

The influence of contact with mental health services on carers' help-seeking attitudes: Contribution of stigma and affective state

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B Psych (Hons)

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Statement of Originality

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

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Acknowledgment of Authorship

I hereby certify that the work embodied in this thesis contains a manuscript of which I am a joint author. I have included as part of the thesis a written statement, endorsed by my supervisor, attesting to my contribution to the joint publication/s/scholarly work.

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(Supervisor)

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Table of Contents

Statement of Originality	ii
Acknowledgment of Authorship	iii
Acknowledgements	iv
Abstract.....	1
Reference style used in this thesis	3
Terminology used in this thesis	3
Critical literature review.....	4
<i>Stigma and mental illness</i>	4
<i>Help-seeking for mental illness</i>	12
<i>Predictors of mental health help-seeking</i>	18
<i>Stigma and carers' helping behaviour</i>	22
<i>Stigma and mood</i>	22
<i>Carer involvement in treatment</i>	23
<i>Mental health carer wellbeing</i>	25
<i>Conclusion</i>	25
Manuscript	27
Abstract.....	28

Introduction	30
Method.....	36
<i>Participants</i>	36
<i>Procedure</i>	36
<i>Measures</i>	36
<i>Statistical analyses</i>	38
Results	39
<i>Demographics</i>	39
<i>Experiences of MH services</i>	42
<i>Help-seeking attitudes</i>	43
<i>Stigma and affective state</i>	44
<i>Mediation analyses</i>	45
<i>Post-hoc power analysis</i>	48
Discussion.....	48
<i>Limitations</i>	53
<i>Conclusions</i>	54
References	56
Appendix A: Journal Submission Details and Guidelines for Authors	66
Appendix B: University of Newcastle Human Research Ethics Approval	78
Appendix C: Online Survey	84

Appendix D: Detailed description of mediation analyses	100
References.....	106

Abstract

Objective: Involving family members and friends in the treatment of mental illness has gained momentum in recent years and forms part of recommended practice. Despite this, little is known about the impact of this collaboration on the mental health stigma and help-seeking attitudes of family members or friends of people with a mental illness. Family member and friend stigma and aversion to help-seeking could potentially have a detrimental impact on the consumer. The first portion of this thesis critically reviews the literature surrounding mental health stigma, help-seeking behaviour and barriers, and the involvement of family members and friends. The second portion reports on a preliminary study investigating an identified gap in the literature: the impact of family member or friends experiences with mental health services on help-seeking, stigma, and affective state.

Method: Fifty-nine self-identified family members or friends of individuals with a mental illness completed an online survey. Data included demographic questions about themselves, the consumer of mental health services and their experience with services, as well as measures of stigma, help-seeking attitudes and affective state.

Results: Correlation analyses revealed significant relationships between experiences of mental health services and stigma, help-seeking attitudes and affective state. Family members or friends who reported negative experiences accessing mental health services on behalf of their consumer showed reduced help-seeking attitudes. Mediation analyses

revealed that both stigma and affective state independently significantly reduced the association between positive experiences of services and more positive help-seeking attitudes. When all three variables were included in the same regression model, predicting help-seeking attitudes, stigma was the only significant contributor to the model.

Conclusions: Results emphasise the importance of mental health services establishing positive engagement with carers of consumers in mental health treatment, as this contributes to more positive attitudes towards help-seeking. It is possible that stigma mediates this relationship, with negative experiences of services exacerbating mental health stigma in carers. These preliminary findings provide direction for future research, clinical practice, and service delivery. It is highly likely that building positive interactions between mental health services and carers will facilitate better access to care for consumers and improve clinical outcomes.

Keywords: stigma, help-seeking, carers, mental illness, mental health services

Reference style used in this thesis

This thesis is written with intention to submit for publication in the Australian and New Zealand Journal of Psychiatry. As such, the thesis is written in line with the journal's preferred style: Sage Harvard. This reference style applies to the entire document.

Submission guidelines for the relevant journal are included in Appendix A.

Terminology used in this thesis

Within mental health services, the term 'consumer' is often used to refer to an individual with a psychological problem or mental illness who is accessing services.

Various other terms that are often used include patient, client or labelling according to illness. The term 'carer' is defined as a person who has a close relationship with a consumer, who provides support to the consumer or whose life is affected by their relationship with the consumer (Pirkis et al., 2010). This carer could be a parent, sibling, child, friend, or another relative. In this context, carer does not refer to a person receiving payment for mental health care provision. For the purpose of this thesis, family members and friends of consumers are referred to using the term *carer* and the individual with the mental illness is referred to as the *consumer*. The term consumer was chosen as this thesis directly relates to mental health service provision and the implications of this.

Critical literature review

Stigma and mental illness

The experience of stigma has been an ongoing challenge for those suffering from a mental illness (MI), despite some improvements in the general public's knowledge and attitudes with regard to MI (Reavley and Jorm, 2011a; Schomerus et al., 2012).

Prevailing views towards those with a MI have improved but remain largely negative, and the experience of stigma continues to be a common concern of those experiencing a MI (Link and Phelan, 2001). One commonly accepted definition of stigma is the situation 'when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold' (p. 367; Link and Phelan, 2001). Stigma is often broken down into many different aspects. Definitions obtained from Clement et al. (2014) identify *anticipated stigma* as anticipation of being treated unfairly or stigmatised against by others.

Experienced stigma is when unfair treatment or stigmatising attitudes are encountered.

Perceived stigma is when one believes that views of the general public towards them regarding their health condition are stigmatising. *Personal or internalised stigma* refers to the beliefs about the health condition held by the individual which are often internalised society views (Griffiths et al., 2008; Reavley and Jorm, 2011b). For sufferers of MI, the stigma associated with their disorder can be more difficult to manage than the illness itself (Day et al., 2007). Stigma can have significant effects on

mental health (MH) outcomes. It is one of the main factors that discourages people from accessing services, leads to increased difficulties securing employment and accommodation, and presents difficulties in interpersonal relationships (Corrigan, 2004; Watson and Corrigan, 2001; Barney et al., 2006). Experiences of stigma negatively impact on self-esteem and contribute to social isolation from peers (Mental Health Council of Australia, 2011).

Stigmatising attitudes remain present in society, as recently illustrated in a large ($n = 6019$) Australian study (Reavley and Jorm, 2011b). This cross-sectional study investigated stigmatising attitudes across the general population. Telephone interviews were conducted using one of six vignettes of an individual with a specific MI. The interview investigated the individual's presentation, treatments, causes and risk factors, as well as the participant's stigmatising attitudes and contact with people similar to the individual in the vignette. Interestingly, stigmatising beliefs varied according to diagnoses. While social phobia was identified as a sign of personal weakness in the individual, schizophrenia was associated with dangerousness, unpredictability and a desire for increased social distance. Perceived stigma was also higher than personal stigma, suggesting that participants generally assume that other people hold more stigmatising beliefs than themselves. These Australian findings are similar to previous findings in other countries. A review of 41 articles, utilising cross-sectional surveys of the general public, from 14 different countries revealed that while some positive regard

towards those with a MI exists, perceptions of the consumer being dangerous and unpredictable still remain prominent, with a desire for social distance (Angermeyer and Dietrich, 2006).

A variety of initiatives have been implemented to improve community understanding of MI and challenge commonly held stigmatising attitudes (Corrigan, 2004; Watson and Corrigan, 2001; Jorm et al., 2006a). These initiatives tend to focus on three main methods: contact with someone with a MI, education about MI, and protest campaigns which aim to highlight the issues in MI stigma. Corrigan et al. (2001) and Corrigan et al. (2002) found that the protest intervention led to little attitudinal change. In contrast, education and contact groups both led to significant improvements, with the contact group leading to the greatest improvement in attitudes. One thorough systematic review compared the effectiveness of all three methods on reducing stigma towards those with a MI (Corrigan et al., 2012). This review of 72 articles revealed that both contact and education consistently improved the general public's attitude and behaviour towards those with a MI. Face to face contact with someone with a MI led to more improvements in attitude than video contact. The protest approach is the least researched and is not generally supported; the minimal results available indicate that protests have little positive impact on attitudes. The protest approach appears to challenge stigmatising views (Corrigan, 2004), but does not promote the development of more positive attitudes. In fact, it has been suggested protests can induce more

negative attitudes (Corrigan et al., 2001). Education and contact, in contrast, appear to consistently improve attitudes towards those with a MI (Corrigan et al., 2012).

Pinfold et al. (2003) and Schulze et al. (2003) investigated the longer term impact of anti-stigma education interventions in schools. Schulze et al. found that their attitude change was maintained at 1-month follow-up assessment, while Pinfold et al. found that attitude changes were maintained at 6-month follow-up assessment. It is possible that the effects may have diminished over a longer follow-up period, and longitudinal studies would be helpful to investigate this. It is suggested that while education leads to improvements in attitudes, these improvements are not robust and may reduce over time (Pinfold et al.). In contrast, contact with someone with a MI appears to result in lasting improvement of stigmatising attitudes (Corrigan et al., 2001).

A concept related to stigma is *Mental Health Literacy*, a term defined as ‘knowledge and beliefs about mental disorders which aid their recognition, management or prevention’ (p. 244; Wright et al., 2007). Schomerus et al. (2012) conducted a multi-national systematic review of 16 studies investigating MH literacy and attitudes towards MI. Inclusion criteria required that each study had a follow-up period of at least 2 years. Studies were included from 1950 to 2008. The trend emerging from their review was that the general public’s MH literacy had improved, with more accurate knowledge regarding the biological correlates of MI. However, improved MH literacy did not result in greater acceptance, as attitudes towards those with a MI remain negative. Schomerus

et al. suggested that improved knowledge of MI might actually reinforce some of the stigmatising beliefs held by the public. This seems consistent with research showing that identifying mental illnesses as genetic diseases does not change attitudes towards sufferers, and in the case of schizophrenia actually increases stigmatising attitudes (Bennett et al., 2007; Angermeyer and Matschinger, 2005). Angermeyer and Matschinger (2003) also found that labelling an individual with schizophrenia (through a vignette) led to a more negative response, such as a stronger belief that the person is dangerous, and increased fear of, and desire for social distance from, the person. Another systematic review of 33 population studies conducted by Angermeyer et al. (2011) revealed a similar trend. Increased knowledge and acceptance of the biological causes of MI does not reduce stigma and discrimination and, in schizophrenia specifically, increased knowledge actually was associated with a greater desire for social distance. This suggests that improving MH literacy through education can paradoxically exacerbate stigmatising attitudes.

Findings consistently suggest that contact with someone with a MI reportedly reduces stigma within the general population (Corrigan et al., 2012). It would seem logical that health professionals, whose role involves regular contact, should display low levels of personal stigma. However, research into the stigmatising attitudes of health professionals reveals that this is not necessarily the case, and negative attitudes appear to be widespread (Rao et al., 2009). A study by Magliano et al. (2004) revealed

that nurses treating individuals with schizophrenia, as well as relatives of the consumer shared similar beliefs to the general public that the individual was unpredictable and dangerous. Magliano et al. (2004) and Horsfall et al. (2010) suggested that high levels of contact with individuals with a MI, particularly in the acute phases of the illness, can actually cause more negative attitudes in carers and MH professionals alike.

Schulze (2007) reviewed the complex relationship between stigma and MH professionals, who are often campaigners in anti-stigma initiatives yet also commonly both stigmatisers and recipients of stigma themselves. They reported mixed results. Sixteen of the 24 studies comparing the attitudes of MH professionals with the general public suggested that health professionals hold views towards those with a MI that were either equal to or more negative than those held by the general public. Review of qualitative studies also revealed that MH professionals are often a source of stigma and discrimination for consumers and their families. Reavley et al. (2014) conducted a large survey comparing stigma in the general public against a range of health professionals. General practitioners reflected the most negative personal stigmatising attitudes of the health professionals. The general public reflected greater stigma in the personal stigma measures and some aspects of perceived stigma, although perceived stigma differences were minor. A review conducted by Wahl and Aroesty-Cohen (2010) revealed inconsistent findings between studies. In 5 of the 19 studies, the attitudes of health professionals were largely negative compared to the general population. In the

remaining 14 studies, the attitudes of health professionals were largely positive compared to the general population. Further, mixed results were obtained within the included studies, with the negative conclusions still reflecting some positive attitudes and vice versa. Wahl and Aroesty-Cohen shared Schulze's previous conclusion that the results were mixed and inconclusive. The inconsistency of research within the field of stigma reflects the complicated nature of stigma itself (Wahl and Aroesty-Cohen, 2010). While the health professionals did not always have more negative views than the public, they were not consistently more positive, suggesting that contact alone does not necessarily lead to less stigmatising and improved attitudes.

Stigma research in carers of people with a MI typically focuses on perceived or experienced stigma, as a result of their relationship with someone with a MI. This type of stigma is often referred to as *stigma by association*, *family stigma* or *courtesy stigma* (Larson and Corrigan, 2008). Stigma often generalises to relatives and friends of those with a MI, and can be an experience of blame or responsibility for their relative's MI (Larson and Corrigan; Lefley, 1989). Drapalski et al. (2008) found that 36% of their family respondents reported experiencing some stigma from the general public. This finding was similar to Angermeyer et al.'s (2003) study of courtesy stigma where 65.3% of participants described at least one incident of directly experienced stigma as a result of their relative's MI. A qualitative study of family stigma by van der Sanden et al. (2014) revealed both perceived and experienced stigma in families of individuals with a

MI. Phelan et al. (1998) reported that approximately half of their participants concealed their relative's MI, with 40% telling no one about the hospitalisation. However, it is difficult to conclusively attribute this to experienced stigma rather than anticipated stigma.

Little is known about the personal stigmatising beliefs held by carers of consumers of MH services. This is surprising, as the carers' close contact and caring role mean that any personally-held stigmatising attitudes potentially have significant impact on the consumer. Research has shown that contact with someone with a MI significantly reduces stigmatising attitudes so it is reasonable to assume that this is also the case for carers (Corrigan et al., 2014). A study by Griffiths et al. (2008) commented on this trend and found that personal stigma was lower in those who reported having a family member or friend with depression; however, perceived stigma was higher. Additionally, Wong et al. (2009) reported low personal stigma in their study of family members of people with early psychosis, although this study used a small sample ($n=19$). In contrast, Thornicroft et al. (2014) reported that the family is actually a common source of discrimination and stigma against the consumer, which can be internalised by the individual with the MI (Moses, 2010). These limited and inconclusive findings emphasise the lack of information known about carers' stigmatising attitudes.

Help-seeking for mental illness

Help-seeking refers to one's attitudes towards seeking support and intervention, in this case, for a psychological problem. Help-seeking attitudes are considered a reliable predictor of treatment seeking, as intentions to seek help are associated with enacted help-seeking behaviour (Mackenzie et al., 2006; ten Have et al., 2010). Help-seeking can be a complex process involving identifying and acknowledging a problem, a willingness to seek help and having the knowledge of available supports (Rickwood et al., 2007). Many factors contribute to the likelihood that one will access health services when needed. These factors include age, gender, certain personality variables, financial resources, services accessibility and the specific illness (Mackenzie et al.; Barwick et al., 2009; Corrigan et al., 2014). Help-seeking research makes distinctions between *formal* and *informal help seeking*. Formal help-seeking refers to accessing professional help, whereas informal help-seeking refers to seeking support from carers.

Help-seeking attitudes and behaviours remain a focus of MH research as many people living with MI may benefit from treatment, yet do not access formal care (Corrigan et al., 2014). A large-scale investigation by Blanco et al. (2008) compared psychiatric disorders, sociodemographic details and help-seeking in college and non-college students through a national survey of alcohol and related conditions. Their survey revealed that less than 35% of young American adults aged 19-25 years with a

MI accessed treatment in the previous 12 months. Similarly, Lally et al.'s (2013) study of Irish university students found that while 48% ($n = 356$) reportedly believed they needed help for a psychological problem only 15% ($n = 109$) accessed professional support in the previous 12 months. This trend has also been observed in Australian samples with only 40% of people with a psychological problem (Andrews et al., 2001) and 34.8% of people who met criteria for a MI (Burgess et al., 2009) accessing professional help in the previous year. Once someone has engaged in treatment, ongoing adherence is also problematic with around 50% of consumers dropping out of therapy within the first three sessions (Watson and Corrigan, 2001; Barrett et al., 2008). Only one in four individuals with psychosis adhere to treatment regimes (Nose et al. (2003).

Not seeking treatment for a MI is associated with adverse MH outcomes, as symptoms and functioning can be improved through professional intervention (Watson and Corrigan, 2001). Similarly, if consumers do not continue treatment once it has commenced, they may not experience symptomatic relief (Barrett et al., 2008; Nose et al., 2003). Boonstra et al. (2012) conducted a systematic review of 16 studies investigating the impact of untreated psychosis on outcomes and negative symptoms. Shorter periods of untreated psychosis were associated with less severe negative symptoms particularly when the untreated period was less than nine months.

Despite the poor adherence rates observed in clinical interventions, perceptions about help-seeking have improved and it is widely recognised that professional support for MI is effective and often necessary (Gulliver et al., 2012; Goldney et al., 2005). An Australian study compared awareness of MI and beliefs about treatment over 8 years, and found that across time the general public increasingly endorse the efficacy of professional help and believed that dealing with a MI alone is harmful (Jorm et al., 2006b). However, findings also identify that beliefs of the general public widely support accessing both informal and formal sources. Reavley and Jorm (2011a) conducted a survey of 6019 Australians, using a vignette of someone with a specific MI. When participants were required to rate various interventions as helpful or harmful, the GP was rated as helpful by between 77% and 90% of people. Counsellors were rated as helpful by 86.4 to 91.9% of participants. Psychiatrists were rated as helpful by 74.1 to 88.1% of participants, and psychologists were rated as helpful by 75.3 to 85.2% of participants. In the survey by Reavley and Jorm (2011a) speaking with family was rated as helpful by between 66.2 and 74.9% of participants and seeking help from friends was considered helpful by 74.8 to 85.5% of participants. The general public's support of both informal and formal sources of help was also found in a German population study where participants were asked open ended questions about recommending treatments for someone with depression or schizophrenia. Between 47 and 67% of participants

recommended informal support as well as 65 to 86% of participants recommending formal support (Angermeyer et al., 2001).

Informal help-seeking is one of the first lines of support sought by consumers of MH services (Komiti et al., 2006; Rickwood et al., 2007). Brown et al. (2014) investigated informal and formal help-seeking in a 12 month period. Participants completed a survey, and were included in analyses if their responses indicated a likely psychological problem. Findings showed that 36.1% of participants reported accessing informal help, whereas only 17.5% reported accessing formal help. Additionally, two thirds of the participants who accessed informal help did not access any formal help. In Komiti et al.'s (2006) research 87% of 300 respondents reported that they would prefer to access informal over formal support. Jorm et al. (2000a) surveyed 422 members of the general public who had reported high levels of depressive symptoms 6 months prior. Participants were asked what actions they had taken to manage their mood. Informal help-seeking was highly favoured, with 50% of participants accessing support from their friends and 46% accessing help from their family. Yap et al (2011) found similar results in a large survey of young people aged 12-25, 30.4% of whom had a family member or close friend with a psychological problem. The vast majority of the participants (87%) spontaneously reported that they had done something to help this family member or friend.

Griffiths et al. (2011) conducted a qualitative study investigating the experiences of MH consumers who accessed informal help from their carers. 84.4% of respondents in the study reported at least one positive from accessing informal help. These perceived positives included: social support, speaking with someone who already knew them and some of their background, being able to ‘offload’, the positive qualities of the carer (such as trustworthy or caring), and improved understanding by the carer. However, there were also a number of disadvantages reported by 39.1% of participants. The most common of these was the experience of stigma from their carer. Additional disadvantages included receiving inappropriate support, the carer having insufficient knowledge or training, feeling as though the participant was burdening the carer, that their relationship would be affected and the negative personal attributes of the carer. A qualitative study by Y-Garcia et al. (2012) found similar results. They conducted focus group discussions with 116 people who had experienced depression and accessed help from family. Four themes emerged regarding the participants’ negative experiences of informal help-seeking: feeling labelled, feeling judged, feeling lectured and feeling rejected. People with depression often report that social support is laden with rejection and a lack of understanding from carers (Vollman et al., 2010). Accessing support from carers has also been referred to as ‘unhelpful’ and ‘toxic’ (p. 7; Christensen et al., 2006). Angermeyer et al. (2001) suggested that the lay person’s opinion may strongly influence the consumer’s help-seeking tendencies. Thus, when the help-seeking

experience is unhelpful and stigmatising, future help-seeking is inhibited, resulting in worse outcomes for the consumer. Clearly, accessing informal support can be a helpful process but does carry some risks.

Research investigating the help provided by carers revealed mixed results. Yap et al. (2011) asked participants aged 12-25 to comment on how they helped a friend or relative with a MI. Of the 608 respondents, 41% reported that they spoke with the person and 33% reported that they provided general support. However, only 15% encouraged professional help-seeking, and 11.3% reported that they did not provide help at all. When prompted, 45% of participants reported that they spoke to their friend or relative firmly about getting their act together and 6% reported encouraging alcohol consumption to help. Yap et al. (2012) also reported that 23% of participants believed that encouraging professional help was not helpful advice, while 34% believed that talking firmly to their relative or friend was helpful.

Studies investigating the helping behaviour of the general public for those with a MI revealed overall poor results, suggesting that the public's ability to provide adequate help and support is limited. Rossetto et al. (2014b) investigated helping behaviour of the general public. Scoring was based on the ALGEE acronym from the Mental Health First Aid (MHFA) training, which aims to educate the general public about how to help people with a MI (Rossetto et al.). Participants were asked to comment on how they could be of assistance to a hypothetical person with a MI. While 50% of participants

mentioned accessing professional help and 38.2% participants mentioned talking to or listening to the person, no other help was articulated. When asked how they have helped someone they know with a similar problem 37.4% of participants reported talking with or listening to the person, 66.6% mentioned giving support or information, and 42.6% mentioned encouraging some professional support. These results were similar to those of Yap and Jorm (2012) where the most frequent actions included talking/listening, providing support and information and encouraging professional support. Again, this finding was consistent with Jorm et al. (2005) in their survey of 3998 Australians asking how they would help if the person in the vignette presented was a family member or friend. The most common responses were to talk/listen to the person and encourage professional support. However, as with the previous studies, responses reflected inadequate helping behaviour.

Predictors of mental health help-seeking

Factors that contribute to the likelihood that one will access professional psychiatric help are well researched and there are many identified variables that can contribute to one accessing help for a psychological problem (Corrigan et al., 2014). MH literacy and beliefs about treatment efficacy are two factors that can help predict treatment use (Corrigan et al.). Wrigley et al. (2005) found a strong positive relationship between believing the treating professional would be unhelpful and reduced likelihood to access help. Beliefs about the helpfulness of the intervention also predicted helping behaviour

(Yap and Jorm, 2012). This finding was consistent with Komiti et al. (2006) who found that help-seeking tendencies and likelihood could be predicted by attitudes regarding accessing MH treatment and the effectiveness of the treating professional. Jorm et al. (2000b) investigated whether initial beliefs about the helpfulness of an intervention predicted its use in a 6 month follow-up survey of 422 Australians. This study yielded mixed results, with perceived helpfulness predicting use for some, but not all, interventions. Being able to correctly identify a MI is also associated with improved help-seeking and treatment preferences in young people aged 12 to 25 years (Wright et al., 2007).

Research investigating the relationship between stigmatising attitudes and help-seeking tendencies abounds with conflicting conclusions (Barney et al., 2006). Barney et al. argue that this arises from the complex nature of stigma and variations in how research studies measure stigma. Barney et al. (2006) investigated the impact of personal and perceived stigma on help-seeking likelihood of depression in a survey of 1312 randomly selected Australians. They found that both types of stigma impacted on help-seeking, reducing the likelihood that someone would access any source of professional help. Wrigley et al. (2005) also found that increased perceived stigma was associated with poorer attitudes towards help-seeking in general. Barney et al. (2009) conducted focus groups with depressed adults, exploring stigma and help-seeking. Qualitative analyses revealed that concerns about stigma inhibit the individual from

accessing both formal and informal help. Corrigan (2004) discussed the relationship between stigma and help-seeking, reporting that there is a strong negative correlation between the two factors.

In contrast, Schomerus et al. (2009) compared the impact of perceived stigma on the individual seeing a psychiatrist, and found that perceived stigma was not associated with help-seeking intentions. This result applied to both the general public and those who had experienced depression. However, the help-seeking behaviour assessed for their study was specifically seeking help from a psychiatrist, which may not generalise to other health professionals. Lally et al. (2013) surveyed 735 university students, differentiating between personal and perceived stigma. They found that increased personal stigma was associated with decreased help-seeking intentions. However, there was no relationship between perceived stigma and help-seeking.

Clement et al. (2014) conducted a systematic review of 144 studies investigating the relationship between stigma and help-seeking. MH related stigma had a small to moderate negative impact on help-seeking. Their investigation of qualitative studies also revealed five main themes that underlie the relationship between stigma and help-seeking. The themes included:

‘(1) dissonance between a person’s preferred self-identity or social identity and common stereotypes about mental health; (2) anticipation/experience of negative

consequences; (3) need/preference for non-disclosure; (4) stigma-related strategies used by individuals to enable help-seeking; and (5) stigma-related aspects of care that facilitate help-seeking' (p. 11; Clement et al. (2014).

Having contact with MH services is also likely to influence future help-seeking tendencies. ten Have et al. (2010) investigated the attitudes towards help-seeking in a large sample ($n=21,425$) drawn from the general population of six European countries. Previous contact with MH services was associated with more positive help-seeking attitudes and less reluctance to talk about problems with a professional. However, previous service use was not associated with greater perceived effectiveness of treatment. In fact, 30% of people who had previously used services believed that professional help was worse than, or equal to, no help. Smith et al. (2002) also found a significant relationship between previous MH service use and positive attitudes towards help-seeking. This result was also obtained by Nose et al. (2003) in their systematic review of treatment non-adherence studies in psychosis. In their review of 103 studies insight accounted for non-adherence and adherence in 17 studies. Previous contact with services was associated with adherence in 8 studies. It is anticipated that attitudes towards help-seeking are influenced by history of service use and whether it was found to be helpful or not (Jorm et al., 2000b)

Stigma and carers' helping behaviour

Yap and Jorm (2011) investigated the role of stigma on the help provided by young people aged 12 to 25 years to family or friends with a MI. This study used a vignette design. Young people's stigmatising attitudes influenced the type of help offered. For example, young people who believed the person was weak were more likely to talk firmly to the person or suggest drinking alcohol to help. Additionally, a desire for social distance was associated with less helpful interventions. Interestingly, if the person in the vignette was perceived as dangerous the participant was more likely to recommend seeing a doctor. In an Australian survey Jorm et al. (2005) found that attributing negative qualities towards the individual depicted in a vignette was associated with less encouragement to access professional help and less personal support being provided. Jorm et al. (2005) also found that personal stigma was associated with less help and support being offered. Utilising data from the 2011 Australian National Survey of Mental Health Literacy and Stigma, Rossetto et al. (2014a) found that the tendency for people to provide unhelpful responses to a carer with a MI was associated with stigmatising attitudes, believing in recovery without professional help, a strong desire for social distance, and believing that the person was weak, not sick.

Stigma and mood

The impact of stigma on the stigmatiser's own affective state is an area that is largely neglected apart from two studies. Masuda et al. (2009) investigated the impact

of stigma on the stigmatiser themselves through an online survey. They found a positive correlation between stigmatising attitudes and psychological distress. Masuda and Latzman (2011) expanded on this previous work by differentiating between two distinguishable components of MH stigma. The first related to the treatability and course of MI, labelled *course/origin*, the second related to people with a MI being dangerous, unpredictable and difficult to engage with, labelled *exclusion*. Only the course/origin factor was significantly associated with psychological distress.

Carer involvement in treatment

Family involvement in the treatment of MI has gradually evolved over the last 50 years (Hatfield, 1994). Family members can play a significant role in the engagement with, and therefore efficacy of, treatments (Mueser et al., 2002). Research has consistently identified that involving and collaborating with carers is a crucial element of the recovery process and reduces relapse, improves treatment participation, improves quality of life and social adjustment, and generally leads to more positive outcomes for the consumer (Mental Health Council of Australia, 2003; Cleary et al., 2006; Mottaghipour et al., 2006; Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders, 2005). Given carers' critical role in consumer outcomes, it is recommended that their involvement in treatment becomes a routine aspect of MH services in Australia (Mental Health Council of Australia, 2003; The Department of Health, 2010;

Lloyd and King, 2003) and services are encouraged to involve carers as a resource to assist maintenance of consumer health (Goodwin and Happell, 2007a). National standards for MH services recommend that both consumers and their carers are involved in all aspects of treatment and care; however, identifying how this collaboration could best be achieved in practice is ongoing (The Department of Health, 2010; Cleary et al., 2006; Department of Human Services, 2006).

In line with the recent emphasis on the involvement of carers in MH services, there has also been a surge of research investigating the quality of their involvement. An Australian qualitative study by Goodwin and Happell (2007a) revealed inconsistent experiences with services. Carers appeared to be largely affected by their interactions with MH nurses, both positively and negatively. Carers largely felt that they were not encouraged to engage in services. They attributed this to staffing issues, where staff are unable to meet the demands of their roles and interact adequately with carers (Goodwin and Happell, 2007b). In their discussions with carers of consumers, Lammers and Happell (2007) also identified that carers felt largely uninvolved with services. This contributed to feelings of isolation in finding support for themselves and the consumer. This finding is similar to that obtained in a survey by Cleary et al. (2005), who found that over 50% of carers of MH inpatients felt uninformed about treatment and resources. Research from carers consistently suggests that they feel uninformed, uninvolved and isolated by MH services.

Mental health carer wellbeing

Carer wellbeing is often compromised, with both physical and emotional impacts identified in providing care for someone with a MI (Lefley, 1989; Phelan et al., 1998; Wynaden, 2007). Carers in a caregiving role exhibit significant levels of psychological distress and ongoing emotional conflict (Ostman and Lars, 2002; Jeon and Madjar, 1998), with rates approaching around 40% in relatives of people with eating disorders specifically (Whitney et al., 2007). An Australian survey of 508 MH carers revealed that 71% of carers believe their health is adversely impacted by caring for their loved one (Mental Health Council of Australia, 2012).

Conclusion

There is a vast amount of research focusing on both stigma and help-seeking attitudes in MH (Reavley and Jorm, 2011b; Schomerus et al., 2012). While this research remains ongoing and, at times, inconclusive, it has provided valuable information about how individuals conceptualise MI and approach treatment and interventions (Barney et al., 2006). Additionally, a number of campaigns have attempted to improve attitudes and engagement with services (Corrigan et al., 2012). Unfortunately, this research has not extended to the carers of consumers, and limited information exists about their personal stigmatising attitudes, attitudes towards MH treatment and professional help for the consumer. Accessing carers for support is often the first step by MI consumers and they are a vital part of MH recovery (Komiti et al., 2006). Therefore, knowledge

about the carer's attitudes can have long reaching implications for the consumer's wellbeing and access to treatment. Additionally, while research has identified that carers' wellbeing is often impaired as a result of the caregiving burden (Ostman and Lars, 2002; Jeon and Madjar, 1998), the impact this has on carer stigma and help-seeking is not known. As MH services strive to continue involving carers in treatment it is important that more is known about the implications of this contact, specifically does the nature of the carers' previous contact with MH services on behalf of their consumer influence subsequent help-seeking attempts?

Manuscript**The influence of contact with mental health services on carers' help-seeking attitudes: Contribution of stigma and affective state**

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Abstract

Objective: Involving carers in the treatment of mental illness has gained momentum in recent years and is currently part of recommended practice. Despite this, little is known about the impact of this collaboration on the mental health stigma and help-seeking attitudes of carers of people with mental illness. Family members' and friends' stigma and aversion to help-seeking could potentially have a detrimental impact on the consumer. This preliminary study aims to investigate the impact of family members' and friends' experiences with mental health services on help-seeking, stigma, and affective state.

Method: Fifty-nine self-identified carers of someone with a mental illness completed an online survey. Data included demographic questions about themselves, the consumer of mental health services and their experience with services, as well as measures of stigma, attitudes towards help-seeking and affective state.

Results: Participant ratings were evenly balanced between positive and negative experiences with mental health services. Correlation analyses revealed significant relationships between experiences of mental health services and stigma, attitudes towards help-seeking and affective state. Family members and friends who reported negative experiences accessing mental health services on behalf of their consumer showed reduced help-seeking attitudes. Mediation analyses revealed that both stigma and affective state independently significantly reduced the association between positive

experiences of services and more positive help-seeking attitudes. When all three variables were included in the same regression model, predicting help-seeking attitudes, stigma was the only significant contributor to the model.

Conclusions: Results emphasise the importance of mental health services establishing positive engagement with carers of consumers in mental health treatment, as this contributes to more positive attitudes to help-seeking. It is possible that stigma mediates this relationship, with negative experiences of services exacerbating mental health stigma in carers. These preliminary findings provide direction for future research, clinical practice, and service delivery. It is highly likely that building positive interactions between mental health services and carers will facilitate better access to care for consumers and improve clinical outcomes.

Keywords: stigma, help-seeking, carers, mental illness, mental health services

Introduction

Family involvement in the treatment of mental illness (MI) has gradually evolved over the last 50 years (Hatfield, 1994). Carers can play a significant role in the engagement with, and efficacy of, treatments (Mueser et al., 2002). Carers are often defined as people who have a close relationship with an individual diagnosed with a MI, referred to as *consumers*. This could be parents, siblings, friends, children or relatives who provide support to the consumers, or whose lives are affected by their relationship with the consumer (Pirkis et al., 2010). For the purpose of this study, family members and friends of consumers are referred to as *carers*. Research has consistently identified that involving and collaborating with carers is a crucial element of the recovery process and reduces relapse, improves treatment participation, improves quality of life and social adjustment, and generally leads to more positive outcomes for the consumer (Mental Health Council of Australia, 2003; Cleary et al., 2006; Mottaghipour et al., 2006; Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders, 2005). Given carers' critical roles in consumer outcomes, their involvement in treatment has become a recommended part of routine practice in mental health (MH) services in Australia (Mental Health Council of Australia, 2003; The Department of Health, 2010; Lloyd and King, 2003). Currently, national standards for MH services outline that both consumers and their carers are involved in all aspects of treatment and care (The Department of Health, 2010).

A common concern of those suffering from a MI is the experience of stigma, as prevailing views towards those with MI are largely negative (Link and Phelan, 2001). Stigma is defined as ‘when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold’ (p. 367; Link and Phelan, 2001). The stigma associated with the MI can be more difficult to manage than the illness itself and can have significant effects on MH outcomes (Day et al., 2007). Stigma is regularly cited as one of the main factors that prevents people from accessing services out of fear of labelling or discrimination, as well as increased difficulties securing employment and accommodation (Corrigan, 2004; Watson and Corrigan, 2001; Barney et al., 2006). Research in this area has focused primarily on the stigmatising attitudes of the general public and health professionals (Reavley et al., 2014; Reavley and Jorm, 2011b). Out of this, a number of programs and initiatives have been implemented, aiming to improve community understanding of MI and challenge some of the common stigmatising attitudes held (Corrigan, 2004; Watson and Corrigan, 2001; Jorm et al., 2006a). Research has consistently found that contact with someone with a MI reduces stigmatising attitudes (Corrigan et al., 2012). Given the carers’ close contact with the consumer, it is reasonable to assume carers would hold less stigmatising attitudes. However, while some studies suggest that personal stigma in carers is lower (Wong et al., 2009; Griffiths et al., 2008), it has also been suggested this is not the case (Thornicroft et al.,

2014). Surprisingly little is known about the personal stigmatising beliefs held by carers of consumers of MH services, even though their close contact with consumers can mean that their stigmatising attitudes have potential for significant impact on the consumer.

Help-seeking is a term that refers to one's attitudes towards seeking support and intervention, in this case, for a psychological problem. Help-seeking attitudes are considered a reliable predictor of treatment seeking, with research suggesting that intentions to seek help are associated with behaviour (Mackenzie et al., 2006; ten Have et al., 2010). Help-seeking can be a complex process involving identifying and acknowledging a problem, a willingness to seek help and having the knowledge of available supports (Rickwood et al., 2007). Many factors appear to contribute to the likelihood that one will access health services when needed, however results are inconsistent and inconclusive to date. These factors include age, gender, certain personality variables, financial issues, services accessibility and the specific illness (Mackenzie et al.; Barwick et al., 2009; Corrigan et al., 2014). Additionally, a distinction between formal and informal help-seeking behaviour is also made in research. Formal help seeking refers to accessing professional help, whereas informal help-seeking refers to seeking support from carers.

Many people with a MI do not access services, with Australian research suggesting that in a 12 month period only 30-40% of people struggling with psychological problems access formal help (Burgess et al., 2009). This means that they

are not able to receive the benefits of treatment and their MH outcomes are less favourable (Watson and Corrigan, 2001; Wrigley et al., 2005). Fortunately, willingness to seek professional help for MI has increased across various areas (Angermeyer et al., 2009) and, more specifically, in Australia professional help is perceived as being more helpful than it once was (Jorm et al., 2006b; Goldney et al., 2005). Despite these developments, the proportion of sufferers who access services remains low (Schomerus et al., 2012).

The role of stigma in help-seeking behaviour is a strong focus of MH research. Avoidance of MH services is often attributed to the stigma associated with MI (Watson and Corrigan, 2001). While some results are inconsistent and the exact factors contributing to the relationship are unknown, there appears to be an association between low stigma and increased help-seeking attitude (Clement et al., 2014). This applies to both personal and perceived stigma (Barney et al., 2006; Corrigan, 2004; Wrigley et al., 2005). Qualitative research was conducted by Barney et al. (2009) exploring stigma attitudes and depression, and found that concerns about stigma inhibits one from accessing help from both informal and formal sources.

Informal help-seeking is one of the first lines of support commonly sought out by consumers of MH services (Komiti et al., 2006). Accessing help from carers can be helpful as the consumer feels supported and the carer can guide towards professional help. However, informal help can also be harmful as the consumer can experience

stigma and discrimination from the carer (Griffiths et al., 2011; Y-Garcia et al., 2012). The experience of stigma has previously been identified as a deterrent to seeking treatment so when it is enacted by carers close to the consumer, the impact on future help-seeking can be markedly detrimental. Further, research also suggests that help provided by the general public for psychological problems portends to be of poor quality (Rossetto et al., 2014b). When the carer holds stigmatising attitudes the assistance they provide, or responses they give, to the consumer can be harmful rather than helpful (Jorm et al., 2005; Rossetto et al., 2014a; Yap and Jorm, 2011).

Routinely involving carer in treatment has become a priority within MH services (Mental Health Council of Australia, 2003; Hervey and Ramsay, 2004). While this can lead to more favourable outcomes for the consumer and improved treatment adherence (Hatfield, 1994; The Department of Health, 2010; Cleary et al., 2005; Mottaghypour et al., 2006; Nose et al., 2003), Carers with personal negative attitudes and beliefs about help-seeking could actually impede treatment for the consumer, reducing access to healthcare services (Griffiths et al., 2011; Kitchen Andren et al., 2013). Research attempting to better regulate the involvement of carers in MH services and explore the experiences of carers has been sparse with limited translation to clinical practice (Cleary et al., 2005; Cleary et al., 2006). Existing feedback from carers suggests that interactions with services are typically poor, with carers reporting feeling uninformed, uninvolved and isolated (Lammers and Happell, 2007; Goodwin and Happell, 2007b).

Given that previous contact with services influences the likelihood of one accessing formal support in the future (ten Have et al., 2010), carers who have poor experiences with services could develop more stigmatised attitudes and reduced help-seeking. Currently, the impact of carers' negative experiences with MH services is unknown despite potentially significant consequences for consumers and their willingness to seek treatment and support in the future (Griffiths et al., 2011). The increasing importance of carer involvement in MH services means that greater emphasis needs to be placed on the experiences of this population.

The current study aims to examine a neglected area with potentially significant impact on the current focus of MH services by obtaining information about carers and their experiences with MH services. Specifically, the current study aims to identify whether the carer's experiences of MH services influence their stigmatising and help-seeking attitudes, a relationship that has never been investigated in previous research. Due to the limited research on carers, our hypotheses are based on previous findings relating to consumers. It was predicted that carers who report positive experiences with MH services will report less stigmatising attitudes and a greater likelihood to access services in the future. Additionally, limited studies have investigated the relationship between stigmatising attitudes and the stigmatiser's affective state (Masuda et al., 2009). Therefore, from the current study we are hoping that we will be able to provide more information about the factors influencing help-seeking and stigmatising attitudes.

Method

Participants

Participants were self-identified carers of consumers of MH services who volunteered to complete an online survey. The survey URL was posted online through social media and relevant MH carer websites. Carers read an information statement. Subsequent completion of the online questionnaire was deemed implied consent. Approval to conduct the study was also obtained from the University of Newcastle Human Research Ethics Committee, which is provided in Appendix B.

Procedure

Carers completed an online survey, provided in Appendix C. This consisted of demographic information about the carer and the consumer, items about the carer's contacts with MH services related to their relationship with the consumer, ratings of the valence of the experiences with MH services, and the opportunity to consider and comment on a specific experience they had with services. This was followed by standardised measures described below.

Measures

Day's Mental Illness Stigma Scale (DMISS; Day et al., 2007). The DMISS is a 28-item scale comprised of statements related to MI and people who have a MI, designed to target stigmatising attitudes and beliefs. Respondents rate statements on a 7-point Likert scale. Development studies reveal adequate internal consistency within

each of the seven subscales. Mean scores are calculated for each dimension. For the purpose of the current study, four items were reverse coded (1, 9, 23, and 28) so that a single mean score could be calculated, reflecting overall stigmatising attitude. A higher score suggests more negative attitudes. In the present study the total scale demonstrated excellent internal consistency ($\alpha = .936$).

Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS; Mackenzie et al., 2004). This 24-item scale is an adaptation of Fischer and Turner's (1970) *Attitudes Towards Seeking Professional Psychological Help* that aims to identify the respondents' attitudes towards seeking professional help for a psychological problem. Respondents rate statements on a 5-point Likert scale. Reliability and validity of the scale was investigated by the original authors and deemed adequate with a strong internal consistency of $\alpha = .87$. Questions are based on three factors, which mean scores were calculated for. Items question help-seeking attitudes for both their own psychological problem and beliefs about seeking help in general. A single mean help-seeking score was also calculated for the purpose of this study, and reflected a strong internal consistency ($\alpha = .86$).

Depression-Happiness Scale (DHS; McGreal and Joseph, 1993). This scale aims to assess the affective state of the respondent over the previous seven days through 25 items regarding the respondents' thoughts, feelings and bodily experiences. The scale includes both positive and negative affective states. Respondents rate items on a 4-point

Likert scale. Calculations by the authors of the scale revealed excellent internal consistency ($\alpha = .93$). A total score is calculated, with a higher score reflecting a happier affective state. In the current study, the scale demonstrated excellent internal consistency ($\alpha = .97$).

Statistical analyses

Statistical analysis was carried out using SPSS statistical package version 20.0 (IBM Corp, 2011). The data was prepared for analysis by recoding variables and reverse scoring items so that full scale scores could be used for analysis. Additionally, major incompletions were deleted or imputation of missing values was conducted. We employed individual mean imputation at the scale level which has been shown to be an effective method for similar multi-question psychometric instruments (Shrive et al., 2006). Demographics and responses on the DMISS and IASMHS were analysed using percentage frequencies. The relationship between key variables (DHS, IASMHS and DMISS) and characteristics of the carer were examined. Given that some of the variables were conceptually similar, analyses were conducted to ensure no violations of the assumptions of multicollinearity between the variables ($r \geq .9$: Pallant, 2013). Pearson correlation coefficients were conducted to investigate associations between experiences of MH services, DMISS, IASMHS and DHS. Multiple linear regression analyses were used to gain further information regarding the predictors of help-seeking attitudes and stigma, with potential predictors entered into the model simultaneously.

Additionally, Adjusted R Squared values are reported due to the smaller sample size in our study.

Results

Demographics

There were 58 carer participants, ranging in age from 11 to 66 years ($M = 41.95$, $SD = 12.62$). Responses from the younger carers were checked to ensure authenticity of responses. Table 1 provides frequencies and percentages of demographic characteristics of the carer participants.

Table 1. *Carer demographic information*

Variable	Frequency	Percentage
Gender		
Male	8	13.8
Female	49	84.5
Not stated	1	1.7
Relationship Status		
In a relationship	11	19.0
Married	28	48.3
Single	18	31.0
Not stated	1	1.7
Country		
Australia	30	51.7
USA	15	25.9
UK	8	13.8
Other	5	8.6
Relationship to Consumer		
Parent	17	29.3
Partner	15	25.9
Child	6	10.3
Sibling	7	12.1
Friend	6	10.3
Other	7	12.1
Distance from Consumer		
Same household	29	50.0
Live separately, within 30km	18	31.0
Live separately, over 30km	11	19.0

As shown in Table 1, most carer participants were female Australians, who were either partners or parents of consumers who lived in the same household or close nearby.

Table 2. *Service type reported by carer.*

Service Type	Frequency	Percentage
Private		
Inpatient	5	8.6
Outpatient	15	25.9
Public		
Inpatient	15	25.9
Outpatient	19	32.8
Other	3	5.2

Table 3. *Consumer mental illness, as reported by carer*

Mental Illness	Frequency	Percentage*
Depressive Illness	28	48.3
Bipolar Affective Disorder	21	36.2
Anxiety Disorder	23	39.7
Obsessive-Compulsive Disorder	8	13.8
Trauma Related Disorders (ie. Post Traumatic Stress Disorder)	4	6.9
Eating Disorders	0	0
Substance and Addictive Related Disorders	5	8.6
Personality Disorder	15	25.9
Schizophrenia and other Psychotic Disorders	8	13.8

* Percentages are not cumulative as carers were asked to identify any mental illness that applied.

As shown in Table 2, the services that carers reported contact with was relatively evenly spread, with the exception of private inpatient services. Table 3 also shows the range of consumer diagnoses as identified by the carer. The large amount of multiple diagnoses selected potentially indicates carer confusion regarding the consumer's diagnosis.

Carer ratings of their consumers revealed that the consumers' age ranged from 7 to 70 years ($M = 36.76$, $SD = 16.32$). Consumer gender was evenly represented with 30 males (51.7%) and 28 females (48.3%).

Using Pearson product-moment correlation coefficients, a significant positive correlation existed between the carer's age and stigma (as measured in the DMISS: $r = .31$, $p = .017$). Higher stigma was associated with an older age. There was no correlation between carer age and help-seeking, or the consumer age and stigma or help-seeking. Gender analyses could not be conducted due to unequal representation of gender in the carer sample. There were no differences in stigma or help-seeking according to the consumer's gender. There were no differences in stigma or help-seeking according to living arrangement, or relationship between the consumer and the carer.

Experiences of MH services

When asked to rate their experiences of MH services, 15.5% of carers rated their experiences as neutral. The remaining carers were approximately evenly distributed between negative (39.3%) and positive (44.8%) ratings of their experiences. Review of

the open-ended question also revealed a number of themes. Carers who rated their experiences with MH services as negative often wrote about incidents where they felt uninformed and not included in treatment, or lacking contact from MH services when they were informed contact would be made. This was reflected in examples such as ‘A registered nurse who was overpowering and did not want family involvement would not listen to either myself or her father. Her psychiatrist she has now also does not want family involved’. Another common theme was beliefs by the carer that the treatment provided was inadequate, which was reflected by statements such as ‘They just medicate and discharge. They are of no real help.’ Those who rated experiences of services as positive often mentioned experiences where they were included and involved in the treatment planning. This included comments such as ‘The contact we had was with the doctor. He was very knowledgeable with ways to help and how as a family we would be able to get through this hard time. He gave ways to offer support and also regulated medicine that worked very well for our situation’. Additionally, they commented on times when the consumer was treated with respect, reflected in the following comment: ‘He was treated very well and cared about. Nurses and doctors were very caring to him.’

Help-seeking attitudes

Help-seeking attitudes were measured using the IASMHS. Carers exhibited generally high help-seeking intentions ($M = 3.9$, $SD = .67$ where the scale midpoint was

2). As shown in Table 4, increased help-seeking tendency was significantly associated with less stigmatising attitudes, happier affective state, and positive experiences of MH services.

Table 4. *Correlations between variables*

	Experience with MH Services	Help Seeking	Stigma	Affect
Experience with MH Services	1	.33*	-.38*	.41**
Help Seeking	-	1	-.48***	.43***
Stigma	-	-	1	-.53***
Affect	-	-	-	1

* $p < .05$; ** $p < .01$; *** $p < .001$.

Stigma and affective state

Stigmatising attitudes in carers were measured using the DMISS. Carers exhibited low overall stigmatising attitudes ($M = 3.02$, $SD = 1.05$ where the scale midpoint was 4). As shown in Table 4, increased stigmatizing attitudes were associated with negative experiences of MH services, lower help-seeking attitudes, and a negative affective state.

Affective state was measured using the DHS, which revealed generally positive affect among the carer participants ($M = 68.64$, $SD = 16.61$ where the scale midpoint was 50).

Mediation analyses

It was clear that negative experiences with MH services were associated with lower help seeking. This was investigated using mediation analyses, including stigmatising attitudes and affective state as proposed mediating variables. These analyses were conducted using the Baron and Kenny (1986) method. (A detailed description of the analysis is included in Appendix D). Utilising regression analyses, we first identified that help-seeking attitudes were significantly predicted by experiences with MH services, as shown in Figure 1 (path c). Experiences with MH services were also uniquely associated with stigmatising attitudes (path a), and stigmatising attitudes were significantly associated with help-seeking attitudes (path b). These results fulfilled requirements of a mediation relationship, outlined by Baron and Kenny. A multiple regression analysis predicting help-seeking attitudes revealed that when stigma was included in the model, and was therefore controlled for, experiences with MH services no longer significantly contributed to the model ($\beta = .17$, $p = ns$). Sobel's test confirmed that stigma mediated the effect of experiences with MH services on the help-seeking likelihood, $z = 2.25$, $p = .02$.

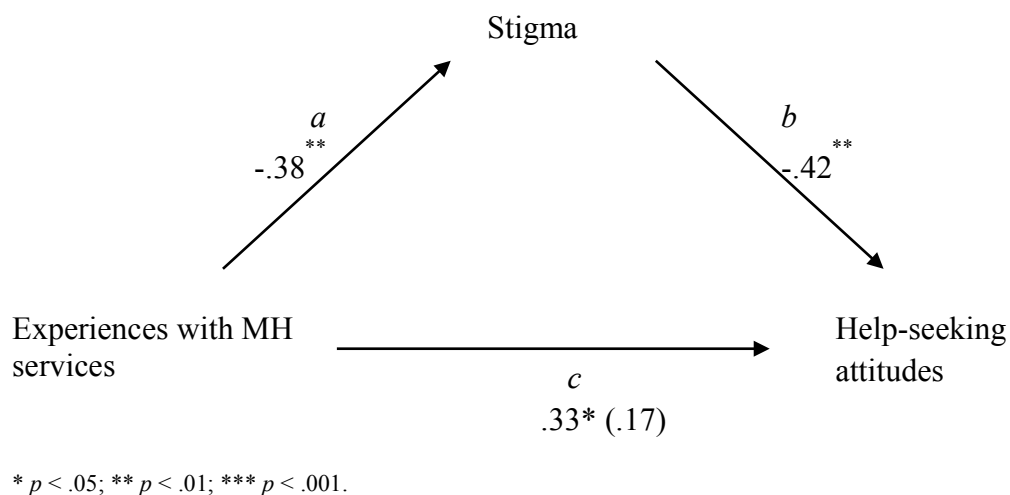


Figure 1. Mediation model with stigmatising attitudes (DMISS) as the mediator.

Another potential mediator of the relationship between experiences of MH services and help-seeking attitudes was affective state. This was investigated using the Baron and Kenny method (1986) and regression analyses. Firstly, experiences with MH services significantly predicted help-seeking attitudes, as shown in Figure 2 (path c). Additionally, experiences with MH services significantly predicted affective state (path a) and affective state also predicted help-seeking attitudes (path b). When both experiences of MH services and affective state were included in the regression analysis model as predictors of help-seeking attitudes, experiences of MH services no longer significantly predicted help-seeking attitudes ($\beta = .18$, $p = ns$). Sobel's test confirmed

that affective state mediated the effect of experiences with MH services on the help-seeking likelihood, $z = 1.14$, $p = .03$.

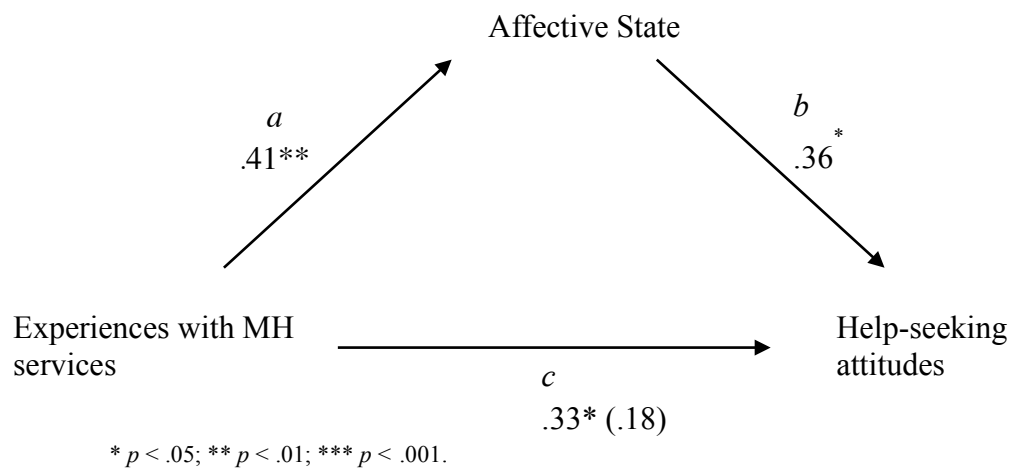


Figure 2. Mediation model with affective state (DHS) as the mediator.

Both stigma and affective state successfully acted as mediating variables on the relationship between negative experiences with MH services and help-seeking attitudes. Multiple regression was therefore utilised to assess the ability of experience ratings, stigma, and affect to predict help-seeking attitudes; and to assess whether stigma or affect was the more powerful mediating variable. With all independent variables included, the total variance explained by the model as a whole was 25.9%, $F(3, 50) = 7.18$, $p < .001$. However, the DMISS was the only measure that made a significant

individual contribution to the model ($\beta = -.33, p = .03$). When all variables were included in the same model and competed with each other, affective state no longer had a significant impact on help-seeking attitudes.

Post-hoc power analysis

Power analyses were conducted using an online calculator by Soper (2015). Post-hoc power analyses revealed that a multiple regression analysis predicting IASMHS with three predictors (experiences of services, DHS and DMISS), 55 participants and an observed adjusted R squared value of .243 had an approximately 94% power. A post hoc analysis of a multiple regression model with dependent variable IASMHS, two predictors (experiences of services and DMISS), 55 participants and an observed adjusted R square value of .256 also had approximately 95% power. Despite the small sample size analyses still yielded strong power.

Discussion

The current study has demonstrated a strong association between carer interactions with MH services and attitudes towards help-seeking on behalf of their consumer. Positive experiences with MH services are associated with more positive help-seeking attitudes. Findings suggest that carer's affective state and stigmatising attitude are the mechanisms through which this association occurs. This means that carers who have poor experiences of MH services are less likely to seek help in the future, which is potentially due to increased stigma and negative affect that arises in the context of

negative experiences with services. Poor experiences of services appear to be associated with carer to feel discouraged and not helped or supported by services, which can result in decreased willingness to access services again.

It is therefore important that providers of MH services recognise that positive interactions with carers of consumers could enhance future engagement with carers. Carer's positive interactions with MH services appear to facilitate a decrease in stigmatizing attitude, and increased likelihood to access services in the future. Additionally, positive experiences with MH services appear to be associated with positive affect, possibly through carers' perceptions of being supported adequately within their roles as carers. These benefits to carers are likely to increase the likelihood that they will actively facilitate their consumer's access to treatment in times of need (Griffiths et al., 2011; Rossetto et al., 2014a).

Further analyses also revealed that when carer stigmatizing attitudes and affective state were placed in the same regression model, therefore competing with each other, stigma had the lasting significant impact. Affective state no longer significantly contributed to the model when stigma was also included. This finding leads to consideration of the predictors of stigma in carers. Previous research consistently confirms that contact with consumers reduces stigmatizing attitudes within the general population (Corrigan et al., 2012). In the case of carers, contact with a consumer is already frequent. It appears that carer's stigma is strongly related to the experiences of

contact with MH services as well. Anti-stigma campaigns directed at carers should aim to enhance positive working relationships with MH services. Future research in this area is warranted, given the previous foci of stigma reduction programs being contact with consumers, provision of psychoeducation, or protest (Corrigan et al., 2012), with little recognition of the potential benefit of increased positive contact with MH services.

The carers' quantitative ratings of their experiences with MH services were balanced between positive and negative. The qualitative open-ended responses similarly reflected both positive and negative experiences. These comments did illustrate the difficulties some carers have engaging with services, despite recommendations that services improve and regulate this contact (The Department of Health, 2010; National Consumer and Carer Forum, 2004). Difficulties engaging in care were reflected in various statements, including; '... I or my husband or her siblings were not considered in the care of her...it was very hard to work out what her treatment plan was or what to do when she was not doing so well as there was no consultation'. Some carers were also unhappy with treatment provided to the consumer, for example 'They just medicate and discharge. They are of no real help'. These results support previous trends and common difficulties that carers have with MH services (Lammers and Happell, 2007; Mental Health Council of Australia, 2009).

Stigma research often differentiates between personal and perceived stigma. The DMISS appears to largely be a measure of personal stigma. Overall, carers had low

levels of stigma, with the mean score falling below the midpoint of the scale. This finding supports research by Griffiths et al. (2008) who also found that personal stigma was lower for those with a family member or friend with a MI. There were some items however that were more strongly endorsed by carers, mainly associated with visibility of MI and the impact of MI on relationships. This finding could be a result of the increased contact that carers have with the consumer, particularly when they are unwell. Additionally, increased contact could have improved their MH literacy meaning that are then better able to recognize MI.

In the current study, there was a strong positive correlation between carer affect and attitudes towards help-seeking. This is the reverse of the pattern observed in help-seeking research with the consumer participants where a decline in emotional health leads to a greater likelihood to access professional help (Rickwood and Braithwaite, 1994; Christensen et al., 2006; Thompson et al., 2004). An inability to cope with increasing MI symptoms is often cited as a reason consumers seek professional help (Thompson et al.); however, the carers are not experiencing this motivation. Worryingly, it appears that the carers who most need support due to their own deteriorating affect are less likely to access MH care on behalf of their consumers. This is consistent with research by Ostman et al. (2000), who suggested that deterioration in the carer's MH was associated with less involvement in the consumer's treatment,

experiencing higher levels of burden from the caregiving role and a greater need for their own support.

The current study investigated attitudes towards help-seeking rather than directly assessing enacted help-seeking behaviour. This is common in MI help-seeking studies. This approach is supported by research suggesting that help-seeking attitude and intention is a reliable indicator of actual help-seeking behaviour and service utilisation (ten Have et al., 2010; Mackenzie et al., 2006). However, Gulliver et al. (2012) argued that this is not necessarily the case, and MI help-seeking behaviour needs further investigation. This is especially relevant for our findings, given that the help-seeking behaviour is on behalf of someone else. Research has suggested that knowledge of, and attitudes towards, MH services often determine help-seeking behaviour of parents responsible for seeking MH support for their children (Raviv et al., 2009), this area requires further investigation.

The current study also investigated the neglected area of the relationship between stigma and affect. There is little research investigating the association between stigma and affective state of the person stigmatising, especially not in carers. Our finding that low affective state was associated with more stigmatising attitudes was consistent with findings within the general population (Masuda et al., 2009; Griffiths et al., 2008). This has profound implications for carers as caring for a loved one with a MI can significantly impair one's physical and emotional health (Ostman and Lars, 2002).

The interactions identified in the current study could have a significant impact on consumers. If carers have poor experiences with services and hold more stigmatising attitudes, the consumers are likely to encounter, and possibly internalise, those attitudes. Further, carers holding strongly stigmatising attitudes towards MI may provide potentially harmful informal support to the consumer, inhibiting the likelihood of the consumer accessing informal or formal help in the future (Yap and Jorm, 2011; Rossetto et al., 2014a). Experienced and internalised stigma in consumers leads to poorer self-esteem, difficulties in interpersonal relationships and less adherence to treatment (Mental Health Council of Australia, 2011; Griffiths et al., 2008). By not improving the quality of contact that clinical services have with carers of consumers, we risk worsening outcomes for the consumer.

Limitations

The cross-sectional survey design of this study also limits the ability to draw conclusions about causal links between variables. Rather, analysis used a mediation model based on previous research highlighting likely pathways worthy of future investigation using a longitudinal design, particularly as mediation models were not designed for use with cross-sectional data. Additionally, carer stigma and attitudes towards help-seeking prior to their interactions with services are unknown. Future research could assess attitudes at the initial stages of carer contact with services, so that pre and post measures can be compared. Further, recruitment used a self-selected rather

than random sample. One criticism of self-selected samples can be the tendency for participants holding a particular set of attitudes to be over-represented therefore resulting in potential biasing of the results. Additionally, only a single item measure was used to identify carers' overall experiences with services which may limit reliability of the findings. Despite these limitations, participants reported a range of experiences with MH services, which were validated with qualitative responses. Lastly, the online survey obtained a mixed nationality sample. This was comprised of mainly Australian and North American carers. The healthcare systems do vary which may mean the carers' experiences of services would be very different. However,, the nationalities that took part in the study have a number of cultural similarities and similar attitudes towards MI and help-seeking (Angermeyer and Dietrich, 2006; Schomerus et al., 2012). Future research with a larger sample size may allow international comparisons to be conducted.

Conclusions

The current study provides valuable information regarding MH stigma and help-seeking in carers of individuals with MI. Importantly, there is a strong association between the quality of experiences carers have with MH services, and stigmatising and help-seeking attitudes. Poor experiences of services is associated with lower help-seeking attitudes through a decrease in affective state and worsening stigma, with stigma having the most powerful influence. Additionally, carer's worsening affective

state also leads to decreased help-seeking, suggesting that overwhelmed carers are least likely to access support for their consumers. Positive relationships between carer carers and MH services are vital to ensure true collaboration that facilitates the best possible outcomes for carers, services, and consumers.

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Appendix A: Journal Submission Details and Guidelines for Authors

Manuscript Submission Guidelines

Australian and New Zealand

Journal and Psychiatry

1. [Peer review policy](#)
2. [Article types](#)
3. [How to submit your manuscript](#)
4. [Journal contributor's publishing agreement](#)
 - 4.1 [SAGE Choice](#)
5. [Declaration of conflicting interests policy](#)
6. [Other conventions](#)
7. [Acknowledgments](#)
 - 7.1 [Funding acknowledgement](#)
8. [Permissions](#)
9. [Manuscript style](#)
 - 9.1 [File types](#)
 - 9.2 [Journal style](#)
 - 9.3 [Reference style](#)
 - 9.4 [Manuscript preparation](#)
 - 9.4.1 [Keywords and abstracts: Helping readers find your article online](#)
 - 9.4.2 [Title page](#)
 - 9.4.3 [Abstracts](#)
 - 9.4.4 [Corresponding author contact details](#)
 - 9.4.5 [Guidelines for submitting artwork, figures and other graphics](#)
 - 9.4.6 [Guidelines for submitting supplemental files](#)
 - 9.4.7 [English language editing services](#)
10. [After acceptance](#)
 - 10.1 [Proofs](#)
 - 10.2 [E-Prints and complimentary copies](#)
 - 10.3 [SAGE production](#)
 - 10.4 [OnlineFirst publication](#)
11. [Further information](#)



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[Back to top](#)

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Editorial: the Editor normally commissions Editorials, however proposals are welcome and should be addressed directly to the Editor. Editorials should address contemporary topics of interest and provide thought-provoking discussion. The presentation of new hypotheses and novel ideas pertaining to psychiatry are welcome.

Debate: These are brief provocative accounts that provide differing perspectives on a single shared issue or topic of discussion. Their focus may be similar to that of editorials and viewpoints but these are generally shorter pieces that make one or two salient points.

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Articles: Articles include Reviews and original Research papers.

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	MANUSCRIPTS						
Category:	Perspectives			Articles		Correspondence	
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Type:	Editorial	Debate	Viewpoint	Review	Research	Commentary	Letter
Description:	The Editor normally commissions Editorials, however	These are brief provocative accounts that provide differing	Viewpoint perspectives are similar to editorials but allow	These papers provide a synthesis of a topic within psychiatry. They	These are papers that report original high quality	This is correspondence typically pertaining to a recent or concurrently published	Correspondence to the Editor is welcomed and encouraged on any aspect of

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Word Count:	2000	1200	1200	4000-7500	5000	800	400
Max Refs:	5	5	5	100	50	5	3
Abstract	No	No	No	Yes	Yes	No	No

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[Back to top](#)

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[Back to top](#)

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[Back to top](#)

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[Back to top](#)

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[Back to top](#)

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[Back to top](#)

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[Back to top](#)

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Objective: questions addressed; principal aims of a review.

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Results: main findings.

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9.4.5 Guidelines for submitting artwork, figures and other graphics

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Tables: Tables should be self-contained and complement, but not duplicate, information contained in the text. Tables should be numbered consecutively in Arabic numerals. Tables should be double-spaced and vertical lines should not be used to separate columns. Column headings should be brief, with units of measurement in parentheses; all abbreviations should be defined in footnotes. Footnote symbols: \$, %, §, ', should be used (in that order) and *, **, *** should be reserved for p-values. The table and its legend/footnotes should be understandable without reference to the text.

Figures: All illustrations (line drawings and photographs) are classified as figures. Figures should be cited in consecutive order in the text. Figures should be sized to fit within the column (80 mm), intermediate (118 mm) or the full text width (169 mm).

Line figures should be supplied as sharp, black and white graphs or diagrams, drawn professionally or with a computer graphics package; lettering should be included.

Individual photographs forming a composite figure should be of equal contrast, to facilitate printing, and should be accurately squared. Photographs need to be cropped sufficiently to prevent the subject being recognized, or an eye bar used; otherwise, written permission to publish must be obtained. Magnifications should be indicated using a scale bar on the illustration.

Photographs should be supplied as high-resolution (minimum 300 dpi.) files, saved in eps or tif format. Digital images supplied only as low-resolution printouts cannot be used.

Figure legends: Legends should be self-explanatory and should form part of the manuscript. The legend should incorporate definitions of any symbols used and all abbreviations and units of measurement should be explained so that the figure and its legend are understandable without reference to the text. (Provide a letter stating copyright authorization if figures have been reproduced from another source.)

Colour figures: Colour figures will be published without charge in both the online version and the hard copy of the journal.

9.4.6 Guidelines for submitting supplemental files

This journal is able to host approved supplemental materials online, alongside the full-text of articles. Supplemental files will be subjected to peer-review alongside the article. This journal is able to host approved supplemental material such as audio or video files or datasets, online alongside the full-text of articles. Supplemental files will be subjected to peer-review alongside the article.

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Please note that data supplements are permanent records just like the articles themselves – ie, they may not be altered after they have gone live (been published).

For more information please refer to SAGE's [Guidelines for Authors on Supplemental Files](#).

9.4.7 English Language Editing services

Non-English speaking authors who would like to refine their use of language in their manuscripts might consider using a professional editing service. Visit [English Language Editing Services](#) for further information.

[Back to top](#)

10. After acceptance

10.1 Proofs

We will email a PDF of the proofs to the corresponding author.

10.2 E-Prints and Complimentary Copies

SAGE provides authors with access to a PDF of their final article. For further information please visit [Offprints and Reprints](#). We additionally provide the corresponding author with a complimentary copy of the print issue in which the article appears up to a maximum of 5 copies for onward supply by the corresponding author to co-authors.

10.3 SAGE Production

At SAGE we place an extremely strong emphasis on the highest production standards possible. We attach high importance to our quality service levels in copy-editing, typesetting, printing, and online publication (<http://online.sagepub.com/>). We also seek to uphold excellent author relations throughout the publication process.

We value your feedback to ensure we continue to improve our author service levels. On publication all corresponding authors will receive a brief survey questionnaire on your experience of publishing in *Australian and New Zealand Journal of Psychiatry* with SAGE.

10.4 OnlineFirst Publication

A large number of SAGE journals benefit from OnlineFirst, a feature offered through SAGE's electronic journal platform, SAGE Journals Online. It allows final revision articles (completed articles in queue for assignment to an upcoming issue) to be hosted online prior to their inclusion in a final print and online journal issue which significantly reduces the lead time between submission and publication. For more information please visit our [OnlineFirst Fact Sheet](#)

[Back to top](#)

11. Further information

Any correspondence, queries or additional requests for information on the Manuscript Submission process should be sent to the Editorial Office as follows: To the Editor, Professor Gin S. Malhi c/o Sonia Bartoulzzi, Assistant to the Editor. journal.assist@sydney.edu.au.

[Back to top](#)

Appendix B: University of Newcastle Human Research Ethics Approval**HUMAN RESEARCH ETHICS COMMITTEE****Notification of Expedited Approval**

To Chief Investigator or Project Supervisor:

Doctor Sean Halpin

Cc Co-investigators / Research Students:

Miss Cristen Challacombe

Re Protocol:

Does Experience Count?

**Are Carers' Experiences with Mental Health
Services Associated with Attitudes Towards
Mental Illness and Help-Seeking Behaviour?**

Date:

23-Jul-2014

Reference No:

H-2014-0209

Date of Initial Approval:

23-Jul-2014

Thank you for your **Response to Conditional Approval** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited** review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **Approved** effective **23-Jul-2014**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2014-0209**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress, Reporting of Adverse Events*, and *Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:

In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- ***Monitoring of Progress***

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- ***Reporting of Adverse Events***

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research.

Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.

3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at <https://rims.newcastle.edu.au/login.asp>) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
 - Causing death, life threatening or serious disability.
 - Causing or prolonging hospitalisation.
 - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
 - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
 - Any other event which might affect the continued ethical acceptability of the project.
5. Reports of adverse events must include:
 - Participant's study identification number;
 - date of birth;
 - date of entry into the study;
 - treatment arm (if applicable);
 - date of event;
 - details of event;
 - the investigator's opinion as to whether the event is related to the research procedures; and
 - action taken in response to the event.
6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- ***Variations to approved protocol***

If you wish to change, or deviate from, the approved protocol, you will need to

submit an *Application for Variation to Approved Human Research* (via RIMS at <https://rims.newcastle.edu.au/login.asp>). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook

Chair, Human Research Ethics Committee

For communications and enquiries:

Human Research Ethics Administration

Research Services

Research Integrity Unit

The Chancellery

The University of Newcastle

Callaghan NSW 2308

T +61 2 492 17894

F +61 2 492 17164

Human-Ethics@newcastle.edu.au

RIMS website - <https://RIMS.newcastle.edu.au/login.asp>

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Gra nt Ref
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Appendix C: Online Survey

Demographics

- | | |
|---|--|
| 1. What is your age? | Please Enter: |
| 2. Gender? | Male/Female |
| 3. What is your current relationship status? | <ul style="list-style-type: none"> a. Married b. In a defacto relationship c. In a relationship not living together d. single |
| 4. What is your relationship to the individual with a mental illness? | <ul style="list-style-type: none"> a. I am a Parent b. I am a grandparent c. I am a grandchild d. I am a child e. I am a sibling f. I am a partner g. I am a cousin h. I am an aunt/uncle i. I am a niece/nephew j. I am a friend k. Other (please specify below) |
| 5. What County do you live in? | |
| 6. What state? | <ul style="list-style-type: none"> a. QLD b. NSW c. ACT d. NT |

7. If you live in Australia, What is your postcode?

8. What is your living arrangement with the individual with a mental illness?

e. VIC

f. TAS

g. SA

h. WA

Please enter:

a. We live in the same household

b. We live separately but nearby (within 30km)

c. We live separately but a moderate distance apart (31 – 100km)

d. We live separately and a large distance apart (100-250km)

e. We live separately and a long distance apart (over 250km)

Please Answer The Following Questions about your Family Member/Friend with a mental illness

1. How old is the family member/friend?

Please Enter:

2. Gender?

Male/Female

3. What is their diagnosis?

Please Tick all that may apply:

a. Depressive Disorder (ie. Depression)

- b. Bipolar Affective Disorder
- c. Anxiety Disorders (ie. Panic Disorder)
- d. Obsessive-Compulsive Disorders
- e. Trauma related disorders (ie. Post Traumatic Stress Disorder)
- f. Eating Disorder
- g. Substance and addictive related disorder (ie. Alcohol Use Disorder)
- h. Personality Disorder (ie. Borderline Personality Disorder)
- i. If you are unsure or the disorder does not fit above, please write what you understand the MH problem to be. (Free text)

Terrible

Wonderful

Overall experience of contact with MH services when caring for your family member/friend

Now think of a specific contact you have had with a mental health care provider about your family member/friend

Would you consider this specific contact to have primarily been:

Positive/Negative/Neutral

Please choose the type of service that best describes this contact

- a. Public inpatient unit
- b. Private inpatient unit
- c. Public outpatient service (ie. Community health centre)
- d. Private outpatient service (ie. Private psychologist)
- e. Other... (please specify)
(Free text)

Please provide us with a brief description of this specific contact you had with mental health services, positive or negative. (Please do not provide any identifying details or names of any individuals or services in your description)

1. There are effective medications for mental illnesses that allow people to return to normal and productive lives.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
2. I don't think that it is possible to have a normal relationship with someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
3. I would find it difficult to trust someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
4. People with mental illnesses tend to neglect their appearance.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
5. It would be difficult to have a close meaningful relationship with someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
6. I feel anxious and uncomfortable when I'm around someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	

	<i>Disagree</i>						<i>Agree</i>
7. It is easy for me to recognize the symptoms of mental illnesses.	1	2	3	4	5	6	7
	<i>Completely</i>						<i>Completely</i>
	<i>Disagree</i>						<i>Agree</i>
8. There are no effective treatments for mental illnesses.	1	2	3	4	5	6	7
	<i>Completely</i>						<i>Completely</i>
	<i>Disagree</i>						<i>Agree</i>
9. I probably wouldn't know that someone has a mental illness unless I was told.	1	2	3	4	5	6	7
	<i>Completely</i>						<i>Completely</i>
	<i>Disagree</i>						<i>Agree</i>
10. A close relationship with someone with a mental illness would be like living on an emotional roller coaster.	1	2	3	4	5	6	7
	<i>Completely</i>						<i>Completely</i>
	<i>Disagree</i>						<i>Agree</i>
11. There is little that can be done to control the symptoms of mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>						<i>Completely</i>
	<i>Disagree</i>						<i>Agree</i>
12. I think that a personal relationship with someone with a mental illness would be too demanding.	1	2	3	4	5	6	7
	<i>Completely</i>						<i>Completely</i>
	<i>Disagree</i>						<i>Agree</i>

13. Once someone develops a mental illness, he or she will never be able to fully recover from it.	1	2	3	4	5	6	7
	<i>Completely</i>			<i>Completely</i>			
	<i>Disagree</i>			<i>Agree</i>			
14. People with mental illnesses ignore their hygiene, such as bathing and using deodorant.	1	2	3	4	5	6	7
	<i>Completely</i>			<i>Completely</i>			
	<i>Disagree</i>			<i>Agree</i>			
15. Mental illnesses prevent people from having normal relationships with others.	1	2	3	4	5	6	7
	<i>Completely</i>			<i>Completely</i>			
	<i>Disagree</i>			<i>Agree</i>			
16. I tend to feel anxious and nervous when I am around someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>			<i>Completely</i>			
	<i>Disagree</i>			<i>Agree</i>			
17. When talking with someone with a mental illness, I worry that I might say something that will upset him or her.	1	2	3	4	5	6	7
	<i>Completely</i>			<i>Completely</i>			
	<i>Disagree</i>			<i>Agree</i>			
18. I can tell that someone has a mental illness by the way he or she acts.	1	2	3	4	5	6	7
	<i>Completely</i>			<i>Completely</i>			
	<i>Disagree</i>			<i>Agree</i>			
19. People with mental illnesses do not groom themselves properly.	1	2	3	4	5	6	7
	<i>Completely</i>			<i>Completely</i>			

	<i>Disagree</i>					<i>Agree</i>	
20. People with mental illnesses will remain ill for the rest of their lives.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
21. I don't think that I can really relax and be myself when I'm around someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
22. When I am around someone with a mental illness I worry that he or she might harm me physically.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
23. Psychiatrists and psychologists have the knowledge and skills needed to effectively treat mental illnesses.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
24. I would feel unsure about what to say or do if I were around someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
25. I feel nervous and uneasy when I'm near someone with a mental illness.	1	2	3	4	5	6	7
	<i>Completely</i>					<i>Completely</i>	
	<i>Disagree</i>					<i>Agree</i>	
26. I can tell that someone has a mental	1	2	3	4	5	6	7

illness by the way he or she talks.

Completely

Completely

Disagree

Agree

27. People with mental illnesses need to take better care of their grooming (bathe, clean teeth, use deodorant).

1

2

3

4

5

6

7

Completely

Completely

Disagree

Agree

28. Mental health professionals, such as psychiatrists and psychologists, can provide effective treatments for mental illnesses.

1

2

3

4

5

6

7

Completely

Completely

Disagree

Agree

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

1. There are certain problems which should not be discussed outside of one's immediate family.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
5. If good friends asked my advice about a psychological problem, I might recommend that	0	1	2	3	4

they see a professional.	<i>Disagree</i>				<i>Agree</i>
6. Having been mentally ill carries with it a burden of shame.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
7. It is probably best not to know everything about oneself.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
9. People should work out their own problems; getting professional help should be a last resort.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
10. If I were to experience psychological problems, I could get professional help if I wanted to.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
12. Psychological problems, like many things, tend to work out by themselves.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
13. It would be relatively easy for me to find the time to see a professional for psychological	0	1	2	3	4

problems.	<i>Disagree</i>				<i>Agree</i>
14. There are experiences in my life I would not discuss with anyone.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
15. I would want to get professional help if I were worried or upset for a long period of time.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
17. Having been diagnosed with a mental disorder is a blot on a person's life.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>

20. I would feel uneasy going to a professional because of what some people would think.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>
24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.	0	1	2	3	4
	<i>Disagree</i>				<i>Agree</i>

A number of statements that people have used to describe how they feel are given below. Read each one and indicate the number that best describes how frequently each statement was true for you in the past seven days, including today. Some statements describe positive feelings and some describe negative feelings. You may have experienced both positive and negative feelings at different times in the past week.

For each item, indicate whether the statement is *never true for you* (0), *rarely true* (1) *sometimes true* (2), or *often true* (3).

	0	1	2	3
1. I felt sad	<i>Never</i>			<i>Often</i>
2. I felt I had failed as a person	<i>Never</i>			<i>Often</i>
3. I felt dissatisfied with my life	<i>Never</i>			<i>Often</i>
4. I felt mentally alert	<i>Never</i>			<i>Often</i>
5. I felt disappointed with myself	<i>Never</i>			<i>Often</i>

6. I felt cheerful	0	1	2	3
	<i>Never</i>			<i>Often</i>
7. I felt life wasn't worth living	0	1	2	3
	<i>Never</i>			<i>Often</i>
8. I felt satisfied with my life	0	1	2	3
	<i>Never</i>			<i>Often</i>
9. I felt healthy	0	1	2	3
	<i>Never</i>			<i>Often</i>
10. I felt like crying	0	1	2	3
	<i>Never</i>			<i>Often</i>
11. I felt I had been successful	0	1	2	3
	<i>Never</i>			<i>Often</i>
12. I felt happy	0	1	2	3
	<i>Never</i>			<i>Often</i>
13. I felt I couldn't make decisions	0	1	2	3
	<i>Never</i>			<i>Often</i>
14. I felt unattractive	0	1	2	3
	<i>Never</i>			<i>Often</i>
15. I felt optimistic about the future	0	1	2	3
	<i>Never</i>			<i>Often</i>

16. I felt life was rewarding	0	1	2	3
	<i>Never</i>			<i>Often</i>
17. I felt cheerless	0	1	2	3
	<i>Never</i>			<i>Often</i>
18. I felt life had a purpose	0	1	2	3
	<i>Never</i>			<i>Often</i>
19. I felt too tired to do anything	0	1	2	3
	<i>Never</i>			<i>Often</i>
20. I felt pleased with the way I am	0	1	2	3
	<i>Never</i>			<i>Often</i>
21. I felt lethargic	0	1	2	3
	<i>Never</i>			<i>Often</i>
22. I found it easy to make decisions	0	1	2	3
	<i>Never</i>			<i>Often</i>
23. I felt life was enjoyable	0	1	2	3
	<i>Never</i>			<i>Often</i>
24. I felt life was meaningless	0	1	2	3
	<i>Never</i>			<i>Often</i>
25. I felt run down	0	1	2	3
	<i>Never</i>			<i>Often</i>

Appendix D: Detailed description of mediation analyses

Potential mediation of the experience with MH services on help-seeking likelihood

The question of why overall experience with services impacts on help-seeking be examined using mediation analysis. Baron and Kenny (1986) described mediation as “the generative mechanism through which the focal independent variable is able to influence the dependent variable of interest” (p. 1173). That is, can the effect of the independent variable (experience with services) on the outcome variable (help-seeking intentions) be explained by a mediating variable? Figure D.1 depicts the causal chain involved in mediation.

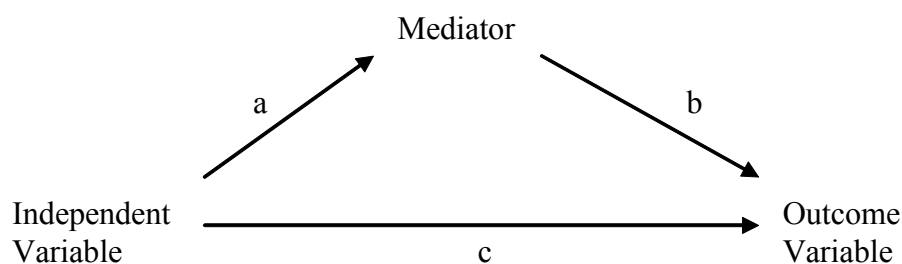


Figure D.1 Causal chain involved in mediation (adapted from Baron & Kenny, 1986).

Baron and Kenny (1986) indicate that a variable functions as a mediator when three conditions are fulfilled. First, the variations in the independent variable significantly account for variations in the potential mediator (Path a in Figure D.1). That is, experiences with MH services must exert a significant effect on the potential

mediator. Second, variations in the independent variable should significantly account for variations in the dependent variable (Path c in Figure D.1). That is, experiences with MH services must account for differences in help-seeking likelihood. Finally, the mediator must affect the dependent variable (Path b in Figure D.1). That is, variations in the mediator should significantly account for variations in help-seeking likelihood. If these conditions are met, then when the effects of the potential mediator are controlled in a regression model by entering both the mediator and the independent variable as predictors, the effect of the mediator on the dependent variable must remain significant while the effect of the independent variable on the dependent variable must lose significance. That is, when the mediator is included as a predictor with experiences of MH services in a regression model, the effect of the mediator on help-seeking likelihood should remain significant, but the effect of experience with services on help-seeking intention should lose effect and no longer be significant. Sobel's (1982) test is used to determine whether any mediating effect is statistically significant. The Sobel's test is a significance test in which a z score is calculated, in order to determine whether the indirect effect of the independent variable on the dependent variable by means of the mediator is significantly different from zero. Two potential mediators were chosen for the current research: stigmatising attitudes and affective state.

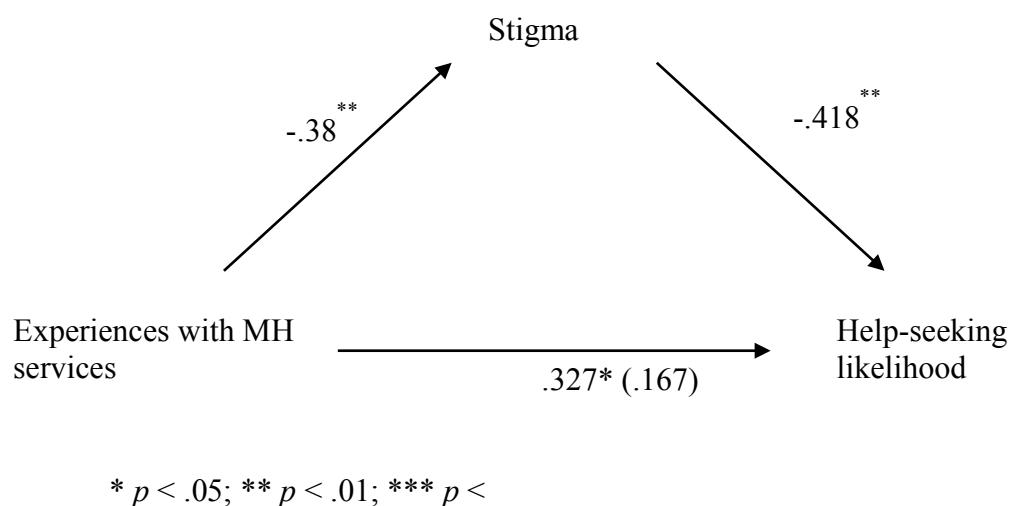


Figure D.2. Mediation model with stigmatising attitudes (DMISS) as the mediator.

I conducted a mediation analysis to explore whether the effect of participants' ratings of their experience with MH services on help-seeking intentions was mediated by stigmatising attitudes. The relationship between variables is depicted in Figure D.2. As the first step in the mediation analysis I conducted a regression analysis investigating whether variations in experiences of MH services accounted for differences in stigmatising attitudes. Experiences of MH services significantly predicted stigmatising attitudes ($\beta = -.38$, $p = .003$). Negative ratings of services were associated with more stigmatising attitudes. This finding fulfilled the first requirement for mediation.

As the second step in the mediation analysis, I conducted another regression analysis identifying whether experiences in MH services accounted for variations in

help-seeking likelihood. Experiences with MH services was a significant predictor of help-seeking likelihood ($\beta = .327, p = .013$). More positive experiences with services were associated with a greater likelihood to seek help in the future. Hence, the second requirement for mediation was met.

As the final step in the mediation analysis, I conducted a regression analysis including both experiences with MH services and stigma as predictors of help-seeking likelihood. This analysis revealed that variations in stigma had a significant impact on help-seeking likelihood ($\beta = -.418, p = .002$), meeting the last requirement for mediation. In this regression model, when stigma was included and therefore controlled for, experiences with MH services no longer had a significant impact on help-seeking likelihood ($\beta = .167, p = ns$). Sobel's test confirmed that stigma mediated the effect of experiences with MH services on the help-seeking likelihood, $z = 2.25, p = .02..$

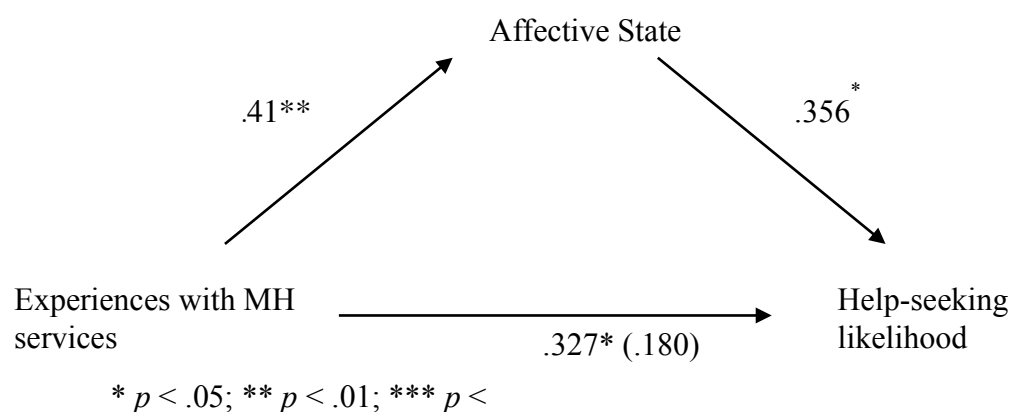


Figure D.3. Mediation model with affective state (DHS) as the mediator.

I conducted a mediation analysis to explore whether the effect of participants' ratings of their experience with MH services on help-seeking intentions was mediated by the carer's affective state, as measured by the DHS. The relationships between these variables are outlined in Figure D.3. As the first step in the mediation analysis I conducted a regression analysis investigating whether variations in experiences of MH services accounted for differences in the DHS. Experiences of MH services significantly predicted affective state ($\beta = .41$, $p = .002$) Negative ratings of services were associated with a lower, more depressed affective state. This finding fulfilled the first requirement for mediation.

As the second step in the mediation analysis, I conducted another regression analysis identifying whether experiences in MH services accounted for variations in help-seeking likelihood. Experiences with MH services was a significant predictor of help-seeking likelihood ($\beta = .327$, $p = .013$). More positive experiences with services were associated with a greater likelihood to seek help in the future. Hence, the second requirement for mediation was met.

As the final step in the mediation analysis, I conducted a regression analysis including both experiences with MH services and DHS as predictors of help-seeking likelihood. This analysis revealed that DHS differences had a significant impact on help-seeking likelihood ($\beta = .356$, $p = .011$), meeting the last requirement for mediation.

In this regression model, when DHS was included and therefore controlled for, experiences with MH services no longer had a significant impact on help-seeking likelihood ($\beta = .180$, $p = \text{ns}$). Sobel's test confirmed that DHS mediated the effect of experiences with MH services on the help-seeking likelihood, $z = 1.14$, $p = .03$.

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