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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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?