatric help was a planned behaviour and suggested that having interventions to better encourage this planned behaviour would increase mental health service users desire to seek help (G. Schomerus et al 2009b).

There need to be strong efforts made to enable patients to believe in and have confidence in the services that general practitioners offer so that they seek help for their mental health and physical health conditions if we are to decrease the mortality gap that exists in mental health.

An Australian study of help-seeking behaviour in patients for psychological and mental health issues from a general practitioner found that the patients had to believe in what the general practitioner was offering and believe that it would be helpful to approach the general practitioner for help, especially as many of them reported past history of rejection and discrimination (A. Komiti et al 2006). The study concluded that patient confidence in the general practitioner and the primary care service improved access to health care.

The views of patients about the services offered and treatments given are very important and sometimes the views provided by patients may provide mixed messages.

A UK study found that patients sometimes give negative scores about the side effects or iatrogenic effects of treatment not because of the treatment itself, but because of the site from where the treatment is provided (A. Rogers and D. Pilgrim 1993). We should therefore be making it easier for patients to have access to services local to them, if possible in primary care centres, to improve their compliance and access to good care.

People with serious mental health problems often suffer from co-morbid physical health conditions which lead to decreased life expectancy. Patients should be encouraged to have a shared dialogue with their doctors and have confidence in the services that they provide. This will require increased training for mental health for all doctors (K. Williams 1998; V. J. Carr et al 2004; M-J. Fleury et al 2012; D. E. Loeb et al 2012).

1.13. ANTI-STIGMA CAMPAIGNS

Public stigma and discrimination has a pernicious effect on the lives of people with mental illness. Knowing about what lay people think about mental illness, its causes, their beliefs is very important (G. Schomerus et al 2006; Yorm 2000). Many populations hold negative views about schizophrenia. This in turn influences how other people think about schizophrenia and how people with schizophrenia think about themselves.

The media is very powerful in shaping public knowledge about mental illness and stereotype and reinforces the negative public stereotype that people with a diagnosis of mental illness are violent (M.C. Angermeyer & B. Schulze 2001).

A study of public knowledge about mental illness found that many people blame schizophrenia on simple life events and do not understand the role of brain neurotransmitters in aetiology or their importance in treatment interventions (G. Schomerus et al 2006). Attitudes and mental health literacy contribute on how people seek help or their decision not to.

An investigation of 1564 German lay people's attitudes and preference regarding mental illness using case vignettes found that people's own social networks had an impact on lay peoples knowledge about mental illness and its treatment and that personal attitudes are shaped by an individuals social networks which supports familiarity and the role of the collective unconscious (M. C. Angermeyer et al 1999)

We need to do a lot to increase public knowledge and attitudes regarding mental health illnesses referred to as mental health literacy and Yorm has argued that if mental heath literacy is not improved there will continue to be difficulty in the acceptance of evidence based treatment for mental illness such as schizophrenia (A.F. Yorm 2000).

A meta-analysis of global studies about challenging stigma in mental illness found that education and contact with people who are mentally ill had a positive effect on the reduction of stigma. This meta-analysis also found that face to face educational interventions were more successful than video or online educational programmes (P. W. Corrigan et al 2012).

Although contact and education have a positive impact on reducing stigma sustained improvement was found to be better with contact with individuals with a mental illness. This finding is important because it can help us to better shape the design of our anti-stigma campaigns in order to be more effective with sustained results. Short anti-stigma initiatives and campaigns have been shown to be ineffective or less effective than more long-term campaigns (S. Evans-Lacko et al 2010).

As my research is interested in examining stigma in psychiatrists, general practitioners and people with a mental health problem it is important to consider the effectiveness of campaigns that have been targeted at health professionals, specifically those targeted at psychiatrists and general practitioners.

Effective campaigns that lead to a reduction is mental health stigma should lead to earlier access to health interventions and lead to a reduction in morbidity and premature mortality in long term chronic health conditions co-morbid with mental illness.

Although the intentions behind many anti stigma campaigns are good, many anti-stigma campaigns are not optimally designed so we are not getting the best from our efforts. A more balanced multi-dimensional approach to designing and delivering anti-stigma campaigns has been advocated because myths about mental illness continue to persist in society and lead to increased stigma. Although some have suggested that adopting a biogenic versus a psychosocial explanation of schizophrenia as a way of decreasing mental health stigma and reducing social distance this is too simplistic because stigma and its aetiology is complex (T. M. Lincoln et al 2008).

An Argentinian survey of 1254 members of the general public living in Buenos Aires was carried out to assess the knowledge and social distance with regards to schizophrenia. This survey showed that over 50% of respondents believed that people with a diagnosis of schizophrenia had a split personality and were dangerous people. Social distance was found to be higher in the elderly population and people who were familiar with mental illness, either as a relative or a health care worker, had social distance similar to that shown by the general public (E. A. Leiderman et al 2010). A Brazilian study of 1400 psychiatrists to assess their levels of stigma and social distance in schizophrenia showed that Brazilian psychiatrists negatively stereotyped individuals with schizophrenia. Those psychiatrists who worked in academic university settings had decreased social distance compared to those working in general settings. The study authors suggested that there should be active anti-stigma campaigns targeted at psychiatrists and other mental health professionals (A. A. Loch et al 2011).

One of the considerations when working with stigma is that of the role of culture and cultural differences. The literature says that stigma occurs in all cultures with similar devastating effects. One of the explanations for this is that mental health stigma and discrimination is very pervasive and is about relationships, and being human (D. Rose et al 2011; I. Durand-Zaleski et al 2012; R. Thara and T. N. Srinivasan 2000).

A national survey of 1000 adults carried out in France using a market research company concluded that 33% of those surveyed thought that the knowledge they had about mental illness was adequate but this knowledge sourced from the media. Although those surveyed had increased social distance to mental illness as a whole, the degree of social distance was highest in schizophrenia compared to bipolar affective disorder or autism. As most of the information about mental illness in the French population is from the media this study suggests the need to make better use of the media for public education (I. Durand-Zaleski et al 2012).

A 2005 critique on the use of media in decreasing mental health stigma noted the unsatisfactory media representation of mental illness and suggested more specific targeting of different groups during media campaigns. This critique noted that most anti-stigma campaigns focus their arguments on the liberal views of psychiatry but this is an over-generalisation and each sector should be tackled differently, depending on what is known to work with each different target group. An example provided is that when violence is presented in the media as part of the presentation of mental illness this is not a myth to some people because they have experienced it a real (S. Harper 2005).

A framework put forward to more systematically develop anti-stigma campaigns suggested that people should take account of individual opinions, attitude and knowledge and to provide more information about mental health (A. H. Crisp et al 2000).

The UK Changing Minds Campaign led by the Royal College of Psychiatrists showed that national campaigns can work if they are well formulated, well-resourced and use a variety of different methodologies. They also require professional engagement and buy-in. Simply talking about aetiology was not enough when dealing with the general public. A message of hope and recovery was essential (D. Pilgrim and A. E. Rogers 2005).

A review of another English anti-stigma campaign called Time for Change launched in 2009 and specifically charged to tackle public stigma and discrimination in mental health showed that public campaigns can work and can be effective. This campaign helped to decrease stigma and discrimination, improved public attitude and behaviour towards people with mental illness but did not improve levels of public knowledge (S. Evans-Lacko et al 2013). There was a significant improvement in social distance towards those with mental disorder over the period of the campaign from 2009 until 2012. The reviewers concluded that mental health anti stigma campaigns work but do not improve mental health literacy or knowledge. A later review of the same campaign found that there was a definite improvement in the attitude of the general population and a decrease in social distance when the pre and post campaign data were compared. When data from 2003 was compared with data from the launch of the Time to Change Campaign in 2009 and beyond there was a steady improvement in public tolerance of people with mental illness and a reduction in social distance over this period. The campaign was considered to have made a significant contribution to decreasing prejudice towards mental health difficulties with the caveat that there could be other confounding issues that one needs to take account of over this period (S. Evans-Lacko et al. 2014)

A Spanish focus group study examining the views of the carers and families of people with a diagnosis of schizophrenia recommended that talking about mental health stigma to the general public can result in a healthier societal reaction to people with a mental illness (M. A. González-Torres et al 2007).

One of my hypotheses in this thesis is that anti-stigma campaigns should result in improved community mental health literacy, resulting in earlier recognition of mental illness leading to prompt access to evidence based care. A study from Singapore found that outreach programmes and networks can lead to early detection of psychosis and therefore a reduction in the time it takes to obtain evidence based treatment (P.L. Yin et al 2013). This programme began in 2001 and showed that general practitioners, the community and other stakeholders are better equipped to make an earlier diagnosis of psychosis and provide appropriate treatment.

Public initiatives aimed at leading to early detection of mental illness must be welcomed because early detection can reduce disability in schizophrenia because it decreases the duration of untreated psychosis (DUP). A prospective review of 163 people with a first episode psychosis who received early intervention were more likely to be in full employment and needed less social support compared with those who had delays in treatment (R.M. G. Norman et al 2006). The effectiveness of early intervention in psychosis has been shown to persist at 5 year follow up after the initial intervention (R.M. G. Norman et al 2011).

A North American review described many successful early intervention for psychosis projects in the United States of America. Some focus on biological factors and others on psychosocial factors. The findings of the review are that the Canadian early intervention services are more systematic than those in the United States of America and lessons can be learnt from this (M. T. Compton et al 2008).

A 2011 systematic review of initiatives to shorten duration of untreated psychosis (DUP) concluded that the most promising evidence to support shortening the duration of untreated psychosis is through intensive public awareness campaigns which will require organisation and resources at regional and national levels. The authors concluded that there remain a lot of knowledge gaps about the best way to deliver more effective anti-stigma campaigns that can effect the outcome (B. Lloyd-Evans et al 2011).

CHAPTER TWO

2. METHODOLOGY

The quantitative research is being presented is part of a larger study to examine stigma and social distance for schizophrenia in psychiatrists, general practitioners and mental health service users to find ways to provide better access to health for people with a mental health condition and address the stereotype of schizophrenia in psychiatrists, general practitioners and mental health service users.

The larger study is part of an initiative to support the integration of mental health into primary care because the evidence provided in Integrating Mental Health into Primary Care: A Global Perspective (M. Funk and G. Ivbijaro 2008) has shown that primary care mental health is effective globally, yet many patients do not make use of this service.

The research presented here investigates the relationship of mental health stigma measured by social distance in schizophrenia, and confidence about managing this long-term condition in primary care.

The Mental Health Case for Change for London and Mental Health Models of Care (London Health Programmes 2012a, 2012b) found that many patients that could be effectively managed in primary care continue to be managed by secondary care mental health services.

Taking this evidence into account it is suggested that improving primary care capability in mental health can lead to improved access to evidence based practice in primary care for patients with a mental health diagnosis.

It is therefore important to identify the barriers that are preventing mental health services from discharging patients, particularly those with an SMI (Serious Mental Illness) such as schizophrenia to be managed by primary care services.

Mental health stigma and discrimination have been recognised as a barrier to patients receiving evidence based practice both in primary and secondary care health, and mental heath settings.

The overall aim of the larger study is to identify the relationship between confidence in the ability of primary care to manage long-term mental health problems and the relationship to stereotypes of mental health stigma and discrimination.

In the context of the themes developed in the section entitled ‘Three Publications – a Critical Review’ this study set out to investigate how social distance for schizophrenia measured in psychiatrists, general practitioners and mental health service users relates to confidence in the general practice management of schizophrenia from the psychiatrists and general practitioners perspectives, and confidence in the general practice management of their individual mental health problems from the mental health service user perspective.

2.1. QUESTIONS POSED IN THIS RESEARCH

For the purpose of the research presented here, three mini experimental designs have been brought together to better understand the perspective of psychiatrists, general practitioners and mental health service users through the lens of managing a serious mental illness such as schizophrenia in general practice.

2.1.1. Mini Experiment One: Psychiatrist - Research Questions (RQ1, RQ2, RQ3)

Mini Experiment One:

Psychiatrists	RQ1	What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist’s confidence in the ability of general practitioners to manage patients with schizophrenia in general practice?
	RQ2	What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist’s belief that general practitioners should be confident in managing patients with schizophrenia in general practice?
	RQ3	What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist’s belief that general practitioners should not manage patients with schizophrenia in general practice?

2.1.2. Mini Experiment Two: General Practitioners - Research Questions (RQ4, RQ5, RQ6)

Mini Experiment Two		
General Practitioners	RQ4	What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner’s personal confidence in managing patients with schizophrenia in general practice?
	RQ5	What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner’s confidence that general practitioners should be confident in managing patients with schizophrenia in general practice?
	RQ6	What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner’s belief that general practitioners should not manage patients with schizophrenia in general practice?

2.1.3. Mini Experiment Three: Mental Health Service Users - Research Questions (RQ7, RQ8, RQ9)

Mini Experiment Three		
Mental Health Service Users	RQ7	What is the relationship between social distance for schizophrenia in mental health service users and their confidence in their own general practitioner managing their mental health problems?
	RQ8	What is the relationship between social distance for schizophrenia in mental health service users and their confidence in their own general practitioner managing their other health problems?
	RQ9	What is the relationship between social distance for schizophrenia in mental health service users and the service users belief that their own general practitioner should be confident in managing their own mental health problems?

2.2. GENERATION OF THE RESEARCH QUESTIONS POSED

These research questions RQ1 to RQ 9 were generated in response to discussions with the Clinical Governance Leads and Mental Health Lead of Waltham Forest Clinical Commissioning Group (CCG) to enable a 360° understanding from those who provide mental health services in primary and secondary care and from those who receive mental health services in primary and/or secondary care.

The research questions were then submitted to the local Outer North East London Research Ethics Committee, modified following feedback and approved.

The research questions take into account that mental health knowledge and skills are important if primary care is to manage patients with long term mental health conditions, and that confidence can be used as a proxy marker for knowledge and skills.

If patients with long-term mental health conditions are to be managed in primary care, psychiatrists working in secondary care need to have confidence in the mental health knowledge and skills of general practitioners before they initiate discharge back to primary care. This was one of the issues raised in the in the Mental Health Case for Change for London and Mental Health Models of Care (London Health Programmes 2012a, 2012b).

Patients who use health services also need to have confidence in the services that they are receiving, and the three mental health service user confidence questions set out to answer research questions RQ 7, RQ 8 and RQ 9.

Measurement of social distance was based on the work of M. C. Angermeyer and H. Matschinger (2004). These researchers asked their subjects to complete a seven point ‘preference for social distance’ scale, measuring how close they would want to be to a mentally ill person, in a range of roles ranging from landlord to child minder (B. G. Link et al 1987) and also used the findings from a range of six questions derived from focus groups held with people who have a diagnosis of schizophrenia, their families and mental health professionals (B. Schulze and M. C. Angermeyer 2003) that produced five dimensions of stereotype about schizophrenia.

These five dimensions of stereotype about schizophrenia have also been considered but are not part of the research presented here which examines the total score on the social distance among mental health service users, general practitioners and psychiatrists using schizophrenia as the paradigmatic severe mental illness for which the evidence base for interventions is strongest.

Written and verbal information about this research project was provided to a variety of stakeholders from August 2009.

2.3. SETTING

This research was conducted in the North-East London Strategic Health Authority Region in the United Kingdom, an inner-city area of deprivation.

All the General Practitioners who participated in this research study worked in the London Borough of Waltham Forest where 44% of the local population come from BME (Black and Minority Ethnicity) backgrounds.

The BME group includes members of the following British and international ethnicities: Bangladeshi, Pakistani, Indian, Indian other, Chinese, Asian other, Black African, Black Caribbean, other Black background, White and Asian mixed, White and African Caribbean mixed and other mixed.

Approximately 49% of the population in the London Borough of Waltham Forest are male and 51% female (Appendix 1 General Practice High Level Indicators CCG Report 2017).

All the psychiatrists who participated in this research study worked in the North-East London Strategic Health Authority Region, employed by either the North-East London NHS Foundation Trust or East London NHS Foundation Trust.

Psychiatrists worked in a range of psychiatric specialties including general adult psychiatry, rehabilitation psychiatry, forensic psychiatry, old age psychiatry, addictions psychiatry, intellectual disability, child and adolescent psychiatry and psychotherapy.

The mental health service users who participated in this research were either registered on the Waltham Forest General Practice SMI (Serious Mental Illness) Register or were community patients under the care of secondary mental health services provided in the North East London Strategic Health Authority Region by either North East London NHS Foundation Trust or East London NHS Foundation Trust.

2.4. ETHICAL APPROVAL

Ethical approval for this study was first applied for on 28th October 2008 using the National NHS Research Ethics Committee website and the project was allocated REC Ref No: 08/H0701/92.

The local Outer North East London Research Ethics Committee considered the application on 3rd November 2008. The Committees queries were addressed and suggestions incorporated and formal written approval to the research project was granted on 9th March 2009 (Appendix 2 - Ethical Approval REF08/H0701/92) with the understanding that all data was collected and published within the strict guidelines of confidentiality.

2.4.1. Ensuring Informed Consent

Full information about the project was provided to all participants and all participants took part on a voluntary basis. Information provided to participants included an information leaflet explaining the nature of this research and a section entitled frequently asked questions (Appendix 3 – Patient Information Leaflet). All participants were informed that they could withdraw their consent at any time during this project.

All participants were clearly informed that, if they found any of the questions distressing or wished to discuss them in more detail they could contact the lead investigator directly using the contact details provided in the participant information leaflet either on the office telephone number, by letter or by e-mail. In addition all participants were offered a face to face interview with the lead investigator on request if they felt that this might be helpful to them.

Participants who were mental health service users were informed that, if requested their, participation in this questionnaire study could be discussed with their psychiatrist, general practitioner or care co-ordinator by the lead investigator.

Those participants who wanted to speak to an independent adviser about this research project were provided with the name and contact details of the Research and Development Manager at NHS Waltham Forest in the participant information leaflet.

2.4.2. Questionnaire Confidentiality Statement:

A confidentiality statement was created to ensure that psychiatrists, general practitioners and mental health service users were empowered to be as frank and truthful as possible in their answers to the questionnaires that they were provided with.

Each questionnaire carried the following statement of confidentiality:

'The identification number at the bottom of this page allows us to keep track of the questionnaires as they are returned. Any information that will permit identification of an individual, a practice or hospital will be held strictly confidential and will only be used for the purpose of this study and will not be disclosed or released to any other person or used for any other purpose.'

The questionnaire confidentiality statement was accepted and approved by the Outer North East London Research Ethics Committee through the NHS REC Application process.

2.5. PARTICIPANT SAMPLE SELECTION

2.5.1. Psychiatrists:

A list of all psychiatrists practising in the two local Foundation Trusts located in the North East London Strategic Health Authority Region was obtained from the Human Resources departments of the North East London Foundation Trust and East London Foundation Trust.

Each Consultant Psychiatrist employed by North East London Foundation Trust and East London Foundation Trust was sent a letter inviting them to participate in this research project which included an information leaflet, a consent form and a copy of the questionnaire.

Each Consultant Psychiatrist was asked if they wanted to be contacted in future to participate in any follow up research related to the outcome of this research study. Respondents to the questionnaire were asked to indicate if they wanted a summary of the research study findings to be sent to them once available.

The questionnaire was sent to 180 psychiatrists in total, and was completed and returned by 76 psychiatrists (42.2%).

2.5.2. General Practitioners:

The Waltham Forest Primary Care Trust Performance List of the North-East London Strategic Health Authority which contains the names and surgery contact details of all general practitioners practicing in the Waltham Forest Primary Care Trust area was obtained from Waltham Forest Primary Care Trust.

Each Principal or Salaried General Practitioner on the Waltham Forest Primary Care Trust Performance List was sent a letter inviting them to participate in this research project which included an information leaflet, a consent form and a copy of the questionnaire.

Each Principal or Salaried General Practitioner was asked if they wanted to be contacted in future to participate in any follow up research related to the outcome of this research study. Respondents to the questionnaire were asked to indicate if they wanted a summary of the research study findings to be sent to them once available.

The questionnaire was sent to 170 General Practitioners in total, and was completed and returned by 72 General Practitioners (42.4%).

2.5.3. Adult Mental Health Service Users:

Adult mental health service users living in the community in the North East London Strategic Health Authority were recruited either directly from their GP or from other local community resources working with people who have serious mental illness.

General Practitioners in the North East London Strategic Health Authority were sent a letter inviting them to inform service users registered on their Practice Serious Mental Illness (SMI) Case Register about this research project and provided each mental health service user with an information leaflet inviting them to participate.

Those service users who volunteered to take part in this research project were sent a letter inviting them to participate in this research project including an information leaflet, a consent form and a copy of the questionnaire.

A list of local mental health community services in the North East London Strategic Health Authority was obtained. The manager of each facility was sent a letter inviting them to inform service users using their facility about this research project. The manager was invited to provide each mental health service user with an information leaflet inviting them to participate and each manger was offered the opportunity to invite the investigator to speak directly with the service user group about this research project.

Those service users who volunteered to take part in this research project were sent a letter inviting them to participate in this research project including an information leaflet, a consent form and a copy of the questionnaire.

Mental health service users could complete the questionnaire in the privacy of their home, at the General Practice premises or in their community mental health facility.

Any mental health service user whose first language was not English who wanted to participate in this research project were provided with the opportunity to complete the questionnaire with the help of an appropriate interpreter arranged by the principal investigator.

Each mental health service user was asked if they wanted to be contacted in future to participate in any follow up research related to the outcome of this research study. Respondents to the questionnaire were asked to indicate if they wanted a summary of the research study findings to be sent to them once available.

The questionnaire was sent to 158 mental health service users in total, and was completed and returned by 66 mental health service users (41.8%).

2.6. RESEARCH INSTRUMENTS

It is important to choose an effective methodology to assess mental health stigma because we need to understand how stigma occurs, and how it affects individuals and groups. A 2004 review provides a helpful insight into how to choose the most appropriate measure of stigma when researching this field (B. G. Link et al 2004).

This review of 123 empirical articles published between 1995 and 2003 recommends that any instrument used to assess stigma and discrimination should enable the researcher to observe and measure the concepts of stigma described by Goffman (1963) and Link and Phelan (2001).

A variety of methodologies have been used to assess and examine stigma including surveys with or without vignettes, experiment with or without vignettes, qualitative studies with content analysis and qualitative studies that include observations of individuals.

The most common research methodology in this field is the use of survey questionnaires without vignettes and accounts for 60% of all studies reported during the period of this review and the most common tools used in an adult population are those that measure social distance. Social distance measures a respondent's willingness to interact or relate to a target individual.

Social distance questionnaires were originally designed to measure stigma related to race in a relationship and many of the current social distance scales date back to the work of Emory Bogardus in the early 20th century. This enabled investigators to consider the role of culture in people's personal and professional lives.

It is thought that the impetus for developing this scale was non-Protestant immigration to the United States of America (C. Wark and J. F. Galliher 2007; C. W. Mills 1959; M. V. Uschan 1999).

According to historical data, it was thought that Robert Park (1923) first introduced the concept of social distance to Bogardus after he had listened to a lecture about this concept by Georg Simmel (R. C. Hinkle 1992) in Berlin when Bogardus and Parks were trying to measure the terms and grades of intimacy and understanding between individuals or social groups and considered prejudice to be a spontaneous disposition to maintain social distance from other groups. They considered that this prejudice could be measured using social distance scales.

Many scales have been modified from the original scales developed by Bogardus to measure social distance and the majority have good internal consistency and reliability ranging from 0.75 to 0.9 particularly in construct validity (Cronbach and Meehl 1955).

Social distance is also related to power in a relationship, because the greater the social distance the more there is a power separation within the relationship (J. C. Magee and P. K. Smith 2013). This may account for why social distance can sometimes result in self-stigmatisation and low self-worth if the stigmatised individual internalises the power difference.

2.6.1. Social Distance Measures

As already stated, measurement of social distance was based on the work of M. C. Angermeyer and H. Matschinger (2004).

These researchers asked their subjects to complete a seven point ‘preference for social distance’ scale, measuring how close they would want to be to a mentally ill person, in a range of roles ranging from landlord to child minder (B. G. Link et al 1987).

These researchers also used the findings from a range of six questions derived from focus groups held with people who have a diagnosis of schizophrenia, their families and mental health professionals (B. Schulze and M. C. Angermeyer 2003) that produced five dimensions of stereotype about schizophrenia.

These five dimensions of stereotype about schizophrenia have also been considered but are not part of the research presented here which examines the total score on the social distance among mental health service users, general practitioners and psychiatrists using schizophrenia as the paradigmatic severe mental illness for which the evidence base for interventions is strongest.

The five dimensions are: Factor 1 - "Dangerousness"; Factor 2 - "Attribution of Responsibility"; Factor 3 - "Creativity"; Factor 4 - "Unpredictability / Incompetence”; Factor 5 - "Poor Prognosis".

(Appendix 4 – Social Distance Measure)

2.6.2. Assessing Confidence in General Practitioners Managing Schizophrenia in Primary Care

Data was collected to assess confidence in the general practice management of serious mental illness such as schizophrenia in day to day practice.

Three additional questions were added to specifically explore perceived competence to manage people with serious mental illness in primary care and the results of the three mini experiments are being presented here.

These additional questions were designed to measure confidence about managing serious mental illness and schizophrenia in primary care from each of three group's perspectives.

Psychiatrists were asked about their confidence in the management of schizophrenia in general practice, general practitioners were asked about their confidence in the management of schizophrenia in general practice and mental health service users were asked about their confidence in their own general practitioner to manage their mental and physical health.

The questions about confidence were answered using a five point Likert scale.

These additional questions, listed below, were approved and accepted by the local Outer North-East London Research Ethics Committee.

2.6.2.1. Questions Asked of Psychiatrists (Appendix 5)

a) 'I am confident that GP's can manage patients with schizophrenia in their practice'

b) 'GP's should be confident in managing patients with schizophrenia in their practice'

c) 'GP's should not manage patients with schizophrenia in their practice'

2.6.2.2.Questions asked of General Practitioners (GP's) (Appendix 6)

a) 'I am confident in managing patients with schizophrenia in my practice'

b) 'GP's should be confident in managing patients with schizophrenia in their practice'

c) 'GP's should not manage patients with schizophrenia in their practice'

2.6.2.3.Questions Asked of Mental Health Service Users (Appendix 7)

a) 'My GP is confident in managing my mental health problems'

b) 'My GP is confident in managing my other health problems'

c) 'My GP should be confident in managing my mental health problems

2.7. PROCEDURE

2.7.1. Questionnaire Distribution Protocol

The distribution of questionnaires to general practitioners, psychiatrists and mental health service users commenced on 1st September 2010.

2.7.2. Distribution to Psychiatrists

Each questionnaire distributed to an individual psychiatrist was marked with an individual code, and a stamped, self-addressed envelope was provided so that completed questionnaires could be returned.

Those psychiatrists who did not return their questionnaire within four weeks were send another copy of the questionnaire with a reminder.

Those psychiatrists who had not returned their questionnaire within the next four-week period were sent another copy of the questionnaire and a final reminder.

2.7.3. Distribution to General Practitioners

Each questionnaire distributed to an individual general practitioner was marked with an individual code and a stamped, self-addressed envelope was provided so that completed questionnaires could be returned.

Those general practitioners who did not return their questionnaire within four weeks were send another copy of the questionnaire with a reminder.

Those general practitioners who had not yet returned their questionnaire within the next four week period were sent another copy of the questionnaire and a final reminder.

2.7.4. Distribution to Mental Health Service Users

Each questionnaire distributed to an individual mental health service user was marked with an individual code and a stamped, self-addressed envelope was provided so that completed questionnaires could be returned.

Those mental health service users who did not return their questionnaire within four weeks were send another copy of the questionnaire with a reminder.

Those mental health service users who had not yet returned their questionnaire within the next four week period were sent another copy of the questionnaire and a final reminder.

2.8. THE NULL HYPOTHESIS

2.8.1. Null Hypothesis Mini Experiment One – Psychiatrists (RQ1, RQ2, RQ3)

Psychiatrists	RQ1	There is no relationship between the social distance score for schizophrenia in psychiatrists and confidence in the ability of general practitioners to manage patients with schizophrenia in general practice
	RQ2	There is no relationship between the social distance score for schizophrenia in psychiatrists and the psychiatrist’s belief that general practitioners should be confident in managing patients with schizophrenia in general practice
	RQ3	There is no relationship between the social distance score for schizophrenia in psychiatrists and the psychiatrist’s belief that general practitioners should not manage patients with schizophrenia in general practice

2.8.2. Null Hypothesis Mini Experiment Two – General Practitioners (RQ4, RQ5, RQ6)

General Practitioners	RQ4	There is no relationship between the social distance score for schizophrenia in general practitioners and the general practitioner's confidence in their own ability to manage patients with schizophrenia in general practice.
	RQ5	There is no relationship between the social distance score for schizophrenia in general practitioners and the general practitioner's confidence that general practitioners should be confident in managing patients with schizophrenia in general practice.
	RQ6	There is no relationship between the social distance score for schizophrenia in general practitioners and the general practitioner's belief that general practitioners should not manage patients with schizophrenia in general practice.

2.8.3. Null Hypothesis Mini Experiment 3 – Mental Health Service Users (RQ7, RQ8, RQ9)

Mental Health Service Users	RQ7	There is no relationship between the social distance score for schizophrenia in mental health service users and their confidence in their own general practitioner managing their mental health problems.
	RQ8	There is no relationship between the social distance score for schizophrenia in mental health service users and their confidence in their own general practitioner managing their other health problems.
	RQ9	There is no relationship between the social distance score for schizophrenia in mental health service users and the service users belief that their own general practitioner should be confident in managing their own mental health problems.

2.9. DATA MANAGEMENT AND ANALYSIS

The results of each returned social distance questionnaire and confidence in general practice management of serious mental illness and schizophrenia were entered onto version 21 of the SPSS statistics package for analysis.

2.9.1. Social Distance and Stereotype Questionnaire

The assumptions made when coding the answers to the social distance questionnaire were based on the factor loading scores and theories put forward by M. C. Angermeyer and H. Matschinger in their 2003 paper entitled “The Stigma of Mental Illness: Effects of Labelling on Public Attitudes Towards People with Mental Disorder” and their 2004 paper entitled “The Stereotype of Schizophrenia and its Impact on Discrimination Against people with Schizophrenia: Results from a Representative Survey in Germany.”

Taking the factor loading scores into account (M. C. Angermeyer and H. Matschinger 2004), the completed responses to the social distance and stereotype in schizophrenia questionnaires were coded as follows:

- Lower numerical scores meant more social distance for questions that reflected negative attribution:
  Strongly Agree = - 2, Agree = - 1, Undecided (which included any original missing data) = 0, Disagree = + 1, Strongly Disagree = + 2

- Three exceptions required the following coding based on factor loading:
  Strongly Agree = + 2, Agree = + 1, Undecided (which included any original missing data) = 0, Disagree = -1, Strongly Disagree = -2

The three exceptions were the statements that read:

D7- "Only a few dangerous criminals have schizophrenia"
C1 - "People with schizophrenia are generally highly intelligent"
C2 - "People with schizophrenia are often more creative than other people"

The sub scores from the social distance and stereotype questionnaire were summed to create an overall "Factor Score." This overall Factor Score was used as the dependent variable for the ANOVA and regression analyses.

2.9.2. Confidence Questions

The completed responses to all the confidence questions were coded as follows:

Strongly Agree = + 2, Agree = + 1, Undecided (which included any original missing data) = 0, Disagree = -1, Strongly Disagree – 2.

3. RESULTS

3.1. Table No. One:

Description of Populations Surveyed

Population	Questionnaires distributed		Questionnaires returned		Male respondents		Female respondents	
	n	%	n	%	n	%	n	%
Psychiatrists	180	100	76	42.2	47	61.8	29	38.2
General Practitioners	170	100	72	42.4	46	63.9	26	36.1
Mental Health Service Users	158	100	66	41.8	36	54.5	30	45.5

Table No. One describes the population surveyed and the percentage of returned questionnaires by group.

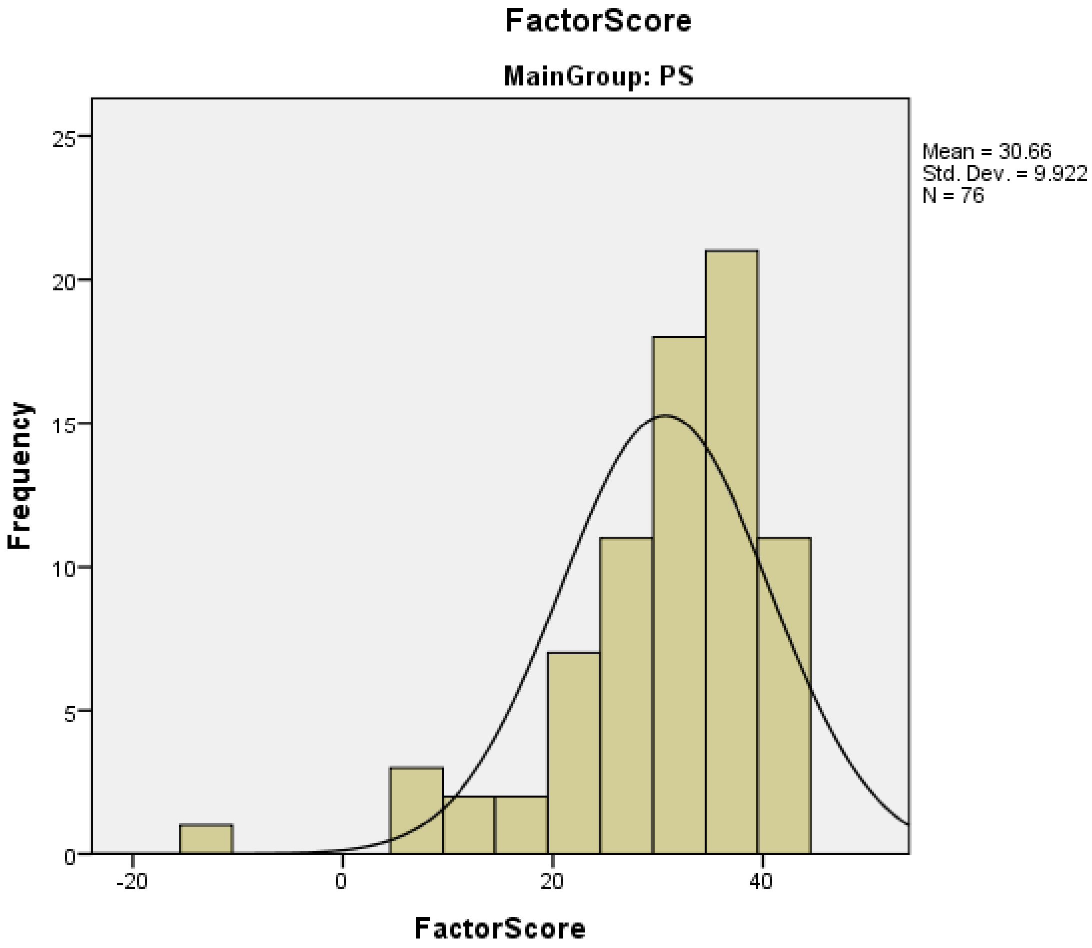
The percentage of returned questionnaires was very similar in all three groups.

41.8% of Mental Health Service Users returned completed questionnaires; 42.4% of General Practitioners returned completed questionnaires and 42.2% of Psychiatrists returned completed questionnaires

More males that females returned questionnaires in all three groups.

3.2. Chart No. One:

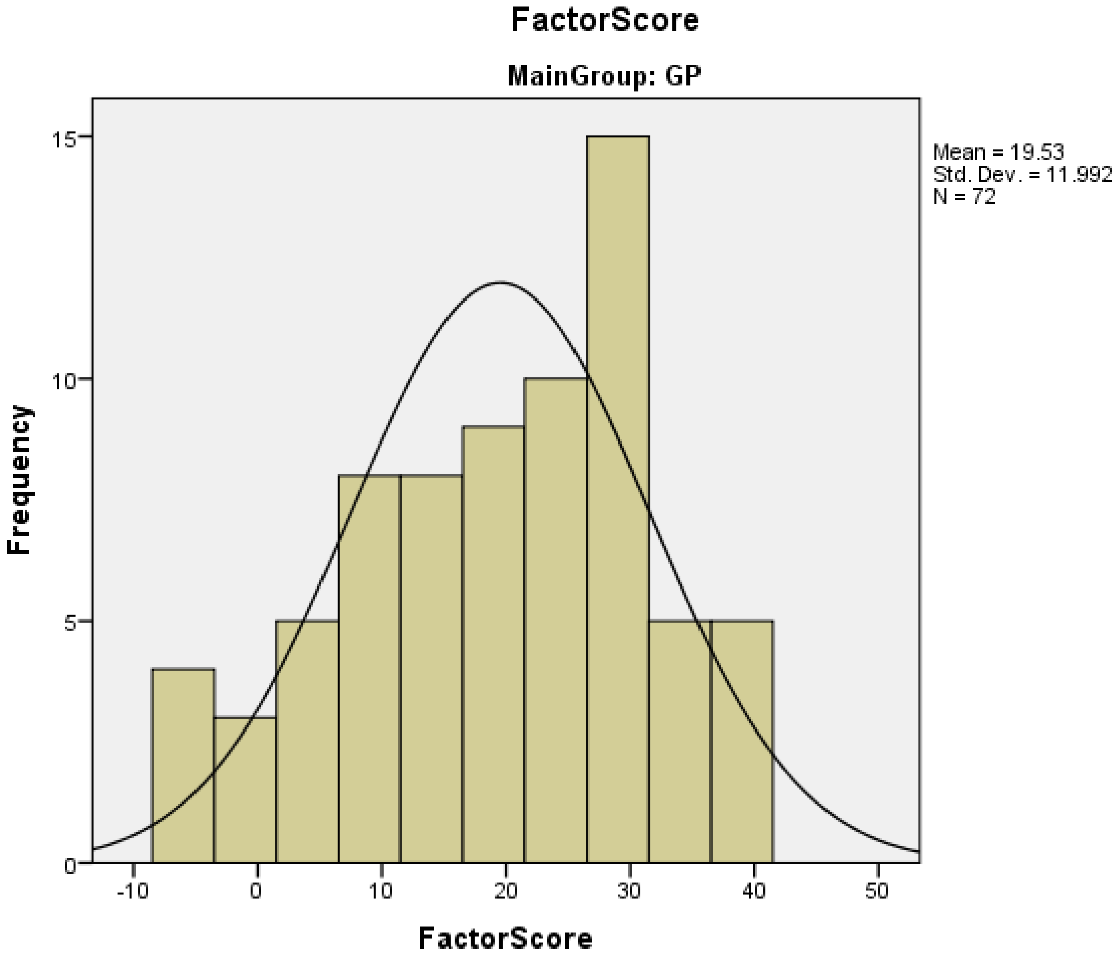
Histogram of Distribution of Psychiatrists Social Distance for Schizophrenia



The mean score for social distance for schizophrenia in psychiatrists was 30.66 and is skewed to the right.

3.3. Chart No Two:

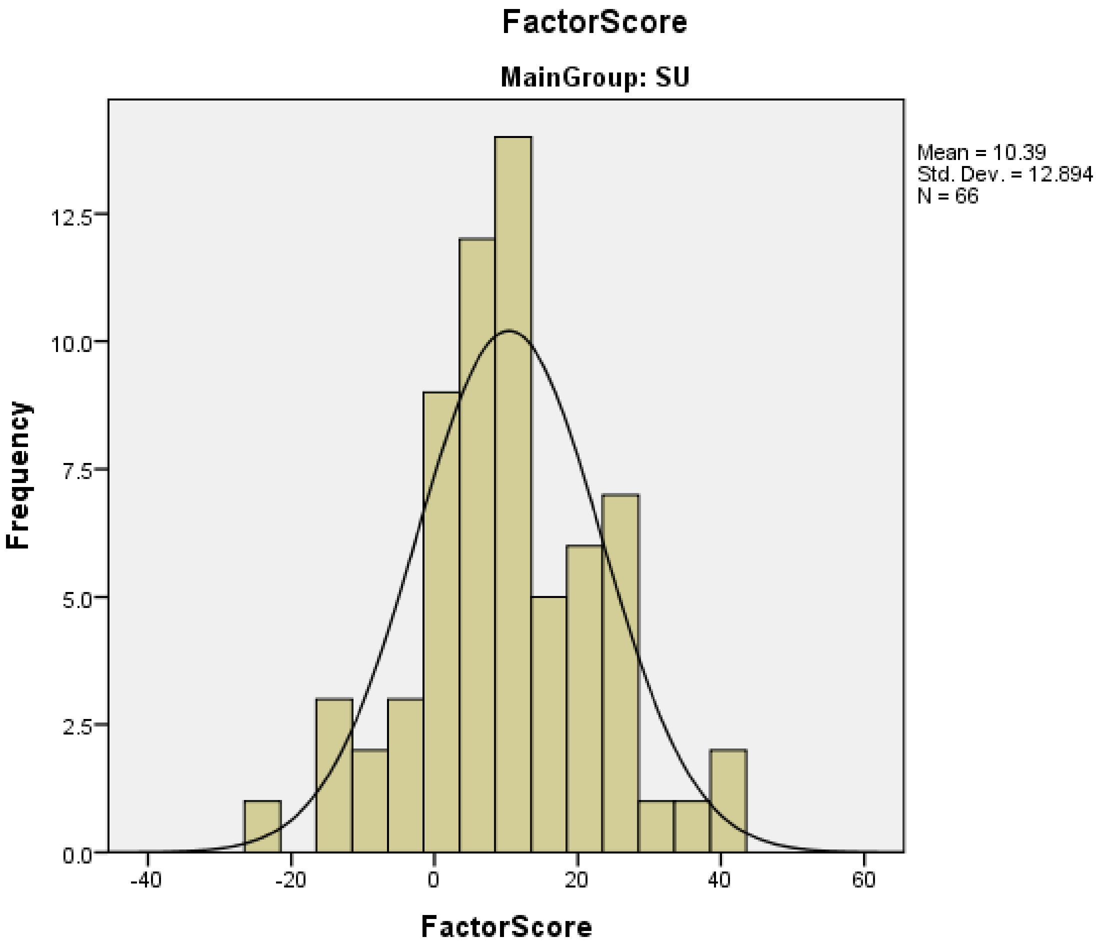
Histogram of Distribution of General Practitioners Social Distance for Schizophrenia



The mean score for social distance for schizophrenia in general practitioners psychiatrists was 19.53 and follows a normal distribution.

3.4. Chart No. Three:

Histogram of Distribution of Mental Health Service Users Social Distance for Schizophrenia



The mean score for social distance for schizophrenia in mental health service users was 10.39 and follows a normal distribution.

3.5. PSYCHIATRISTS: RELATIONSHIP BETWEEN SOCIAL DISTANCE AND CONFIDENCE IN MANAGEMENT OF SCHIZOPHRENIA IN GENERAL PRACTICE

3.5.1 Table No. Two: Pearson Correlations Between Psychiatrists Factor Scores and GP Confidence Questions (n = 76)

	Factor Score	1	2	3
Factor Score	1.00			
1. I am confident that GP's can manage patients with schizophrenia in their practice	0.198	1.00		
2. GP's should be confident in managing patients with schizophrenia in their practice	0.237	0.536	1.00	
3. GP's should not manage patients with schizophrenia in their practice	0.349	0.272	0.617	1.00

3.5.2 Table No. Three: ANOVA - Psychiatrists Confidence Question One

"I am confident that GP's can manage patients with schizophrenia in their practice"

	Sum of Squares	df	Mean Square	F	Significance
Regression	289.575	1	289.575	3.021	0.086
Residual	7093.531	74	95.859		
Total	7383.105	75			

3.5.3 Table No. Four: ANOVA - Psychiatrists Confidence Question Two

"GP's should be confident in managing patients with schizophrenia in their practice"

	Sum of Squares	df	Mean Square	F	Significance
Regression	415.539	1	415.539	4.413	0.039
Residual	6967.567	74	94.156		
Total	7383.105	75			

3.5.4 Table No. Five: ANOVA - Psychiatrists Confidence Question Three

"GP's should not manage patients with schizophrenia in their practice"

	Sum of Squares	df	Mean Square	F	Significance
Regression	901.494	1	901.494	10.292	0.002
Residual	6481.612	74	87.589		
Total	7383.105	75			

3.6. GENERAL PRACTITIONERS: RELATIONSHIP BETWEEN SOCIAL DISTANCE AND CONFIDENCE IN MANAGEMENT OF SCHIZOPHRENIA IN GENERAL PRACTICE

3.6.1. Table No. Six: Pearson Correlations Between General Practitioner Factor Scores and GP Confidence Questions (n = 72)

	Factor Score	1	2	3
Factor Score	1.00			
1. I am confident in managing patients with schizophrenia in my practice	0.281	1.00		
2. GP's should be confident in managing patients with schizophrenia in their practice	0.301	0.735	1.00	
3. GP's should not manage patients with schizophrenia in their practice	0.282	0.546	0.576	1.00

3.6.2. Table No. Seven: ANOVA - General Practitioners Confidence Question One "I am confident in managing patients with schizophrenia in my practice"

	Sum of Squares	df	Mean Square	F	Significance
Regression	806.714	1	806.714	6.005	0.17
Residual	9403.231	70	134.332		
Total	10209.944	71			

3.6.3. Table No. Eight: ANOVA General Practitioners – Confidence Question Two "GP's should be confident in managing patients with schizophrenia in their practice"

	Sum of Squares	df	Mean Square	F	Significance
Regression	926.859	1	926.859	6.989	0.010
Residual	9283.086	70	132.616		
Total	10209.944	71			

3.6.4. Table No. Nine: ANOVA General Practitioners Confidence Question Three "GP's should not manage patients with schizophrenia in their practice"

	Sum of Squares	df	Mean Square	F	Significance
Regression	810.372	1	810.372	6.035	0.017
Residual	9399.573	70	134.280		
Total	10209.944	71			

3.7. MENTAL HEALTH SERVICE USERS: RELATIONSHIP BETWEEN SOCIAL DISTANCE AND CONFIDENCE IN THE MANAGEMENT OF MENTAL AND PHYSICAL HEALTH IN GENERAL PRACTICE (n=66)

3.7.1. Table No. Ten: Pearson Correlations Between Mental Health Service User Factor Scores and GP Confidence Questions (n = 66)

	Factor Score	Q 1	Q 2	Q 3
Factor Score	1.00			
1. My GP is confident in managing my mental health problems	0.130	1.00		
2. My GP is confident in managing my other health problems	0.086	0.826	1.00	
3. My GP should be confident in managing my mental health problems	0.002	0.467	0.357	1.00

3.7.2. Table No. Eleven: ANOVA Mental Health Service Users Confidence Question One

"My GP is confident in managing my mental health problems"

	Sum of Squares	df	Mean Square	F	Significance
Regression	1.689	1	1.689	0.010	0.921
Residual	10804.069	64	168.814		
Total	10805.758	65			

3.7.3. Table No. Twelve: ANOVA Mental Health Service Users Confidence Question Two

"My GP is confident in managing my other health problems"

	Sum of Squares	df	Mean Square	F	Significance
Regression	76.189	1	79.189	0.472	0.494
Residual	10726.569	64	167.603		
Total	10805.758	65			

3.7.4. Table No. Thirteen: ANOVA Mental Health Service Users Confidence Question Three

"My GP should be confident in managing my mental health problems"

	Sum of Squares	df	Mean Square	F	Significance
Regression	0.029	1	0.029	0.000	0.990
Residual	10805.729	64	168.840		
Total	10805.758	65			

3.8.OVERALL FINDINGS

3.8.1 Table No. Fourteen: Findings Mini Experiment One – Psychiatrists

	Research Question Posed	**p value**	**Sig**	**Finding**
RQ 1	What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist's confidence in the ability of general practitioners to manage patients with schizophrenia in general practice?	0.086	ns	There is a non- significant relationship between psychiatrists social distance for schizophrenia and their confidence in the ability of general practitioners to manage schizophrenia in general practice
RQ 2	What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist's belief that general practitioners should be confident in managing patients with schizophrenia in general practice?	0.039	<0.05	There is a significant relationship between psychiatrist's social distance for schizophrenia and their belief that general practitioners should be confident in managing schizophrenia in general practice. Those psychiatrists who think that GP's should be confident in managing schizophrenia have lower social distance.
RQ 3	What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist's belief that general practitioners should not manage patients	0.002	<0.01	There is a significant relationship between psychiatrist's social distance for schizophrenia and their belief that general practitioners should not manage patients with schizophrenia in general

	with schizophrenia in general practice?			practice. The greater the psychiatrists agreement with this question the less the social distance

3.8.2 Table No. Fifteen: Findings Mini Experiment Two – General Practitioners

	Research Question Posed	**p value**	**Sig**	**Finding**
RQ 4	What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner's personal confidence in managing patients with schizophrenia in general practice?	0.017	<0.05	There is a significant relationship between general practitioner's social distance for schizophrenia and their belief that general practitioners should be confident in managing patients with schizophrenia in general practice. The greater the GP's agreement with this question the less the social distance
RQ 5	What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner's confidence that general practitioners should be confident in managing patients with schizophrenia in general practice?	0.010	<0.01	There is a significant relationship between general practitioner's social distance for schizophrenia and their belief that general practitioners should be confident in managing schizophrenia in general practice. The greater the GP's agreement less the social distance.
RQ 6	What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner's belief that general practitioners should not manage patients with schizophrenia in general	0.017	<0.05	There is a significant relationship between general practitioner social distance for schizophrenia and their belief that general practitioners should not manage patients with schizophrenia in general practice. The greater the GP's agreement with this question the

	practice?			less the social distance.

3.8.3 Table No. Sixteen: Findings Mini Experiment Three – Mental Health Service Users

	Research Question Posed	**p value**	**Sig**	**Finding**
RQ 7	What is the relationship between social distance for schizophrenia in mental health service users and their confidence in their own general practitioner managing their mental health problems?	0.921	ns	There is no relationship found
RQ 8	What is the relationship between social distance for schizophrenia in mental health service users and their confidence in their own general practitioner managing their other health problems?	0.494	ns	There is no relationship found
RQ 9	What is the relationship between social distance for schizophrenia in mental health service users and the service users belief that their own general practitioner should be confident in managing their own mental health problems?	0.990	ns	There is no relationship found

CHAPTER FOUR

4. DISCUSSION

This research brings together two critical components that have the potential to affect how patients access primary care mental health; social distance for people with schizophrenia and serious mental illness and confidence in general practitioners to manage these conditions in primary care.

Often, patients who suffer from mental illness do not make best use of standard medical facilities such as general practice facilities, and other primary care services. This puts them in a disadvantaged position when it comes to their health needs, especially as there is evidence that primary care is effective, more accessible and produces more positive long-term outcomes leading to a reduction in mortality and morbidity (B. Starfield et al 2005; WHO 2008; M. Funk and G. Ivbijaro 2008).

The World Organisation of Family Doctors (Wonca) and the World Health Organisation (WHO) published a document on Primary Care Mental Health in 2008 (M. Funk & G. Ivbijaro 2008). This publication concluded that integration of mental health service users into primary care provides the best option for mental health service users, similar to the findings of Barbara Starfield (2005).

We need to find ways to ensure that psychiatrists, general practitioners and mental health service users work together in a collaborative way to identify and address barriers to good health.

The three mini experiments reported here build on evidence from the literature that effective collaboration between mental health service users, primary and secondary care can lessen the barriers to access to mental and physical health.

This research has chosen to measure social distance in schizophrenia as a proxy for mental health stigma. Social distance for schizophrenia has been measured in general practitioners, psychiatrists and other mental health professionals and has robust content and face validity (M. C. Angermeyer and H. Matschinger 2004; V. Carr et al 2004; B. G. Link et al 2004; M. Angermeyer and H. Matschinger 2005; A. L. Smith and C. S. Cashwell 2011).

This research also measures general practitioner skills using the proxy measure of confidence (D. Goldberg and P. Huxley 1980; R. Gater 1991; P. F. M. Verhaak 1995; T. Burns and T. Kendrick 1997; S. Kerwick et al 1997).

4.1. PSYCHIATRISTS

The research questions asked about the psychiatrists total social distance scores for schizophrenia and the relationship to confidence in managing schizophrenia in general practice were:

RQ 1 What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist’s confidence in the ability of general practitioners to manage patients with schizophrenia in general practice?

RQ 2 What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist’s belief that general practitioners should be confident in managing patients with schizophrenia in general practice?

RQ 3 What is the relationship between social distance for schizophrenia in psychiatrists and the psychiatrist’s belief that general practitioners should not manage patients with schizophrenia in general practice?

The findings were that there was no relationship between psychiatrist’s social distance for schizophrenia and their confidence in the ability of general practitioners to manage schizophrenia in general practice (See 3.5.2. Table No. Three). However, psychiatrists believed that general practitioners should be confident in managing schizophrenia in general practice (see 3.5.3 Table No. Four).

Looking at these findings the inference that one can draw is that although psychiatrists think that in theory general practitioners should be skilled and confident in managing people with schizophrenia in their practice they did not have confidence in general practitioners ability to do so (see 3.5.4. Table No. Four).

There was a significant relationship between psychiatrist’s social distance for schizophrenia and their belief that general practitioners should not manage patients with schizophrenia in general practice from which one can infer that psychiatrists think that only they have the skills and confidence to manage people with schizophrenia.

If we take into account he Goldberg and Huxley Filter-Model (1980), patients with a diagnosis of schizophrenia are easily recognised by general practitioners and more readily referred to secondary care. However, once they reach secondary care, the psychiatrists belief that only they can manage people with schizophrenia such patients are not readily referred back to have their long term mental health condition managed in general practice.

This is consistent with the findings of the Mental Health Case for Change for London (London Health Programmes 2012a) therefore perpetuating and reinforcing the negative stereotype and stigma associated with mental health resulting in patients with a mental health diagnosis not receiving a holistic evidence based primary care that tackles mental and physical health co-morbidity (M. Funk and G. Ivbijaro 2008; B. Starfield 2005; N. H. Liu et al 2017).

In order for psychiatrists in East London to actively initiate referral back to primary care there is a need to recognise that the Goldberg Huxley Filter Model needs to be bi-directional. In addition there is a need to improve mental health literacy among psychiatrists so that they can recognise that the best evidence to support mental health recovery is through a multi -level intervention framework such as that put forward by Liu et al (2017). If not the well - recognised premature mortality in people with long term mental health conditions such as schizophrenia will continue.

The current literature shows that people with mental health conditions, such as schizophrenia and bipolar affective disorder have a mortality rate two to three times higher than the general population (C. W. Colton, R. W. Manderscheid 2006; T. M. Lauren et al 2012; E. E. McGinty et al 2016, M. Funk and G. Ivbijaro 2008). The majority of excess mortality in this group of people can be attributed to preventable conditions such as diabetes, COPD (chronic obstructive pulmonary disease), obesity, other metabolic syndromes, cardiovascular disease. Many of these conditions have effective primary care interventions such as smoking cessation, dietary advice and weight loss programmes and medication management (N. H. Liu et al 2017).

4.2 GENERAL PRACTITIONERS

The research questions asked about the general practitioners total social distance scores for schizophrenia and the relationship to confidence in managing schizophrenia in general practice were:

RQ 4 What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner's personal confidence in managing patients with schizophrenia in general practice?

RQ 5 What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner's confidence that general practitioners should be confident in managing patients with schizophrenia in general practice?

RQ 6 What is the relationship between social distance for schizophrenia in general practitioners and the general practitioner's belief that general practitioners should not manage patients with schizophrenia in general practice?

The findings were reassuring because general practitioners had confidence in their personal ability to manage people with schizophrenia (see 3.6.2 Table No. Seven) and also believed that their general practice colleagues should be confident in managing patients with schizophrenia in General Practice (see 3.6.3 Table No. Eight).

The findings show that the higher the confidence the less the social distance for schizophrenia. This is consistent with the findings that familiarity with people who have a mental health condition reduces mental health stigma.

Familiarity with mental illness has been shown to be a factor in reducing social distance in (V. J. Carr et al 20014; A. C. Watson et al 2007). In trying to shed light on familiarity and social distance in people with a serious mental illness such as schizophrenia (P. W. Corrigan et al 2001) 208 college students in the United States of America were studied. Over 90% had previous contact with people with a mental illness through films, two thirds had previous contact with people with a mental illness through documentaries, one third had friends or family members with a mental illness, 25% had worked alongside somebody with a mental illness and 2% disclosed a diagnosis of serious mental illness. The findings were that familiarity resulted in decreased social distance towards people with a serious mental illness. The inference that we can draw from this is that providing more teaching to general practitioners about mental health will lower the social distance resulting in improved outcomes for people with a mental disorder.

The findings of this mini experiment showed that, despite general practitioners being confident in their own personal skills in managing people with schizophrenia in general practice and had confidence in their colleagues to do so they did not think that general practitioners should manage patients with schizophrenia in their practice (see 3.6.4 Table No. Nine).

This discrepancy needs to be explored further because the literature tells us that people with a mental illness attend appointments with their general practitioner significantly more frequently when compared to members of the general population (I. Nazareth et al 1993; T. Burns and T. Kendrick 1997).

4.3 MENTAL HEALTH SERVICE USERS

The research questions asked about the mental health service users total social distance score for schizophrenia and the relationship to confidence in their mental and physical health needs being manged in general practice were:

RQ 7 What is the relationship between social distance for schizophrenia in mental health service users and their confidence in their own general practitioner managing their mental health problems?

RQ 8 What is the relationship between social distance for schizophrenia in mental health service users and their confidence in their own general practitioner managing their other health problems?

RQ 9 What is the relationship between social distance for schizophrenia in mental health service users and the service users belief that their own general practitioner should be confident in managing their own mental health problems?

The conclusions that can be drawn from mini experiment three are that there is no relationship between social distance in schizophrenia and the three general confidence questions asked (see 3.7.2. Table No. Eleven; 3.7.3 Table No. Twelve; 3.7.4 Table No. Thirteen).

An inference that can be drawn which is consistent with the literature is that mental health service users feel stigmatised and discriminated against by the general public and by the health care system as a whole. Health care system barriers include inadequate training, discriminatory policies, poor accountability and poor mental health governance.

Discrimination and social exclusion contribute to the difficulty in achieving mental health integration in Primary Care and new ways of dealing with this problem are needed particularly as mental illness contributes to the increasing costs of hospitalisation (A. Bowling 1997; D. De Vaus 2002; R. Winter & C. Munn-Giddings 2001; G. Ivbijaro et al 2014).

In the United States public stigma about mental illness is widespread and leads to many negative consequences for the individuals concerned, irrespective of age (A.M. Parcepese et al 2013). The 1999 US Surgeon General’s Report noted that public stigma and negative attitudes to mental health significantly contribute to poor engagement for people who use mental health services, poor retention of those people who engage with mental health services, poor treatment adherence and subsequent poor outcomes (US Department of Health and Human Services 1999).

Mental health stigma is not limited to the general public. It occurs in people who offer treatment to people with mental health difficulties, and in people that use mental health services (A. C Watson et al 2007; S. Wrigley et al 2005; S. H. A. Hernandez et al 2014; A. C. Iversen et al 2011; C. Nordt et al 2006). Families and carers are stigmatised because of their relationship to people with a mental illness a concept known as courtesy stigma (E. Goffman 1963), or stigma by association.

When a person with a diagnosed mental illness has co-morbid physical health conditions they often do not receive the evidence based interventions for their physical health conditions that they need.

There is robust evidence from cardiology that shows that the stigma associated with mental illness results in people not being put forward for this effective cardiovascular procedure. (B. G. Druss et al 2000) and this also true for other common elective surgical procedures (Y. Li et al 2011) and, once referred, people with mental illness who undergo a surgical procedure are more likely to suffer from post-surgical complications (B. G. Druss et al 2001).

The inference from the mental health service users responses about social distance for schizophrenia and confidence in primary care to deliver good physical and mental health outcomes is that the current system of primary care has no effect of reducing mental health stigma as reflected by total social distance scores for schizophrenia.

Health care providers, particularly general practitioners/family doctors and psychiatrists need to do more to engage their patients with a mental health diagnosis so that stigma can be reduced so that patients can feel confident that they will get what they need for their mental and physical health when using health services. There is evidence in the literature that general practitioners are sometimes in a hurry when they see people with a mental health condition and therefore miss crucial physical and mental health cues provided by patients during the consultation (Toews et al 1996; Craven et al 1997; Falloon et al 1996).

As already described, the literature review found that mental health stigma and discrimination as assessed by social distance occurs in mental health service users such as those with a diagnosis of schizophrenia and affects their access to health.

Those people who work with mental health service users and the families of mental health service users also experience stigma and discrimination, so called courtesy stigma or stigma by association.

The public attitude to mental health service users remains negative despite over fifty years of mental health anti-stigma campaigns.

We need to do more if we are to tackle the earlier mortality and access to health for people that experience mental health conditions and the research presented here begins the journey to develop new initiatives and new partnerships.

4.4. OPPORTUNITIES

The Psychiatrists mean Factor Score is 30.66, the General Practitioners mean Factor Score is 19.53 and the Mental Health Service Users mean Factor Score is 10.39 (see 3.2 Chart No. One; 3.3 Chart No. Two; 3.4 Chart No. Three). This suggests that Psychiatrists may have the least social distance for schizophrenia and the Mental Health Service Users the greatest social distance for schizophrenia with General Practitioners somewhere in between.

Working with my research team and collaborators, this data will be subjected to further statistical analysis and the findings published in a reputable peer reviewed journal.

Working with my research team and collaborators, we will further analyse the Factor Score by examining the five dimensions of stereotype which are dangerousness, attribution of responsibility, creativity, unpredictability/incompetence and poor prognosis and how they relate to confidence in the general practice management of schizophrenia and mental health using the lens of the Psychiatrist, General Practitioner and Mental Health Service User.

We will use the information from the overall study to inform the development of an assessment tool to assess social distance for mental health service users which can be used in the routine assessment of people with a mental health problem managed in primary care that is sensitive to change over time.

4.5. LIMITATIONS

These three mini experiments are part of a larger study that considers social distance and schizophrenia stereotype so there may be more relationships to be explored between confidence and the five dimensions of schizophrenia stereotype.

The response rate, although good for a survey of this type ranges between 41.8% is 42.4% in the groups surveyed. Those people that did not return the questionnaire may represent a different population and this needs to be kept in mind.

The majority of respondents are males. Research tells us that females generally have a lower social distance score in mental illness when compared to men (A. Holzinger et al 2012) so this needs to be kept in mind when interpreting our findings.

Although the majority of patients who responded live in East London, the psychiatrists and general practitioners who work in the area may not live in the area so this may also introduce another bias.

All the psychiatrists and general practitioners who took part in this survey are graduates which may not be the case for the mental health service users who participated and as education has a positive effect in reducing stigma in mental illness in adults (P. W. Corrigan et al 2012).

CHAPTER FIVE

4. CONCLUSION

I have provided a detailed literature review to understand the role of mental health stigma and discrimination and how it affects to health care. I have also provided the findings from three mini experiments examining the relationship between social distance and confidence in the general practice management of schizophrenia from a 360° perspective taking account the views of psychiatrists, general practitioners and mental health service users.

Taking account the findings from this group of East London health professionals and mental health service users regarding confidence in managing long term mental health conditions in primary care and reducing social distance for schizophrenia a great deal of work needs to be done to work with these three groups to improve mental health skills knowledge and confidence in primary care so that patients can feel more confident to use the mental and physical health services that are provided in primary care. Psychiatrists need to better understand that they cannot manage people with a diagnosis of schizophrenia alone especially as decreasing mortality and morbidity depends upon targeting evidence based care for physical health needs which is best provided in primary care.

The filters in the original Goldberg and Huxley Filter Model (1980) needs to be regarded as bidirectional if we are to achieve collaborative or integrated care in serious mental health conditions such as schizophrenia.

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CHAPTER SIX

6. THREE PUBLICATIONS – A CRITICAL REVIEW

6.1 INTRODUCTION

My work in primary care mental health at a global level dates back to 2001 and my thesis brings together the common thread of my work which is how to provide improved access to healthcare for people who suffer from mental health conditions irrespective of race, gender, social and economic status.

I have evidenced my achievements in this field by reviewing three of my past publications. These three publications bring together the role of policy in mental health access, the role of skills training in the primary care workforce to support this and the treatment options available as a result of collaborative care.

The three publications I will now critically review are:

i. Integrating mental health into primary care: A global perspective (Funk and Ivbijaro 2008)

ii. Companion to primary care mental health (Ivbijaro 2012)

iii. Informing mental health policies and services in the EMR: cost-effective deployment of human resources to deliver integrated community-based care (G. Ivbijaro et al 2015)

6.2 INTEGRATING MENTAL HEALTH INTO PRIMARY CARE: A GLOBAL PERSPECTIVE

M. Funk and G. Ivbijaro (Eds): Integrating Mental Health into Primary Care: A Global Perspective. World Health Organisation (WHO) and World Organization of Family Doctors (Wonca), 2008). ISBN: 978-92-4-156368-0.

I have chosen to critically review this publication because it is one of my most important contributions to the field of Mental Health in Primary Care. The evidence provided in this 2008 document was relevant globally then (C. Collins et al 2010) and remains relevant today (WHO 2013; G. Ivbijaro 2017; G. O. Ivbijaro et al 2014).

I am thankful to every person that contributed to this publication either as a contributor or reviewer, because this breadth of perspectives made a valuable contribution to its success.

In 2006, recognising that people with mental health conditions often have a lower life expectancy when compared to the general population and that this could be addressed by having better interventions in primary care settings, and recognising that there were already isolated good practice examples producing good outcomes that addressed this problem worldwide, I wrote a letter to the Director of the Department of Mental Health and Substance Abuse at the World Health Organization (WHO) in Geneva, Switzerland outlining the opportunity to address this significant global problem. I also formally highlighted this issue to the Chief Executive Officer and the President of the World Organization of Family Doctors (Wonca).

Once support from the WHO and Wonca was confirmed I arranged a stakeholder event during the First International Primary Care Health Conference of the Gulf and Arab States in Abu-Dhabi in January 2006. A position paper I had developed in collaboration with Michelle Funk at the WHO was presented, setting out the challenges faced by primary care mental health globally and suggestions about how family doctors can play their part (Wonca 2006). This meeting was a significant event because it gave me a global platform to sell my vision to primary care.

Image: WHO Wonca Stakeholder Event Abu-Dhabi 2006

This stakeholder meeting resulted in a formal collaboration between Wonca and the WHO that produced a WHO fact sheet about primary care mental health (WHO 2007). I then worked with Michelle Funk at the WHO to co-ordinate a detailed literature review which resulted in the publication in the final 2008 report Integrating Mental Health into Primary Care: A Global Perspective (M. Funk and G. Ivbijaro 2008).

This publication highlighted that hundreds of millions of people world-wide are affected by mental disorder. World-wide approximately 154 million people suffer from depression, approximately 25 million people suffer from schizophrenia, approximately 91 million people have an alcohol misuse disorder, approximately 15 million people have other substance misuse disorders, approximately 50 million people suffer from epilepsy, approximately 24 million people suffer from dementia and approximately 877,000 people die from suicide every year (page 23). The publication also showed that a significant number of people with mental disorder did not receive treatment (pages 24-25).

The publication highlighted the poor recognition of mental illness in the primary care setting in all countries regardless of region and economic status and there was regional variation with a rate of failure to recognise mental disorder ranging between 10-75%.

This publication highlighted evidence that enhanced primary care with good training can improve rates of recognition of mental illness in primary care and deliver treatment interventions with improved patient outcomes.

The report recommended that, based on the evidence highlighted by the literature review, integrated care provided an opportunity for primary care transformation and improved access to care or those with a mental illness.

The report outlined ten key principles for integration which are:

1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behaviour.
3. Adequate training of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Specialist mental health professionals and facilities must be available to support primary care.
6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process, not an event.
8. A mental health service coordinator is crucial.
9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
10. Financial and human resources are needed. (page 49)

The findings and recommendations from this publication have been well received globally and have led to improvements in service redesign and the range of interventions available to treat mental health in primary care.

A 2010 report entitled ‘Models of Behavioral Health Integration in Primary Care’ by the influential Milbank Foundation in the United States of America quoted the ten key principles for integration when it set the scene for making the case for change for integrated care in the United States of America, and endorsed them (C. Collins et al 2010). This resulted in many groups in the United States of America adopting the ten key principles in their integrated and collaborative care service re-design projects.

A recent American Psychiatric Association (APA) Academy of Psychosomatic Medicine (APM) Report entitled ‘Dissemination of Integrated Care within Adult Primary Care Settings: A Collaborative Care Model’ agreed with the publications initial 2008 findings that primary care can be transformed to do more mental health interventions. The APA and APM report highlighted the need for improved training in mental health and agreed that this was applicable to training across the whole spectrum of physical and mental disorder (APA 2016).

Many researchers and practitioners have found the 2008 publication ‘Integrating Mental Health into Primary Care: A Global Perspective’ very useful. A United States of America example from the nursing profession is a mini review of integrated care that also identified a need to improve training and review skill mix to deliver better quality integrated care (D. McIntosh et al 2015). Just as in our 2008 publication, McIntosh et al (2015) highlighted leadership as key and reiterated that integrated or collaborative care results in good patient outcomes. This was also highlighted by another 2015 nursing paper considering curricular enhancement to better integrate mental health into the management of chronic disease (C. C. Hendrix et al 2015).

An important finding highlighted by ‘Integrating Mental Health into Primary Care: A Global Perspective’ was that integration into primary care can reduce the stigma associated with mental illness and can improve skill mix with associated improvements in health worker job satisfaction.

A 2017 survey of physician satisfaction with integrating mental health into pediatric care carried out in the United States of America found that there was significantly increased satisfaction in physicians who worked in an integrated care setting with increased access to care compared with those that did not. This survey also found that integrating mental health into pediatric care decreased barriers encountered by families and individuals compared to those receiving care from non-integrated care systems (J. F. Hine et al 2017).

Page 15 of the World Health Organization Mental Health Action Plan 2013-2020 notes that integrating mental health into general health was a way forward in tackling the skills shortage, early diagnosis and the treatment gap that currently exit in mental illness (WHO 2013). This is an endorsement of the findings of the original 2008 Integrating Mental Health into Primary Care: A Global Perspective publication.

A 2014 joint publication by the World Health Organization and the Calouste Gulbenkian Foundation entitled ‘Integrating the Response to Mental Disorders and Other Chronic Diseases in Health Care Systems’ also drew on the original conceptualisation for mental health integration proposed ‘Integrating Mental Health into Primary Care: A Global Perspective.’ The 2014 WHO/Calouste Gulbenkian publication noted a need for a whole systems and multi-sectoral approach to ensure that integrated care was central to the delivery of patient care and, on page 25, reinforced the importance of the original ten principles put forward in the 2008 publication (WHO 2014).

There is evidence to show that Integrating Mental Health into Primary Care: A Global Perspective has been an important element in mental health policy and scaling up health services worldwide.

A situational analysis of mental health in the Eastern Mediterranean region identified the skills shortage in the region and noted that training of the primary care workforce in mental health would improve this populations access to better mental health, noting that numbers of workers in primary care trained in metal health was low (R. Gater et a 2015).

A need for de-centralisation and de-institutionalisation of mental health services to an integrated community based model was suggested as the way forward to tackle this skills gap and improve access (B. Saraceno et al 2015).

Transformation of primary care in this region is possible and requires government policies to support this which, if done properly, can lead to a reduction in stigma and better, earlier access (Ivbijaro et al 2015).

A 2017 literature review noted that there was still excess mortality for people with mental illness was due to multiple factors, and suggested the need to intervene at multiple levels in a coherent way which also lends itself to the effective implementation of collaborative care (N. H. Liu et al 2017).

In a commentary to this paper it was noted that there has been a systematic failure of policies to address mental and physical illness co-morbidity and, just as recommended in the 2008 publication, collaborative care should be actively encouraged (G. Ivbijaro 2017). Integrated primary care has also been proposed as a way forward in the 2013 Commonwealth Health Partnerships Review (G. Ivbijaro 2013).

Effective integrated and collaborative care is cost-effective as demonstrated by the 2016 APA/APM review and expenditure can be reduced with effective collaborative care (G. Ivbijaro 2014; G. O. Ivbijaro et al 2014).

6.3 COMPANION TO PRIMARY CARE MENTAL HEALTH

G. Ivbijaro (Ed.). *Companion to Primary Care Mental Health.* Wonca and Radcliffe Publishing, UK,2012. ISBN-13: 978-1846199769. ISBN-10: 184619976X

Another important global contribution made to the field of primary care mental health is a book that I edited called the Companion to Primary Care Mental Health (G. Ivbijaro 2012).

The link between the Companion to primary Care Mental Health (2012) and Integrating Mental Health into Primary Care: A Global Perspective (M. Funk and G. Ivbijaro 2008) is straightforward.

The first publication set out the evidence for primary care mental health and the need to intervene and additional training is required to support the implementation of policies to better integrate mental health into primary care.

Primary care mental health is an emerging discipline and, if it is to be promoted, family doctors and other primary care workers interested in mental health needed a resource to support new developments in this field. The Companion to Primary Care Mental Health was conceptualised to provide the knowledge and skills required by the range of professionals working in this emerging field.

I started the project by using my skills in literature search, primary care re-design and project management to bring together over one hundred contributors from all over the world from a range of mental health disciplines. Each chapter of the book was peer reviewed and I am thankful to the peer reviewers for their contribution because the book has been a great success.

In 2012 the Companion to Primary Care Mental Health was reviewed using the The Doody’s review process described below:

‘For each specialty, there is an Editorial Review Group Chair (ERG Chair) who coordinates reviews of titles in his/her field. The Chairs work with over 5,000 academically-affiliated clinicians who prepare a formatted review and fill out a ratings questionnaire for each title. The reviewer’s name and affiliation appear with each review.

Unique to the review process is the Doody's Star Rating that accompanies each review. The stars correlate to the numerical ratings that are derived from an 18-point *questionnaire completed by the reviewer in the course of assessing the title. The questionnaire highlights 16 different elements (such as the authority of the authors, and the quantity, currency, and pertinence of the references) of the title. The reviewer must rate each element essentially on a 5-point scale.*

When the reviewer's responses are entered into Doody's system, a rating is automatically calculated. The highest rating a title can receive is 100 and the lowest is 20. When plotted, the ratings produce a bell-shaped curve on the high end of the 20-100 scale, which makes sense in light of the quality control publishers exercise before investing in the publication of a new title or a revision.

The numerical scores result in 1- to 5-star ratings and titles that fall into each category can be described as follows:

- *5 stars (97-100) Exceptional title with nearly flawless execution*
- *4 stars (90-96) Outstanding title, with minor problems in execution*
- *3 stars (69-89) Very good title, but usually with one or more significant flaws*
- *2 stars (47-68) Average title, usually with several flaws (or one major flaw) or significant weakness versus its competition*
- *1 star (<47) Substandard title*

Overall, 8% of the titles have received 5 stars, while 11% have received 2 stars or less.

The rating system helps ensure that each review is as fair and as objective as possible. Thus, Doody's Book Reviews™ incorporate a good blend of quantitative and qualitative analysis in the reviews. As a result, they have become well known around the world for reflecting a timely, expert, unbiased approach to rating medical publications.'

The Companion to Primary Care Mental Health was awarded a five-star 100% Doody's Book Review.

The Doody's review attests to the methodology used to develop this publication, including the evidence used and it's utility in supporting everyday practice. This publication understood the problem that needed to be addressed both at a population and individual level, looked at possible interventions across settings and in different economic circumstances and provides an opportunity for people to develop a framework against which they can measure their performance.

A book review published in a family medicine journal in 2014 (W. Ventres 2014) described the Companion to Primary Care Mental Health as a single volume publication that concisely brings together the evidence for primary care mental health. The reviewer stated:

'In a systematic fashion, interweaving individual and local population-based case studies from high-, middle-, and low-income countries, the Companion reviews rationales for involving primary care physicians in mental health services, processes for developing these services and collaborative models, and principles for implementing interventions.'

This reviewer commented that psychiatrists, family doctors, psychologists and those people interested in integrated care would find the book very useful. The reviewer also stated that this publication was an excellent complement to Integrating Mental Health into Primary Care: A Global Perspective, and I agree with this sentiment.

A book review by Padma de Silva from Australia (de Silva 2014) also recommended the publication and stated:

'I highly recommend this book because the authors have succeeded in compiling vast amounts of information and knowledge into a single work of reference. This book guides health professionals, not only on the treatment, but also on the practical aspects of integrating management of the patient holistically, in any primary health care setting.'

One of the scientific principles informing my design of this book was the realisation that over 95% of mental health problems globally are dealt with in primary care (M. Agius et al 2005). M. Agius et al listed twenty-eight standards that needed to be met it order to be able to treat the majority of people presenting to primary care with a mental illness and recommended ongoing training provided using evidence based medicine. The design of the Companion to Primary Care Mental Health into thirty-three chapters provides an incremental, manageable way for doctors in primary care to learn the knowledge and skills that they require to manage mental health problems effectively in their daily practice.

Primary Care Mental Health is not only for common mental health conditions but is also for serious mental health conditions including schizophrenia and bipolar disorder, and the Companion to Primary Care Mental health followed Agius et al's recommendations by describing the skills required to manage schizophrenia, bipolar disorder and substance misuse at a community level.

A review about improving psychiatric knowledge, skills and attitudes in primary care physicians over a 50 year period until 2000 identified a gap in the training of family doctors and psychiatrists (B. Hodges et al 2001). Part of the aim behind producing the Companion to Primary Care Mental Health was to address this training gap.

The Companion to Primary Care Mental Health is being used in many residency and postgraduate programmes as a core text and the chapter on schizophrenia has been referenced by nurses in a review of treatment and discharge planning in schizophrenia (D. Simona, B. Marshall 2017). Chapters of this book have been widely drawn on to support training, research and dissemination. An example is the schizophrenia chapter that has been re-printed in Ghana (A. Ofori-Atta and S. Ohene 2014). The chapter on mental health evaluation has also recently been cited in an article about collaborative and integrated care in substance misuse (B. Rush 2014).

The Companion to Primary Care Mental Health was used in the design and development of the Primary Care Mental Health Diploma programme at NOVA University, Lisbon and was subsequently used as the basis for making an application for accreditation for a Masters Degree. The NCE/14/00061 feedback about the course design was that:

‘this Masters is quite unique in Europe and will fill a gap in the training offer for highly trained professionals in mental health in the context of primary care.’

In a personal communication to me a leading psychiatrist Professor Norman Sartorius described the Companion to Primary Care Mental Health as my opus, meaning that it was a large scale artistic work which was an honour. My hope is that we can continue to produce more such publications to address mental health knowledge and skills gaps so that we can narrow the science to service gap in mental health to benefit of patient outcomes.

6.4 INFORMING MENTAL HEALTH POLICIES AND SERVICES IN THE EMR: COST-EFFECTIVE DEPLOYMENT OF HUMAN RESOURCES TO DELIVER INTEGRATED COMMUNITY-BASED CARE.

G. Ivbijaro, V. Patel, D. Chisholm, D. Goldberg, T. A. M. Khoja, T. M. Edwards, Y. Enum, L. A. Kolkiewicz. “Informing Mental Health Policies and Services in the EMR: Cost-Effective Deployment of Human Resources to Deliver Integrated Community-Based Care”. In: *Eastern Mediterranean Health Journal.* 2015, 21(7), pp. 486-492.

This publication to support the delivery of the expectations of the Global Mental Health Action Plan 2013-2020 was brought together so that access to mental health can be realised in the World Health Organisation Eastern Mediterranean Region. I carried out a detailed literature review and wrote a draft paper which was shared with the wider group for their comments and feedback, before submission for final peer review.

This publication further builds on my previous work in the report ‘Integrating Mental Health into Primary Care: A Global Perspective’ (2008) and provides a platform and methodology for skilling up services across the Eastern Mediterranean Region. The information in this publication can also be generalised and used by other WHO Regions.

The publication draws on global tools and instruments, such as the Global Mental Health Action Plan 2013-2020, as the basis for understanding the problems faced. It also enabled me to apply the skills I had already utilised as a member and contributor to the 2011 Mental Health Services Case for Change for London (London Health Programmes 2011 a; 2011 b) and lead author for the management of long term mental health conditions (London Health Programmes 2011 b).

Proposing service change in the Eastern Mediterranean Region requires an understanding of the role of culture and gender in accessing care. I drew upon my previous work in understanding the role of culture and gender in health (G. O. Ivbijaro et al 2005; G. O. Ivbijaro 2010; S. Parvizy et al 2013). This helped me to better understand how to frame the publication using language that would be acceptable in the Eastern Mediterranean Region.

In developing this publication I reflected on the concept of ‘No mental health without primary care’ put forward in 2008 (G. Ivbijaro, M. Funk 2008) and the Wonca description of the role of family doctors (Wonca 1991).

This publication recognises the need for workforce transformation and skill mix in order to be able to provide the necessary care, and key enablers for successful workforce transformation are specifically listed out on page 448.

The key enablers include a clear philosophy underpinning the proposed service structure, leadership and clinical champions, infrastructure needs and the legal framework to support change. These key enablers are consistent with those proposed by other authors (C. A. Dubois and D. Singh 2009; B. D. Fulton et al 2011).

I developed a diagrammatic schema to enable the readership to better understand how to develop primary care networks, and their relationship to other community services including hospitals recognising that not all patients can have their mental health needs fully managed in primary care (D. Goldberg, P. Huxley 1980) because approximately 5% of people with a common mental health condition will require secondary care input (M. Agius et al 2005). This diagrammatic schema is reproduced on page 490 of the publication.

This publication takes into account that up to 30% of people with mental disorder will have a co-morbid long term physical health condition that requires primary care to collaborate with other health care service providers such as general hospital and community health services (G. O. Ivbijaro et al 2008; T. Edwards et al 2012; C. Naylor et al 2012; G. Ivbijaro 2012; G. O. Ivbijaro et al 2014).

This publication supports the re-organisation of mental health services in the Eastern Mediterranean Region from an institutional mental health to a community mental health model of care (B. Saraceno et al 2015; M. Funk and N. Drew 2015; D. Chisholm 2015; R. Gater and K. Saeed 2015).

This publication provides another example of my focus on improving mental health access through the implementation of primary care mental health and sets out principles and a methodology to suggest how change can be scaled up across services and systems.

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APPENDICES

Appendix 1:	General Practice High Level Indicators CCG Report: 08W - NHS Waltham Forest CCG January 2017
Appendix 2:	Ethical Approval (REF08/H0701/92) – Integrating Mental Health into Primary Care
Appendix 3:	Participant Information Leaflets (01/02/2009) - Integrating Mental Health into Primary Care
Appendix 4:	Social Distance Questionnaire
Appendix 5:	Confidence Questions for GP’s
Appendix 6:	Confidence Questions for Psychiatrists
Appendix 7:	Confidence Questions for Service Users
Appendix 8:	Study Consent Form